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Tough choices: moral challenges experienced by aid workers during the Covid-19 pandemic

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The truly unprecedented nature of the pandemic has mobilised and confused humanitarian NGOs and their staff as much. Forced inaction mixed with setting up programmes within a context of high uncertainty has resulted in strong, sometimes painful, moral experiences. The research project initiated within *Médecins Sans Frontières* Switzerland has already made it possible to collect useful data both for the present crisis and for others to come.

Moral questions linked to medical practice and operational choices have been raised within *Médecins Sans Frontières* (MSF) since the organisation's creation. Managing humanitarian programmes often involves complex decisions, for example, when compromises have to be made with belligerents in order to gain access to populations[1], or decisions on fundraising principles or political and public positioning. Difficulties are also common when humanitarian teams must decide on how to allocate limited medical resources in settings where there are many people in need, as was experienced by colleagues during the HIV pandemic[2].

Moral experiences are issues that reflect what is at stake ethically for individuals and communities, "encompassing a person's sense that values that he or she deems important are being realised or thwarted in everyday life. This includes a person's interpretations of a lived encounter, that fall on spectrums of right-wrong, good-bad or just-unjust"[3]. Moral experiences are not limited to conventional ethical dilemmas or scholarly arguments but take place in everyday life.

What these events have in common is the tension between priorities and values, that the person experiencing the situation is involved in it and cannot act according to their own values. This can lead to moral distress, which is defined as arising when one "knows the right thing to do, but institutional, contextual or cultural constraints make it nearly impossible to

[1] Chiara Lepora, Robert E. Goodin, *On complicity and compromise*, Oxford University Press, 2013.
[2] Ruth Macklin, *Ethics in Global Health: Research, Policy and Practice*, Oxford University Press, 2012.
[3] Matthew R. Hunt, Franco A. Carnevale, "Moral experience: a framework for bioethics research", *J Med Ethics*, vol.37 (11), November 2011, p.658-662.

pursue the right course of action"[4].

It has recently been recognised that moral distress affects aid workers[5]. There is evidence to suggest that, if unaddressed, it contributes to staff demoralisation, desensitisation and burnout and ultimately, to lower standards of patient safety and quality of care[6]. Thus, there is a need to find a way of managing feelings of insufficiency, powerlessness, meaninglessness and frustration so as to avoid harmful consequences for individuals and the quality of humanitarian work[7]. Coping strategies and how individuals overcome moral challenges are likely to be affected by how well they are supported before, during and after a difficult situation.

The analysis of moral experiences that may lead to moral distress in humanitarian work has been a focus of research at MSF's Operational Centre in Geneva since 2018. The ongoing "moral experiences" project acknowledges the importance of theses ones in the conduct of humanitarian action and is designed to provide staff with a space to share experiences and strategies to prevent or alleviate moral distress. The objective is to gain a better understanding of the moral experiences likely to cause moral distress and ultimately, to offer staff greater support in these situations by developing induction and training material, peer-based support strategies and more general ethical guidelines.

The impact of the Covid-19 pandemic

Like all aid organisations, MSF has been dramatically affected by the consequences of the Covid-19 pandemic. For a medical humanitarian organisation, it is particularly difficult to support the response to Covid-19, while at the same time keeping regular medical programmes running for tens of thousands of patients. We face huge practical obstacles, including the movement of staff across borders and challenges arising from the shortage of available medical supplies. The current situation potentially increases moral distress. Decision-making is ethically challenging because of the rapidly evolving crisis and the uncertainty in which decisions need to be made.

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[4] Andrew Jameton, "Dilemmas of moral distress: moral responsibility and nursing practice", *AWHONN's clinical issues in perinatal and women's health nursing*, vol. 4 (4), 1993, p.542-51.

[5] Sarah Gotowiec, Elizabeth Cantor-Graae, "The burden of choice: a qualitative study of healthcare professionals' reactions to ethical challenges in humanitarian crises", *Journal of International Humanitarian Action*, vol.2, December 2017; Sofia Nilsson *et al.*, "Moral Stress in International Humanitarian Aid and Rescue Operations: A Grounded Theory Study", *Ethics & Behavior*, vol. 21:1, February 2011, p.49-68; Liza Schwartz *et al.*, "Western clinical health ethics: How well do they travel to humanitarian contexts?", *in* Caroline Abu-Sada (ed.), *Dilemmas, Challenges, and Ethics of Humanitarian Action: Reflections on Médecins Sans Frontières' Perception Project*, McGill-Queens University Press, 2012, pp.73-88.

[6] Michiyo Ando, Masashi Kawano, "Relationships among moral distress, sense of coherence, and job satisfaction", *Nursing Ethics*, vol. 25 (5), August 2018, p.571-579; Ann B. Hamric, Elizabeth G. Epstein, "A health system-wide moral distress consultation service: development and evaluation", *HEC Forum*, vol. 29(2), 2017, p.127-143; Settimio Monteverde, *Handbuch Pflegeethik Ethisch denken und handeln in den Praxisfeldern der Pflege*, Verlag W. Kohlhammer, 2020, p.27-31.

[7] Sofia Nilsson *et al.*, "Moral Stress…", art. cit.

The "moral experiences" project interviews carried out during the pandemic were considered as essential for gaining a better understanding of how the situation was affecting aid workers and contributing to the discussion on how to prevent and alleviate potential moral distress in this context. We conducted a preliminary analysis of the moral experiences of staff linked to the Covid-19 pandemic using a qualitative approach to identify recurring themes and extracted representative examples from the interviews. It is important to note that the sampling was not intended to be representative and that the interviews focused on moral experiences in general, not just Covid-19.

A total of 12 interviews took place during the pandemic (April and May 2020), including operations and support staff at headquarters (6), country and project coordinators on and between assignments (4), other international staff on and between assignments (1) and national staff (1). Half of them (6) had a medical or health-related background. Since the project is ongoing, further interviews with field and national staff are scheduled. The semi-structured interviews were conducted via Zoom, in French or English, and lasted between 45 and 60 minutes. A particular effort was made to reach national colleagues; however, this was unsuccessful, mainly due to technical issues. This article therefore presents a partial view of the moral experiences of aid workers, which will be complemented by further research.

Moral challenges during the pandemic

We have identified three main categories of morally challenging circumstances experienced by interviewees due to the Covid-19 pandemic. Firstly, given that the pandemic has affected the high-income countries where most of our headquarters are based, and from where most of our international staff originate, staff have had to balance loyalty to their work abroad with that to family and friends left behind. Furthermore, this has highlighted the challenges of humanitarian interventions in wealthy countries. Secondly, the constraints on resources and international mobility have acted as a catalyst for moral distress in staff and projects in already complex situations. Thirdly, when staff were condemned to inaction, which may have happened due to lockdown, prioritisation of other projects, restrictions on international travel, or because they were evacuated for their own protection if they belonged to an at-risk group, the feeling of doing something morally wrong was strong.

A crisis affecting everyone, everywhere

For the first time on this scale, our staff were running emergency interventions providing aid in high-income countries. These interventions raised many questions for those involved, ranging from the feeling of a never-ending "job" as a result of family and friends experiencing the same crisis to moral issues related to the appropriateness of allocating resources in a wealthy country.

> *Operations staff, HQ:* "When we were looking into helping here, I just kept thinking – is it right that we are using resources here? If resources become very scarce, who should

get priority, the fields or our new Covid-19 project here? In the end, in our project, we provided technical expertise to organisations supporting the most marginalised groups, which was greatly appreciated, and no resources were diverted. This was a very satisfactory resolution."

Both the humanitarian workplace and family and friends at home were suddenly exposed to an acute health threat. At the same time, international travel was partially interrupted which exposed staff to feelings of being torn between the demands of work and family. It also led to a cumulation of challenges in their professional and private lives.

Support staff, HQ: "When we start this work, we're going into the field accepting a level of risk, prepared to face tough situations, but we have this confidence and trust that the organisation is managing our safety and that we can go home at any time if something happens to our families… But this option is not easily available anymore, and the organisation can't do anything about it."

Head of Mission (HoM), international staff: "When international travel started to shut down, I spoke to every one of the team to inform them that if they wanted to leave, they had to go now. Later on, there would be no guarantee that they could go back to their fami-lies if something happened to them. […] As the situation developed, besides working very long days, these staff spoke to their families every evening, comforting and supporting them, but this just added extra worry about the family back home."

The Covid-19 pandemic as a catalyst

In contexts which are already complex, such as highly insecure environments or cross-border projects, the Covid-19 pandemic and its consequences have added a layer of difficulty for staff. Reduced or zero travel and evacuation options combined with deteriorating security contexts and lockdown, have become too much for some.

Nurse, international staff: "I ended up feeling like I had to decide to leave the project. With the deterioration in the security situation, the inefficiencies of remote working, increasing difficulties in travelling within the country and the potential lack of personal protective equipment (PPE)… I felt so powerless in this situation […]. I feel like I was giving up on the project. And the people."

Medical staff has witnessed increased constraints such as limited options for referring patients to much needed specialised care.

Nurse, international staff: "For our cross-border project, we used to refer patients from an internally displaced persons camp to a surgical facility. But now the border was closed it was a daily struggle to negotiate with the authorities. If they said no, the woman who needed an urgent Caesarean would not be able to receive it. It just didn't make sense to me […] as far as we knew, there were no Covid-19 cases in the region… It was really hard for me to accept, that we couldn't just open this border up to transfer

patients."

Inaction imposed upon aid workers

A strong sense of a loss of purpose was particularly prominent when staff, committed to the values and actions of MSF, found themselves prevented from or unable to act where they had been assigned due to Covid-19 related lockdowns, quarantines or travel restrictions.

> *HoM, international staff:* "One project was about to finish and another had not yet started. Then the lockdown began. So essentially, we just had to stay at home and wait until the lockdown was over. The team was unsettled. They had to do something, otherwise they did not see a reason in being here. What's my job here if we're not doing anything, we don't have a single patient?"

Participants expressed their frustration when local authorities asked MSF for support in managing the Covid-19 pandemic: field teams wanted to propose interventions and sometimes even had the resources and equipment, but they feel that their situation was not immediately prioritised by the managers at headquarters.

> *HoM, international staff:* "We didn't ask for anything, no human resources, no PPE, no money, we managed to make these resources available from our other projects in the country, but headquarters still said no to our Covid-19 intervention proposal at first. And this was really hard for the doctors and nurses dealing with patients."

Even when the teams understood the decisions, there was another difficulty in explaining the reasoning to local communities and staff.

> *Medical Coordinator, national staff:* "Putting a project on hold is definitely a tough decision to make. But it's even more difficult to explain this to local staff and the community. They know that MSF is there for emergencies and Covid-19 is currently an emergency, and we can explain the limited resources – people don't understand why MSF is leaving now."

Pragmatic solutions from participants

Participants described a range of strategies which have helped or may have helped them when they are in these difficult situations. Access to regular and comprehensive information was the most important one, increasing the feeling of being able to act and have control over a situation as well as being included in decision-making and sharing responsibilities and experiences.

> *Nurse, international staff:* "While I was waiting for a flight home, the HoM calling me almost every day to let me know what was being done, even if it was "no news", was

> really helpful. I was assured that people were working on it and I hadn't been forgotten."

Most of the information was seen as being lost at all management levels. Therefore direct contact and open information sharing were considered necessary. In addition, participants highlighted that information is often shared by email or on institutional platforms, although not all staff have equal access to institutional connections, computers and the internet and consequently, the information. A more inclusive approach was suggested. A space for discussion was proposed, where staff could express disagreement, criticise, debate and ask questions in situations where the decisions are morally difficult. For staff having to make decisions, it was useful to have the support of the team and management, to dispel doubts, but also to create collective coherence.

> *HoM, international staff:* "We were a really good coordination team, so I was able to share my concerns and we could discuss the decisions made, this reduced my doubts about what had to be done."

Sharing experiences with peers who are in the same situation and therefore able to understand was mentioned as the main tool in alleviating distress. Often, friends and family at home could not fulfil this role because it seemed important to have a shared experience of the situation.

Lessons and courses of action

Moral experiences arising from Covid-19 have similarities with other moral experiences in humanitarian contexts, but the constraints imposed by the pandemic intensify the moral challenges. This includes referral difficulties that may cost a patient's life, rapid project closures and questions about prioritisation. However, it has also created quite unique situations, affecting headquarters as much as the field, due to the inaction imposed by the shutdown of international travel, or the challenges of intervening in high-income countries. This has caused moral distress in some participants, while others have found effective coping mechanisms.

We expect the nature of morally difficult situations to evolve for our staff during the Covid-19 pandemic. The questions currently raised in Europe and the USA regarding health professionals' duty to care for patients with limited protective equipment, risking infection and transmission to their families; the allocation of limited treatment resources (ventilators, oxygen), and the dilemmas related to non-pharmacological public health measures (lockdown, quarantine)[8], have not yet been raised by interviewees, probably due to the still

[8] Sofia Nilsson *et al.*, "Moral Stress…", art. cit.; Lisa Schwartz *et al.*, "Ethics in humanitarian aid work: learning from the narratives of humanitarian health workers", *Ajob Primary Research*, vol.1, September 2010, p.45-54; Christina Sinding *et al.*, "'Playing God Because you Have to': Health Professionals' Narratives of Rationing Care in Humanitarian and Development Work", *Public Health Ethics*, vol.3(2), July 2010, p.147-156.

relatively low numbers of severely ill patients in most of our intervention countries.

Although many causes of moral challenges cannot be avoided in the context of humanitarian work, especially given that experiences are subjective, supportive interventions may help people experiencing these situations. The helpful tools and strategies suggested above by participants resonate with the existing literature on alleviating moral distress[9].

On an individual level, a better understanding of moral stressors can reduce perceived moral distress and can support the search for suitable coping strategies and encourage moral resilience ("the capacity of an individual to sustain or restore integrity in response to moral complexity, confusion, distress or setbacks"[10]) through access to information and ongoing education to develop and sustain ethical competence.

On an organisational level, mechanisms for addressing ethical concerns, protecting moral integrity and organisational priorities for ethical practice help to decrease the occurrence of moral distress. Through shared dialogue structures, staff can ensure their voice is included in decisions and policies should encourage staff to express their concerns. Supervisors at all levels can inquire on a daily basis about any moral concerns. This, combined with the presence of well-prepared ethics resources can provide an opportunity for early intervention and perhaps reduce the degree of distress experienced by staff at all levels[11].

It is already obvious that the Covid-19 pandemic is contributing to an environment that is likely to trigger moral distress: an inability to act, being confronted with unsatisfactory choices, working in degraded conditions and a lack of equipment and resources. It may be worth putting this in perspective by further exploring the positive effects of this new environment on moral experiences, such as feelings of solidarity, more equal access to information as all home workers were on an equal footing, or greater autonomy in decision-making in the field.

Interventions to support staff and prevent or alleviate moral distress are needed and require a commitment at all levels of the organisation. This project is an important first step, but we need to find ways to improve our understanding of the moral experiences of our national colleagues who make up the majority of our global workforce, to ensure that their views are taken into account.

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[9] Ann B. Hamric, Elizabeth G. Epstein, "A health system-wide…", art. cit.,; Settimio Monteverde, *Handbuch Pflegeethik…*, *op. cit.*; Colleen Varcoe *et al.*, "Moral Distress: Tensions as Springboards for Action", *HEC Forum*, vol.24(1), 2012, p.51-62.

[10] Cynda Hylton Rushton, "Moral Resilience: A Capacity for Navigating Moral Distress in Critical Care", *AACN advanced critical care*, vol.27(1), 2016, p.111-119.

[11] Ann B. Hamric, Elizabeth G. Epstein, "A health system-wide…", art. cit.; Adam S. Burston, Anthony G. Tuckett, "Moral distress in nursing: Contributing factors, outcomes and interventions", *Nursing Ethics*, vol. 20(3), 2013, p. 312-324; Neil Greenberg *et al.*, "Managing mental health challenges faced by healthcare workers during covid-19 pandemic", *BMJ*, 2020.

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