Jacob (Blue Sky):

Hello, and welcome to Catholic Ethics and the Challenge of COVID-19, a live webcast series presented by the Catholic Health Association and Georgetown University, in cooperation with the Pellegrino Center for Clinical Bioethics. Thank you for joining us. My name is Jacob and I will be the operator for today's presentation. Before we get started, I would like to acquaint you with a few features of this web event technology. At any time, you may adjust your audio using any computer volume settings that you may have.

Jacob (Blue Sky):

There will be a question and answer portion of the webinar. To submit a question, please click on the Q and A icon located at the bottom toolbar of the Zoom platform and enter your question. Please note that today's presentation is being recorded and both the recording and slides will be emailed to you. We are joined today by Brian Kane, Senior Director, Ethics, for the Catholic Health Association. At this time, I would like to turn the presentation over to Brian for opening remarks. The floor is yours, Brian.

Brian M. Kane:

Thank you, Jacob. And good day, everybody. Thank you for joining us for part four of our webinar series, Catholic Ethics and the Challenge of COVID-19. Before I introduce today's panelists, let us take a moment to reflect upon a prayer by Lynn Ungar.

Brian M. Kane:

What if you thought of it as the Jews considered the Sabbath, the most sacred of times. Cease from travel, cease from buying and selling, give up just for now on trying to make the world different than it is. Sing, pray, touch only those to whom you commit your life, center down. And when your body has become still, reach out with your heart. Know that we are connected in ways that are terrifying and beautiful. You could hardly deny it now. Know that our lives are in one another's hands. Surely that has become clear. Do not reach out to your hands. Reach out your heart, reach out your words, reach out all the tendrils of compassion that move invisibly, where we cannot touch.

Brian M. Kane:

Promise this world your love for better or for worse, in sickness and in health, so long as we show live. We are very pleased today to be joined today by three presenters from Georgetown University. We'll focus on the topic of moral distress on caregivers and patients dying alone.

Brian M. Kane:

Dr. Claudia Sotomayor is a clinical ethicist at the Pellegrino Center for Clinical Bioethics, as well as an adjunct assistant professor of internal medicine at Georgetown University Medical Center. Also joining us today is Dr. Sarah Vittone, who serves as a clinical bioethicist for the Pellegrino Center for Clinical Bioethics, and as an assistant professor at Georgetown School of Nursing. She also works in clinical nursing administration at Suburban Hospital, John Hopkins Medicine in Bethesda, Maryland. And finally Dr. Kevin Donovan is the director of the Pellegrino Center for Clinical Bioethics and a professor of pediatrics. Kevin will serve as the moderator for today's discussion. Welcome to you all.

Brian M. Kane:

Today's event is 30 minutes. If you have questions during the discussion, please enter them in the Q and A module, and we will answer them at the end of the presentation. So with that, Kevin it is all yours.

G. Kevin Donovan:

Thank you so much, Brian. I'm really pleased to be participating in the CHA webinars once again with the Pellegrino Center for Clinical Bioethics at Georgetown med school. As you've mentioned, the two main discussions today are clinician bioethicists who work in the Pellegrino Center. The interesting thing that we will be talking about though is not the typical ethics consultation approach, but the issues that come up so frequently in terms of moral distress.

G. Kevin Donovan:

So Dr. Sotomayor will lead us through a case overview that kind of demonstrates the issues of moral distress as well as the other issues we often see. And then she will take us through how this may affect patients and their families in terms of moral distress. And Dr. Vittone will then cover the same aspects in medical personnel. Dr. Sotomayor.

Claudia Sotomayor:

Thank you for having us again. It is a privilege for us to be here sharing with you this presentation. Before I start describing the case, I want to invite you to answer these simple questions. Am I in distress? I might be crazy here, but I would dare to say that most of us replied yes, we are in distress. Now, what kind of distress are we into? As we go along with this presentation, I want you to analyze yourself within this information we're giving you.

Claudia Sotomayor:

So the case we're presenting today, is about a Ms. Smith. She is a 70-year-old woman, Catholic. She was married for 50 years. She lived in Pennsylvania and became a patient of MedStar Georgetown in 2019 when she received a transplant. The transplant was successful. She came regularly for follow ups. So she was well-known by the medical personnel. And one thing that stood out about her was the relationship with her husband. They were always together. For her follow up appointment in March, she presented with [inaudible 00:05:50], fever, cough, and myalgias. She was obviously tested for COVID and she tested positive. So she was admitted to the hospital.

Claudia Sotomayor:

Shortly after her admission, she developed shortness of breath. So she was transferred to the ICU where she was intubated. Unfortunately, as you can imagine, she was isolated just as anyone with COVID-19, and she was rapidly deteriorating. So the medical team thought at that point that there was nothing else to do for her. So they requested an ethics consultation to help with end of life conversations.

Claudia Sotomayor:

At the same time, parallelly, her husband, Mr. Smith started presenting symptoms himself. So he was tested for COVID as well, but at that point it was pending. So he was a person under investigation, and he was being isolated at his hotel. The conversations were held via Zoom. He was very amicable. Mr. Smith agreed for a DNR. The patient was made DNR afterwards and a day after that conversation was held, the patient passed away.

Claudia Sotomayor:

Now most of you probably are thinking, "Well, this was a very straightforward case in terms of ethics," right? The patient was in the ICU. She deteriorated. A family meeting was held. It was noneventful. Everyone was in agreement. She was made DNR. The patient passed away. No conflicts. The problem here wasn't the conflict itself, but the moral distress that was cost. When we define moral distress, we think about it as the inability to act according to core values. In this case, this patient was well-known by the medical personnel. They knew that the relationship between her and her husband was very close. He was always there holding her hand when she was in pain, when she was afraid, when she was going into the OR, when she was happy. He was always there.

Claudia Sotomayor:

And now when she probably needed him the most, he wasn't, and that created a huge amount of moral distress within the medical personnel. When I was looking for the definition of moral distress, everywhere you will find that it the emotional state there arises from a situation when someone feels that the ethical correct action to take is different from what he or she is tasked with doing. In this case, the policies and procedures in place are limiting the possibility of creating that moment, that saying goodbye moment, or that moment.

Claudia Sotomayor:

One thing I want you to be aware of is that moral distress is very different from emotional distress. Let's not get confused here. Emotional distress is more common and it is triggered by the exposure of fear, grief, frustration, information overload. I know that probably all of us are Googling and looking at all the news out there about COVID, and you're getting so saturated with information that is creating emotional distress. Now, this is different from moral distress because moral distress is asking us to do something, to act, to do something that is probably against our core values.

Claudia Sotomayor:

To share some examples and to help us get situated, I brought these examples. As you can see in this picture, there is a man dying and he's surrounded by family members. I think this is a very good presentation of what dying means for us. I think dying is a process, a cultural process, and right now we are not seeing this. Right? We are dying alone. And dying alone itself, it's fearful. I think fear to die alone is nearly universal. In each culture, death is associated with rituals, with customs that help not only the person who is leaving us, but to help us to grieve. It helps us with the grieving process, and the idea, just the idea of having my loved one isolated without me is creating some emotional distress because it's giving me ... I'm afraid of it, right?

Claudia Sotomayor:

Another example. Let's say I am not fluent in English and I have to go there and they're talking to me and everybody's weighing all these things. And I cannot communicate as I would like to do, because everything is so loud. And then they bring these machines and I don't understand them. And it's just that miscommunication creates frustration and frustration is a trigger for emotional distress.

Claudia Sotomayor:

Here's another example. Uncertainties. We are [inaudible 00:12:39] isolated. Some of us are lucky enough to be isolated at our homes. Then we are uncertain when is this going to end? Is this going to

end? If I get COVID, am I going to be of the group of people who are okay and get just mild symptoms? Or am I going to be one of those who has to go to the hospital? Am I going to die? So those uncertainties as well create emotional distress.

Claudia Sotomayor:

Now, when can a patient feel moral distress? Because we've heard moral distress in the literature, you will find it more related to medical personnel. But what about the patients? Can the patients feel moral distress? And I would say, yes. These patients, for example, Mrs. Smith, she was a devout Catholic. Now she is isolated. According to our faith, we know that receiving the sacraments is very important, especially at the end. But now how are we going to provide those sacraments has been a matter of debate, right?

Claudia Sotomayor:

Should the priest go in or not? Is it safe or not? What are the policies and procedures? It's something that is creating a lot of debate out there. But in the meantime, the patient is wondering, "How am I going to do what I'm supposed to do? I'm supposed to get the confession and get the Eucharist and get all the final rights. But now I'm not sure if I will be able to get them." That is creating moral distress. Another example. We are seeing now the patients who are diagnosed with COVID-19 are either attempting suicide or getting suicide. Suicide is against our moral values in general, right?

Claudia Sotomayor:

But these people are pushed towards these crazy amount of fear and you know, all other things that psychologists and psychiatrists might you have a more understanding of this, but it is going against our own morality. So yes, it is causing moral distress. Another example that I have here in the bottom. You see all these spaces? I wanted to represent the multicultural part of it, right? Let's say my culture says that I cannot communicate to another male directly. It has to be through my husband, but now I am isolated at this room and I have no other option. I have to communicate directly to my male physician, even though I know it's against my own core values.

Claudia Sotomayor:

And this is important because when our patients are in distress, either emotional or moral, it is affecting our medical personnel. And if our medical personnel gets distressed, then it is going to affect the outcome of our patient care. And I think it's like a never ending circle here. This is where I hand off of the conversation to Sarah. What do you think Sarah, about the-

G. Kevin Donovan:

Yeah. Let me ask you a question, if I may though, Claudia. I want to be sure that I'm clear and that everybody in the audience is clear. Because you brought up something quite unusual in terms of how we conceive of moral distress. Dr. Vittone is going to take us in the direction that we kind of expect. We expect that something is constraining our action from doing what we normally would want to do in a moral sphere. But you've pointed out that this isn't just a problem for healthcare workers. This is a problem for our patients and their families, looking at their core values, their faith, having access perhaps to the sacraments at the moment of death, family.

G. Kevin Donovan:

And you didn't mention all the possibilities, but those of course would include the fact we're hearing that people aren't even taking their loved ones to the doctor. They're not taking them to the ER because they're afraid if they don't have COVID that they may acquire it in a medical setting. And so we're seeing increasing illness outside the hospital, and the conflicts between work responsibility and family responsibility that everybody's feeling, whether they're healthcare workers or not. Am I getting that right? And are we-

Claudia Sotomayor:

Yes. And you bring up an important point. I didn't talk about it. The uncertainty and the problems of if I get to the hospital, she will get COVID-19 is important, but also people are losing their jobs. They're rationing, and some of their way of rationing is not getting the medicines they need to get treated. And that is also a moral distressor. I need to get my medication, but I need to get food. So I need to make a decision of should I buy food or my medication while I go and buy food?

G. Kevin Donovan:

This is why then although we can easily recognize all the emotional distress that everybody's feeling to some extent, the idea of moral distress is really within the purview of an ethicist and can come up in the context of ethics discussion. And we should be aware of it in our patients and their families as well as in the medical professionals. Now medical professionals certainly experience moral distress even outside of pandemic. And I know that this is extremely common among professionals who perhaps have a nursing background and Dr. Vittone, you happen to have that. Can you take us through that?

Sarah Vittone:

All right, So I do think this is an important foundation for the conversation because the pandemic has put us in an unfamiliar situation. We are completely unexpected to have the depth and breadth of the distress that we've all been under. And I'm going to talk about some specific pieces that are affecting professionals, but one of the pieces that really are affecting the professionals are the issues around what the patients are experiencing. And so when we think about how teams may start to feel helpless and distress itself, coming from a moral dilemma, moral distress influences really all health professionals. It's well documented in nursing and with physicians, but all health professionals can feel it. It can lead to existential suffering such as a feeling of isolation. When you can't do what you need to do, it can lead to a feeling of worthlessness, helplessness, and even compassion fatigue.

Sarah Vittone:

This distress can involve a threat to a professional's own moral integrity. That sense of wholeness, that worth that comes from having clearly defined values that are congruent with your own actions. Moral distress is the inability to act on your core values. And because of this unusual sense of stress, we need to think about it a little bit differently. So we might unpack that and categorize it in two different groups. So we have the distress around uncertainty where choices might have unclear moral options, but we also think about it in a grouping of constraint where there's an obstacle in the way that we can act on. And in some ways the pandemic itself has seemingly become almost that obstacle. We can't do what we want to do because we can't treat the virus. We can't get ahead of the things that are happening around it.

Sarah Vittone:

And beyond the distress itself, we may have a risk for moral injury. And I only comment on this because should we continue to have people who are not dealing with this distress, they may have this consequence. And this really comes from this unexpected stress that a moral injury really can lead to a feeling of helplessness when you can't practice at the way that you want to. Next slide. So here's an example of a list of things that I wanted to mention that are affecting how doctors and nurses and other professionals are thinking about moral distress. And so these aspects include things like fear. So professionals are trying to keep safe and we're wearing the masks and the gowns and all of the face shields, the various things that you need to do, and you're doing your best to do your best, to keep yourself safe.

Sarah Vittone:

And yet you know you have a family to go home to, and you have to come back the next day. And if you don't come back the next day, who's going to come back for you? So you need to keep safe and in keeping safe, it just adds to that idea of protection and you want to be safe. And there's a little bit of a fear there. We know that doctors and nurses are the ones that are always stepping into the fire. They're going that extra mile for patients, and they have to keep themselves safe to be there for the next patients. There's also a sense of uncertainty in this idea around the science, and we know more and more and more about this virus. Just in the last 60 to 90 days things have changed and we're unsure about what's next coming. We're unsure about the surge. Has the surge happened? Are we having another surge? When is the next surge?

Sarah Vittone:

The pandemic is going to be over in how many months? It's going to be how long? When is the next phase? Are we going to have another phase of the pandemic? And when will it be normal again? That uncertainty piece adding to our distress. The pace, the pace of things that picked up over the last 90 days, seemingly unsustainable. There were patients and then there were more patients. And then there were more patients and then they were sicker. And then we grew out of our hospital spaces and we had to move patients into areas in the hospital. We had to be creative. We had to take and do things that were different, that were novel. And it was one thing. And then it was the next, and this pace can lead to emotional strain and it can be very wearing.

Sarah Vittone:

And on top of this, we're wearing the masks and the shields and the gowns, and it's hot and it's hard to work and it's tiring. And so the pace is adding to, again, more and more of the distress. I'll mention I have on here the patient's distress and Claudia did a great job of talking about. We want to do and fix things for the patients. We don't want the patients to be distressed. We want to bring in their family members, but we're constrained. We can't do it. We have to keep them safe. We have to stay tuned all the time for the new treatments, the new science. It brings hope, right? We have research going. So we're going to be hope. There's going to be help.

G. Kevin Donovan:

And Sarah, we are getting questions from the audience that are so pertinent to what you're saying, because I think everybody's registering the distress, even as you describe it. And they want to know, how can it be mitigated? How can it be managed? What can professionals do in conjunction with the family add a compassionate approach? And I get the sense that you're just about to take us there.

Sarah Vittone:

I am. Claudia, why don't we go onto the next slide? So I want to just bring up the idea that when we're distressed, we have to fall back on what we know. We have to focus on what we are doing. What are we doing that are good? And these are the things that a Catholic identity can bring to us. Now, these are additive to our professional values and this list embraces what identifies Catholic healthcare. Catholic healthcare has always had certain principles. And we share these with our colleagues in other health systems. And in fact, we have a lot of non-Catholics that work in our systems. So when you see this list, and it's guided really from our ethical and religious directives, but I'll just say that the church has always sought to embody our Savior's concern for the sick. Jesus' healing mission has gone further than caring for the physical affliction.

Sarah Vittone:

He touched people at the deepest level right of their existence, and he sought their physical, mental, and spiritual healing. And that is what empowers our practice. The respect for dignity. The idea that our care is holistic. We're looking at the whole person. We practice this sense of justice. We are concerned about the needs of the poor and the disenfranchised. The things that we do contribute to the common good, the success of the pandemic is the success for all of us, and when necessary, we need prayer. And we need to think about that for ourselves and for our patients. Next slide.

Sarah Vittone:

I want to mention a few things that bioethics brings to the table to help us through moral distress. I'm going to mention four things. One, how consultants come and listen. We listened to the distress and we help staff to process that, to identify the values and the commitments that they're struggling with. And in listening to that, then we can be party to building moral resilience. So clinical ethicists can take a couple of the approaches that are going to go into more resilience. One being, helping to support ethical competence. So helping staff to regain or review their own values and review how to strive forward in a stressful time.

Sarah Vittone:

And also in ethics education, helping us go back to the principles, keeping us through ideas around beneficence to do the good, and autonomy to help people to make their own choices, and how justice is important. We also know that ethics consultants use facilitation as a primary strategy in resolving uncertainty and conflict. So it helps us to work through and identify issues, aid in communication, and integrate perspectives, all the stakeholders, and even in yourself to help build an ethical resolution.

Sarah Vittone:

And then finally all of this building our moral integrity and developing moral courage. When you feel confident, you can act, you continue to look forward, and you look for ways of doing [inaudible 00:27:58]. And our final slide, Claudia. And so this is the point. To be faithful, to have the hope, to find the connection, continue to have those moments with your families, continue to care those professional connections, and most importantly care for yourself and connect and be patient with yourself. This is a trying time. It's unprecedented, and we're so thankful that the Catholic Healthcare Association can find time to bring moral distress and emotional distress to a wider audience. And I know that they are going to have some sessions coming up, Kevin, starting next week.

G. Kevin Donovan:

You're absolutely right. And in conjunction with what you've just been saying, we've been getting some comments from the viewers. One of them has talked about losing a colleague and wanting to have a memorial for them. But that's one of their values. They're constrained by the fact that they can't get so close. They're trying to think, can they do this outdoors in order to gather and still show the respect. Others have pointed out that, as you were saying, you can be mutually supportive in reaching out to the doctors or your clergyman, that kind of support. One of the things that Claudia already reflected on was how difficult it is for our patients and their families not to have access to clergy at the end of life, as some of them do. That for the most part, the questions that have been coming in front of the audience have been well addressed and well answered by your presentation. So I have to commend you both.

G. Kevin Donovan:

There are of course, many more things to think about. And as Dr. Vittone just pointed out, the CHA is going to have a series on our well being/. We have webinars that we'll share, wellness resources that starts next Wednesday at 2:00 PM Eastern time, and we'll have a series just on that topic alone. So I think that will be really great for people who have interest and unanswered questions here. As far as the ethics webinars are concerned, sponsored by the Pellegrino Center at Georgetown Medical School with the CHA, they will continue this coming month. Next Thursday on the 14th, Dr. [Geodonald 00:30:24] from our center will be discussing the ethical issues around pandemic surveillance.

G. Kevin Donovan:

So I think that it will be highly controversial and very interesting. I'm looking forward to hearing it myself. I hope you all can tune in for that. Finally, it is always asked, and we will remind people, slides will be made available to all the attendees following this presentation. And the slides will also have some selected references, as you can see, if you'd like, on the next slide. I want to thank both of our speakers. I think you've done a fine job and really opened our eyes to how moral distress is not only an emotional issue, but an ethical issue that can be addressed and needs to be. Thank you so much.

Sarah Vittone:

All right. Thank you. Bye-bye.

Jacob (Blue Sky):

And with that, on behalf of the Catholic Health Association and Georgetown University, I would like to thank you for participating in today's event. A recording will be sent in an email and will also be posted on CHA's website at www.chausa.org/coronavirus, where you can also find recordings of previous sessions in this series. This concludes today's program. Thank you, and have a great day.