

## Special Article

## Health Moral Impasse and Emotional Resilience Enhancement Measures During Covid 19 Pandemic

**Irene Magionou, BSc, MSc**

Nursing in National Public Health Body at Leros, Greece

**Maria Malliarou, BSc, MSc, PhD**

Associate Professor, Nursing Department, University of Thessaly, Greece

**Correspondence:** Irene Magionou, nursing in National Public Health Body at Leros, Greece  
email: iatreioeody@gmail.com

### Abstract

**Aim:** This systematic review aims at presenting the moral impasse factors on health professionals in times of crisis such as pandemic covid-19 but also in the wider framework of the last decade and seeking enhancement methods of mental resilience.

**Methodology:** The sources searched were based primarily on literature Pubmed database. Keywords such as "moral impasse", "mental resilience", "moral distress" and "covid-19" were used. The articles found, without timing, were 102 and here 13 were used. Inclusion criteria were the statistical representation, conclusions were presented additionally coupled with Covid-19 era and moral impasse and the creation of emotional resilience in healthcare sector according to the most recent studies.

**Results:** Factors that contribute to healthcare workers' moral burnout are categorized into three classes: internal factors, external and clinical conditions. The emergence of SARS-CoV-2 revealed new factors for instance the availability and management of limited resources, the lack of protection for themselves and their loved ones, the time and critical cases management, the end of life care, the communication skills between colleagues, the infections' prevention and the imposition of new health protocols, which, added to already existing areas though. Analysis of factors and address them leads to the need for mental resilience enhancement of healthcare providers, which can be carried out at individual, interpersonal, but mainly in administrative-organizational level.

**Conclusion:** The essential and foremost interventions pertain to the perception of ethical problems by the health administration at the time, the provision of understanding and solidarity to the clinical caregivers and their inclusion in the decision-making process but also the common response of the ethical issues that arise in the health sector both in times of crisis and in more general terms.

**Key Words:** moral impasse, mental resilience, moral distress, covid-19, healthcare providers, administrative level.

### Introduction

A variety of studies detect mortality percentages correlation between suicide and occupations with ethical concerns and discomfort in their daily work, classifying health professionals in the 1st place regardless of gender and marital status. (Robertson, 2016). The terms moral distress and moral impasse have an evolving definition first coined by the nursing philosopher Jameton (1984): «The situation that arises when an individual knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right action and in the course of time both amendments and additions

were made for instance» nursing is a moral endeavor and nurses strive to preserve their moral integrity (Kelly, 1998). "Moral distress is defined as psychological disequilibrium, negative feeling state and suffering experienced when nurses make a moral decision and then they cannot follow through with the chosen action because of institutional constraints" (Corley, 2002).

In essence, moral impasse is a state in which clinicians either cannot act in accordance with their ethical beliefs because of external and organizational factors or they are not aware and act with moral responsibility fearing patients'

consequences. In both cases, people who deliver patient care are “stressed” to their mental and emotional limits while according to Julia Nagy, health care providers often feel “obliged” in order to oppose to oath they take to prevent any harm and act in best interest for the patients (Institute for Healthcare Improvement, 2020).

Healthcare professionals have been exposed at risk (HIV/AIDS, SARS, EMPOLA, H1N1) for the last fifty years and currently at Covid 19.

Although, Covid 19 pandemic is not recorded as deathly as HIV or H1N1, the initial inadequate information regarding not only contagion but also pathophysiology of the virus in combination with lack of personal protective equipment constituted severe danger to caregivers (Morley, Grandy & MCarthy, 2020), while at the same time American Nurses Association (2015) revised code of conduct comes against to pre mentioned documentation as on the one hand it highlights the duty of nurses to provide care to patient, family, community and on the other hand points out the obligation for their health and safety promotion (Morley, Grandy & MCarthy, 2020).

From December 2019 to April 2021 SARS-CoV-2 pandemic starting from Yuhan in China, records 129.783.124 Covid 19 confirmed cases worldwide and over 2.8 million deaths (University of Johns Hopkins, 2021) leading to unprecedented health crisis.

During the first wave of the pandemic (January to May 2020) and the second one which still running (since October 2020), the huge amount of Covid 19 cases at treatment centers, the depreciation to chronic disease patients with the purpose of bed capacity increase in those.

The rapid spread virus and the over coverage both in Intensive Care Units (ICU) and Covid 19 wards in conjunction with inadequate health systems in personal protective equipment, human resources, health workforce, experience and building facilities resulted in physical, mental and moral fatigue in every healthcare service.

## Methodology

In this bibliographic review methodology, factors leading to moral impasse in the midst of crisis were investigated but additionally with these in a more general concept and ways to their ethical repair enhancing. Bibliography was searched mainly through the bibliographic database pubmed.gov, using widely the terms «moral impasse», «mental resilience», «moral distress» having likewise keywords such as «Covid 19» and «healthcare providers» without time limit as literature majority belong to a year after 2020 (due to Covid-19). 102 articles were detected which demonstrate primarily small surveys in specific hospitals through questionnaires either to healthcare professionals or to patients and a certain amount of bibliographic reviews. 13 articles were utilized with criteria the statistical representation, conclusions were presented additionally coupled with Covid-19 era and moral impasse but also the creation of emotional resilience in healthcare sector according to the most recent studies.

## Results

World health organization has warned about the potential negative impact of the COVID-19 crisis on the mental well-being of health and social care professionals mentioning that mental health problems commonly include depression and anxiety due to excessive workload but also owing to moral dilemmas they have experienced, would appear (Pollock & Campbell, 2020). Meanwhile, states health authorities try to mental health synthesis and resilience for doctors and nurses with interventions both in the workplace and at a personal level. It is characteristically reported than in an ICU nurses survey in the United Kingdom, 24.7 % had the belief they are ill and therefore got isolated the last four to six weeks, 17,2% suffered from depression while English healthcare system resilience relied on 65%, percentage which represents moderate to high health professionals' resilience (one of the top European rankings), whereas there is a rise in resilience equivalent to increasing people's age and work experience (Robertson, 2020).

**Table 1: moral impasse factors (intertemporal)**

<b>INTERNAL FACTORS</b>	<ul style="list-style-type: none"> <li>• Lack of nursing practical and specialist skills knowledge and experience</li> <li>• Moral distress</li> <li>• Awareness of the gap between nursing education and clinical practice</li> <li>• Lack of self-care</li> </ul>
<b>EXTERNAL/ ORGANIZATIONAL FACTORS</b>	<ul style="list-style-type: none"> <li>• Shortages of experienced nurses and resources</li> <li>• Ageing workforce</li> <li>• Frequent staff position change</li> <li>• Miscommunication between healthcare professionals</li> <li>• Difficulty to retain nurses in workforce (those who remain, some experience stress and burnout)</li> <li>• Bullying/depreciation/oppress (from colleagues, sister and matrons)</li> <li>• Health programming instability due to government insecurity ( government change→new healthcare system goals setting for achievement)</li> </ul>
<b>CLINICAL CONDITIONS</b>	<ul style="list-style-type: none"> <li>• Excessive workload</li> <li>• End of life patients</li> <li>• Mistakes made</li> <li>• Implementation of unnecessary interventions</li> <li>• Consent without information/truth hiding/false expectations</li> </ul>

Reference: data analysis processing from <https://onlinelibrary.wiley.com/doi/full/10.1111/j.1365-2648.2007.04412.x> In health crisis times, for instance at Covid 19 pandemic, a balance is necessary between the two health aspects (clinical practice ethical duties - public health) in order to as many lives as possible to be saved from healthcare professionals with the performance of a fair limited resources

distribution (Morley,2020). Pandemic outcome constitutes the dominance of moral injury and moral impasse in the majority of health professionals with minor differences to caused factors, as according to Karampelia (2020) there is fine line between preparedness and alarmism in healthcare sector and care crisis standards are activated.

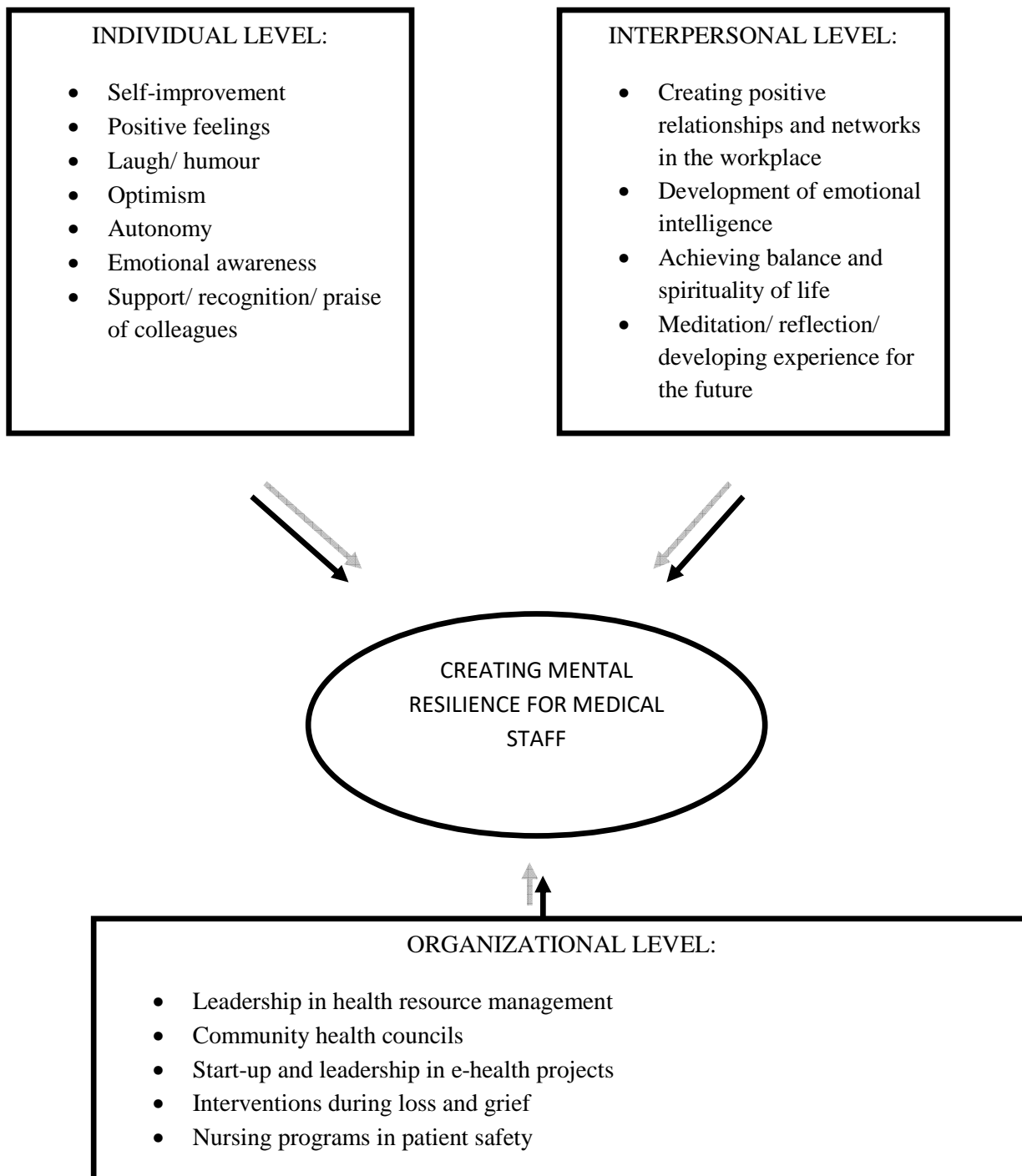
**Table 2: Factors and examples of moral impasse in the Midst of the COVID-19 Pandemic**

<i>Factors increasing the moral impasse creation in healthcare providers during pandemic</i>	<i>Examples( ¥ )and references of each factor</i>
1. Availability and management of (limited) resources [clinical conditions]	<ul style="list-style-type: none"> <li>• Insufficient resources - at risk care (critical cases covid-19) and equal access to quality health care</li> <li>• increasing demand for ICU / HDU beds - mechanical ventilation devices and extracorporeal oxygenation equipment( ECMO)</li> </ul>
2. protection of health professionals / emotional and financial shortage towards their families [internal factors]	<ul style="list-style-type: none"> <li>• The lack of protection, + high rates of transmissibility and mortality, --&gt; considerable anxiety among health professionals (particularly true of those working in the ICU) and their families but also to their ability to provide future services (disproportionate altruism level and self -sacrifice) (Morley, Grandy &amp; McCarthy, 2020)</li> <li>• Depleted diagnostics → fear of spreading the virus to family and other patients (ethical responsibility)</li> <li>¥ 2 nurses committed suicide due to stress caused by working conditions while working in ICU (Italian Ministry of Health, 2020)</li> <li>¥ lack of equipment: caregiver’s dilemma whether to provide services to covid-19 patient or to give priority to his safety</li> </ul>
3.Circumstances surrounding decision-making ( clinical conditions)	<ul style="list-style-type: none"> <li>• Pressure of time-undermined ethical decision-making</li> <li>• Decisions to admit patients in ICUs (lack of management experience – scientific evidence) «moral damage» of doctors</li> <li>•Consent form signed up by relatives( at intubated patients mainly)</li> <li>• Neither many countries are able for institutionalized bioethics regulations (Switzerland, Spain, Belgium, France, Italy and the United Kingdom) nor healthcare centers- ICU doctors take the responsibility regarding admissions criteria (Riva, 2020)</li> <li>¥ Italy, Spain and USA followed triage classification system (Falco-Pegueroles, 2020)</li> </ul>
4. End of life care	<ul style="list-style-type: none"> <li>• Main trigger of moral distress: Prohibition or limitation of visits to the dying patient- prohibition of officiating farewells and funerals→ emotional and physical impact on healthcare workers/ compassion fatigue</li> <li>• Interpersonal communication of end of life patients through video calls or with nurses dresses in full PPE→ emotionally-charged</li> </ul>
5. Interprofessional communication skills (horizontal-vertical) { External factors }	<ul style="list-style-type: none"> <li>• Poor vertical communication / afraid of senior staff members/ experienced or senior health care professionals lack to understand nurses regarding ethical issues</li> <li>• Bullying among team/” nursing bullying syndrome”/ shortage of solidarity/ healthcare workers are afraid of decisions related to Covid-19</li> </ul>

6. Infection prevention training { Internal factors }	<ul style="list-style-type: none"> <li>• Unskilled nurses/ lack of knowledge concerning various infections/ inexperienced staff</li> <li>• Healthcare team being moved to different positions frequently/ redeployment of healthcare workers without experience to ICU or Emergency Department (ED) during Covid 19</li> </ul>
7. Health care regulations/ national policies { External factors }	<ul style="list-style-type: none"> <li>• Policies of health care services with the intention overcrowding avoidance - impacts on chronic diseases patients either due to the their strict isolation restrictions within hospital or results in their health deterioration owing to limitation of visits--&gt; Health care workers' moral responsibility</li> <li>• Protocols due to Covid-19--&gt; ethical restriction whether healthcare professionals' ability for ethical independent decision-making process is limited ( ethical conflict)</li> </ul> <p>¥ Oncology patients receiving daily chemotherapy by themselves because of both escorts and visits prohibitions - trigger of moral distress among nurses as long as they are acutely aware of that above situation being unable to alleviate their suffering but they cannot do something about it. (Morley, Sese &amp; Rajendram, 2020)</p>

\*When doctors are repeatedly expected in the course of providing care to make choices that go beyond their long term and consistent commitment in patients' healing (Ins for Healthcare Improvement, 2020). The aforementioned moral conflict and factors causing moral impasses either in relation to pandemic or in a more generic framework do not constitute a phenomenon to be analyzed but a problem of greater importance which can lead to healthcare professionals desire to distance themselves from their occupation (disastrous at this time, as specialized staff in the midst of pandemic leave their position whilst human resources are already understaffed) (Morely, 2020) up to extreme physiological fluctuations. The answers to moral distress and moral injury are moral repair and moral resilience which is «a person's ability to adapt positively to adversities». Reference: data analysis processing from : <http://www.ihi.org/communities/blogs/turning-moral-distress-into-moral-resilience-during-the-covid-19-pandemic> The individual level indicates the actions a professional can take by himself in order to discharge his moral distress in the middle of pandemic, creating daily mental practice with a view to distract his attention from current experiences in the workplace focusing on his physical wellbeing, on his skills development through practice, on the reasons why he chose to concern himself with the health and on his mental growth and psychological

equilibrium (Institute for Healthcare Improvement, 2020). Simultaneously, the creativeness of positive impact in the workplace but also the reality acceptance is auxiliary (it is impossible for everyone to survive in a pandemic). On the interpersonal level, there is a talk about mutual support and «fellowship» via solidarity and understanding between similar moral impaired healthcare workers in relation to their emotional deficiency and reactions, exchanging information regarding ways for stress and adversity dealing. Furthermore, participation in physical / emotional / mental activities of health care providers helps to maintain balance in life and then contributes to the workplace (Jackson, 2007). However, the foremost for changes implementation is the organizational level as it forms the background to carry the above out effectively. It is necessary the clarification of moral values, their implementation obstacles to create a strategic plan addressing movement. Additionally, administrative executives must now create partnerships with caregivers based on understanding rather than intimidation and adding all health professionals in decision-making. Typical example is nurses (the world's largest healthcare workforce / perhaps the most affected by the pandemic) but their opinions are rarely considered. Policy makers need to include them in decision-making (local + globally) to minimize structural injustices they experience on a daily basis

**Figure1: 3 levels of enhancing mental resilience in health care providers****Discussion**

Moral distress and mental burnout of workers in the health sector both generally and during the current pandemic have had multidisciplinary implications which especially highlighted the value of mental resilience of health more than

ever pointing out its 3 composition levels, the individual, the interpersonal and the organizational which are considered fundamental in terms of at the administrative level. The retrospect of factors creating moral impasse reflects methods of enhancing resilience.



Emphasis is given to the clarification of moral values, their implementation obstacles and then the motion planning deal from administrative point of view, to create partnerships between managers and caregivers and joint decision-making on health policies. However, the category of nurses, the largest health team in the world, is seldom included in administrative proceedings, although probably constitute the "solution" and have greater "experience" for any form of health impasse.

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