

Compassion-Fatigue and Moral Distress in Health Care During COVID-19

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INTRODUCTION

As a high-risk pregnancy fellow and obstetrician, I continue to be involved in caring for pregnant patients during this pandemic. More patients with COVID-19 trickle into hospital ICUs and acute care units each day. North American health systems are increasingly strained, and we are preparing for them to potentially become overwhelmed.

ANALYSIS

Despite the outward show of strength and confidence, and a desire to fulfill our duty of care for the public in a crisis, many individual health care providers are *already* struggling when we come home from the frontline. We hold it together for patients which, for me, are a lot of scared, pregnant women. We acknowledge their anxiety, provide reassurance, and empathize with their concerns about ever-increasing visitor restrictions. To contain transmission and preserve personal protective equipment (PPE), most hospitals in Canada and the US currently allow a single support person once the woman is in labor, with no visitors permitted on antenatal and postpartum wards and no partners allowed in the operating room during Cesarean sections. We remain professional, despite everyone being on edge. But we have witnessed patients stealing masks from our clinics and other parts of the hospital. Other physicians, especially in communities that do not yet have a high number of COVID-19-positive cases, are telling us off for wearing surgical masks (not even N95s) because it will “scare patients” and will deplete the PPE supply. But the evidence favors basic contact precautions for all patient encounters, regardless of symptoms, because of community-transmission.¹

Then there are the larger ethical dilemmas that cause moral distress. Notably, in obstetrics, we have limited evidence regarding whether the SARS-CoV-2 virus is aerosolized with maternal pushing efforts in the second stage of labor. Aerosolization is more dangerous and infectious than transmission by contact or droplets because viral particles that hang in the air can infect anyone in the room (and therefore require a higher level of PPE, including N95 masks and protective eyewear, as opposed to regular surgical masks).

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Different societies and experts have been making conflicting recommendations, with some advising to err on the side of caution and ensure that all health care providers in the room caring for patients with COVID-19 wear higher level PPE, including N95 masks.² Other societies and organizations, more concerned about equipment shortages advocate against liberal PPE use, citing insufficient evidence to make the same recommendation.³ These dichotomous decisions reflect variation in attitudes toward both risk and resource allocation. There is a palpable tension between the need to preserve PPE due to the global shortage and the need to protect our patients, families, and ourselves, so that we can ultimately serve more patients. Sick and/or dead health care workers help no one, and preserving PPE is useless in their absence.

As far as bioethical dilemmas go in this pandemic, this is the tip of iceberg. In labor and delivery, we have not yet had adverse outcomes due to delays in performing emergency C-sections so that we can properly don PPE (which takes an extra 3-4 minutes). We cannot simply skip this step because the risks of exposure to health care providers is significant, and if we have to put the woman to sleep under general anesthesia, placing a breathing tube in the patient's throat is an aerosolizing procedure. No single patient's individual emergency is worth risking the lives of many physicians, nurses, and allied health workers needed to care for the avalanche of patients expected from the community. In Canada and most of the US, physicians have not yet had to decide who lives and who dies, though the popular press is covering some anticipated ethical dilemmas including allocation of limited ventilators and implications for CPR. We are anxious about having to face these moral quandaries in real life.

By the time we leave the workplace, our empathy tanks are running on low. A stop for groceries will empty whatever is left, when we still cannot find toilet paper and observe shoppers wearing the same N95s that we are only allowed to wear in hospital if performing "aerosolizing procedures" like CPR and placing a breathing tube in someone's throat. We arrive home, running on empty – bless our loved ones for putting up with us.

The medical profession boasts a culture of martyrdom, placing duty of care above all else, especially in life-and-death emergencies. Physicians enjoy saving lives and being heroes. Our time is here, yet we are surprised by how scared we feel. Fortunately, absence of fear is not a prerequisite to showing up and doing our jobs (that's courage, right?). We are used to pushing through our discomfort. But simply pushing through on an empty empathy tank serves nobody well. When we discover that other doctors are sick or stepping back, an inner meanness whispers "were they careless?" or "will I have more shifts?" though outwardly we try to be understanding. This is often followed by a deep sense of shame: "Don't you *want* to help as much as possible?!" What we often don't realize is that those resentments are a direct consequence of not dealing with the uneasiness we feel amid the uncertainty.

CONCLUSION

Ultimately, like our surgical safety checklists adopted from the airline industry, we need to adopt the airplane safety principle, "Secure your own oxygen mask, before assisting someone else." The PPE issue is a literal manifestation of that principle. The empty empathy tanks we bring home every day are the less tangible ones. We need to find ways to acknowledge and address compassion-fatigue among health care workers, especially during this public health crisis. We are in this for the long haul. And health care professionals cannot fly without an abundance of fuel, not only in the form of physical supports, but also social and emotional ones.

¹ Bai Y, Yao L, Wei T, et al. Presumed asymptomatic carrier transmission of COVID-19. JAMA 2020 Feb 21.

² Society for Maternal-Fetal Medicine and Society for Obstetric Anesthesia and Perinatology – Labor and Delivery COVID-19 Considerations. Available online: [https://s3.amazonaws.com/cdn.smfm.org/media/2277/SMFM-SOAP_COVID_LD_Considerations_3-27-20_\(final\)_PDF.pdf](https://s3.amazonaws.com/cdn.smfm.org/media/2277/SMFM-SOAP_COVID_LD_Considerations_3-27-20_(final)_PDF.pdf)

³ Elwood C, Boucoiran I, VanSchalkwyk J, et al. Updated SOGC Committee Opinion –COVID-19 in Pregnancy. Society of Obstetricians and Gynaecologists of Canada. 2020 March 13. Available online: https://sogc.org/en/content/featured-news/Updated-SOGC-Committee-Opinion__COVID-19-in-Pregnancy.aspx