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Traumatic Stress and Clinician Wellbeing in the Time of Covid-19

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I. The problem of clinician distress during public health disasters

The Covid-19 pandemic is a public health disaster that poses grave threats to the wellbeing of healthcare professionals. As we mark the one year anniversary of lockdown intended to slow the spread of the virus, it is a fitting time to pause and reflect on the causes of and potential responses to clinician distress. This article will briefly touch upon traumatic stressors and their possible effects on clinicians, and explore the moral imperative for healthcare organizations to provide resources and support for healthcare workers who are risking their very lives in fulfillment of their professional duties. Finally, as an advanced practice mental health nurse providing support for hospice clinicians during the past year, I look at selected organizational initiatives and personal practices that can mitigate clinician burnout and moral distress.

Like all disasters, the Covid-19 pandemic imposes societal changes that seed volatility, uncertainty, complexity, and ambiguity. Though health-care clinicians are skilled at responding to patient and family dynamics that revolve around pain, suffering, and death, clinicians now find themselves in a novel space where there is heightened awareness of their own mortality—with all the corresponding emotional urgency and impact on their mental and physical health. Multiple risks and losses, related to changes imposed by SARS-COV2 and efforts to mitigate its spread, strain clinicians' work and home lives. This disruption of personal and professional worlds is associated with a triple threat of traumatic stress. There is the prime experience of *trau-*

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Greetings
FROM THE PRESIDENT

Greetings from Northeast Ohio! It is hard to believe spring is almost upon us! In these unprecedented times, I continue to look forward to the year ahead and finding creative and innovative ways to further our organization's mission. First, I want to acknowledge that BENO would not be where we are today without the dedicated members who have recently left the board to participate in other exciting roles in the field of bioethics. I would like to thank our former board members, Stephanie Fabbro and Danielle Paulin, who have recently rotated off the board. Their commitment and vision will be missed. Welcome to our new member Kathy Grannan!

Sadly, our board is less one member due to the recent death of Dr. Robert Taylor. He was re-elected to the board this year for another 3-year term this past fall. He was very active in BENO for many years and was a great teacher and collaborator. This was truly a loss for the field of bioethics, as well as BENO. He will be missed. As a board, we are working on a way to honor his legacy.

Unfortunately, our annual conference at the end of April had to be cancelled this past year due to the coronavirus pandemic. Because of the uncertainty that still surrounds the pandemic, this year we are planning an exciting virtual conference to take place at the end of April 2021! We have many wonderful speakers lined up, covering some interesting topics. Look for details in this newsletter regarding registration! It promises to be an educational day!

As a board, we are constantly discussing ways in which we can further bioethics education throughout Ohio in a way that is accessible to many people in different locations, and that meets the needs of our members. We recognize our members are often balancing many other activities, both professional and personal, and are looking for something that will fit easily into their schedules. We hope to share these opportunities with you in the near future.

We are always looking for new and exciting ways to engage our members. If you have ideas on how we can do that, or needs that we can assist with, please do not hesitate to contact us. I look forward to growing our organization together with you!

Warm regards,

Cassandra

Traumatic Stress *continued from page 1...*

matic stress, defined as experiencing situations that have potential to threaten, endanger, or end their own lives. There is *secondary traumatic stress* that accumulates from witnessing the trauma or suffering of others. During the pandemic, secondary or vicarious trauma can result from the suffering inside clinical situations—such as witnessing multiple deaths of patients without the comfort of families present. It can also accrue from variables outside the clinical situation—such as exposure to the stressors of political division, racial inequity and injustice, the ongoing opioid epidemic, insecure employment or finances, housing instability, or even difficulties obtaining enough food to eat. Finally, there is *moral distress*, the accumulating distress that results from not being able to care for patients and families in the best way possible due to a range of external or organizational conditions that thwart best practices. Moral distress is said to occur when clinicians know the right thing to do in practice settings, but are without the resources to do it. (Jameton).

These kinds of traumatic stress are consistently reported by clinicians giving end-of-life care during the pandemic. In her poignant piece about practicing medicine in a Covid-19 ICU, Rana Awdish expresses bewilderment related to those who would frame her distress as a kind of mental health disorder:
But there was real danger. We were appropriately terrified. We took issue with their terminology. When they framed our experiences in terms of depression and anxiety and PTSD, we withdrew, feeling unheard and misread. What we were experiencing was not a diagnosis, it was a tragedy.
- Rana Awdish (2020), The Shape of the Shore

Yet, as Awdish recounts, there are very uncomfortable bio-psycho-social consequences for clinicians working in the pandemic that can include panic, fear, dread, insomnia, hypervigilance, emotional detachment and/or avoidance of situations that trigger the stress response. The fight or flight mechanism is activated and unless it is regulated, clinicians are at risk for developing a range of stress induced illnesses. Recent clinician wellbeing literature advocates for understanding these stresses and reactions as job related and context driven. For example, moral distress is known to be more prevalent in end-of-life care where repeated exposure to death and dying occurs—this includes Covid-19 intensive care units, hospice, and palliative care settings.

Moral distress can feel like alienation from your deepest self and from others. It is a complex construct that implies conflict at the intersection of personal and organizational values (Rushton) and can erode personal integrity and professional identity. The residue of repeated traumatic stress can culminate in unresolved emotional, physical, behavioral and/or spiritual effects that crescendo in burnout (Epstein & Hamric), a major reason for leaving the health professions. Burnout, a work-related syndrome, is characterized by emotional exhaustion, depersonalization, cynicism, and feelings of ineffectiveness, and often occurs when demands exceed the resources needed for doing a job. At the end of her piece, Awdish implies that what staved off burnout and buoyed her up was the community of caregivers to which she belonged as they cared for dying patients under extremely stressful conditions.

II. Responding to clinician distress

The problems of moral distress and burnout in healthcare are not new. The Covid-19 disaster has simply amplified and intensified rising pre-pandemic levels of clinician distress. Noting that physicians and other health care professionals are suffering burnout at

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alarming rates due to a range of conditions present in contemporary workplace settings, the National Academy of Medicine (NAM) launched the Clinician Wellbeing Collaborative in 2017. The NAM estimates physician burnout at over 60%, with physician suicide occurring at twice the rate of the general population. Rates of emotional exhaustion for nurses are estimated at over 50%, with highest rates of burnout in critical care and hospice settings. If not acknowledged and addressed, burnout and moral distress can result in anxiety, guilt, shame, fear, anger, depression, and other affective mental health dynamics that contribute to increased substance abuse and suicide (Dyrbye).

It is important to note that the NAM literature on clinician wellbeing points to systemic, organizational, and cultural

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***Traumatic Stress** continued from page 3...*

factors as the most salient contributors to clinician wellbeing, and these *external* variables far outweigh personal or *internal* factors. During the pandemic, external variables that contribute to higher levels of clinician wellbeing include adequate staffing; sufficient resources such as personal protective equipment; education about best practices for treating SARS-COV2 infected patients; opportunities for ethics discussions, debriefing, and case conferences; frequent communication from administrators; flexible scheduling that allows for needed breaks; and more. Internal or personal variables that influence clinician wellbeing include factors such as education, experience and skill levels, role responsibilities, and coping styles and ability. In the pandemic, issues such as the concurrent burden of family caregiving and fear of infecting loved ones, comfort with redeployment, and even basic needs such as good nutrition, hydration, and sleep, could also be considered relevant personal variables. Further distress for clinicians results from a general lack of health or science literacy in the lay population and misinformation in media, leading to behaviors that exacerbate the spread of the virus—for example patients/families who do not believe the pandemic is real, do not believe that masks reduce risk and therefore don't wear them, or are ignorant of other facts regarding stopping the spread during this public health crisis.

The Covid-19 disaster has simply amplified and intensified rising pre-pandemic levels of clinician distress.

The most comprehensive approaches for reversing clinician distress during the pandemic include a combination of organizational initiatives and personal practices. Shanafelt et. al. recommend that healthcare organizations spend time listening to and caring for clinicians by providing essential training and equipment, by assuring breaks and rest periods during work shifts, and even by sustaining front line workers with food and help with childcare. For moral distress, nursing authors advocate for focused ethics discussions and ethics education conducted in supportive clinician communities (Rushton; Traudt; Zannata).

On the side of personal coping strategies, trauma-informed therapeutic practices (Grabbe) can reverse effects of secondary traumatic stress for clinicians, though many authors call for reframing clinician distress as an expected occupational hazard rather than mental illness, since the stigma of asking for mental health services is a reality. The burgeoning field of trauma studies offers strategies for post-traumatic growth and resilience that involve body-centered practices focused on creating safety and security by accessing inner references of peace and calm, and by resourcing a caring community (Miller-Karas). Through centering exercises that involve mindful movement, attention to breathing, and other restorative practices, clinicians can regulate and balance the autonomic nervous system beyond the fight or flight response. Resilience, as defined here, is a construct that describes a recovery process of adaptation and psychic reconfiguration for human beings after a traumatic event. Resilience practices can foster hope, restore agency, and help a person to relegate traumatic experience to the past. Human beings are resilient and post-traumatic growth is possible! Learning, acceptance of moral suffering, and meaning making can occur through peer based dialogue and community support. In the aftermath of traumatic experiences, acceptance of moral suffering and renewed commitment to professional values can be outcomes of focused reflection on the shared sorrows and joys of working through tragedy (Dean-Haidet).

In my hospice workplace, we offered a variety of interventions to support clinicians including weekly Covid-19 case conferences that focused on patient and clinician wellbeing. We moved to offer clinician support through virtual Restorative Circles of Peer Support which provided much needed peer contact that was lacking due to changed clinical practices and reduced workplace gatherings. These early morning 15-20 minute virtual drop-in sessions offered a chance to check in with each person present, to practice a brief mindfulness exercise, and contemplate a poem or prayer. Community Conversations were 30 minute end of the workday virtual gatherings that focused on more social interaction. Individuals took turns hosting community events such as cooking demos, leading art projects and music broadcasts, sharing pets online, and more. We hosted a group we called Beloved Conversations on Race in conjunction with our diversity and inclusion council in order to address thoughts and feelings that followed major outbreaks of racial violence in the national news. We

created podcasts for mindful masking, for letting go of the workday, and for guiding virtual good-byes to loved ones who could not be together at the end of life. We converted a weekly newsletter to include wellness tips for all hospice workers. The psycho-educational strategies listed here focused on awareness of psychological distress, initiation of stress reduction techniques, exploration of professional

values, and particular ways of enhancing clinician wellbeing through peer group support (Zannata).

III. A view from the field: coping with multiple losses

As a mental health consultant, I have participated in over sixty clinician support groups conducted in hospice and palliative care during the past year. After the initial shock and adjustment period which contained much uncertainty and lack of clarity about transmission of the virus and the protective measures needed, the reality of multiple losses became clear to clinicians. The effects of multiple deaths and the debilitating effects of Covid-19 were felt by clinicians in various degrees based on role, setting, and patient population. However, no matter the setting, clinicians lost the face to face practice of providing care. Their personal lives were also riddled with losses….graduations, weddings, funerals, and other milestone events were cancelled or postponed indefinitely. Loss of life, employment, income, housing, and other devastating life changes accompanied the spread of the virus.

In reference to living with Covid-19, the contemporary thanatology literature is focused on the cumulative losses and complicated grief that we are facing as Americans and clinicians alike. One of the most devastating losses remains the inability to gather in person as we follow masking and social distancing guidelines. This loss is acutely felt by patients and families who are separated due to the risk of contagion, and also by clinicians who previously gathered formally and informally to debrief the difficult aspects of their jobs. These complex losses can cause prolonged grief related to disrupted relationships and unsatisfactory leave-taking ritual. The emotional impact of these losses may eventually be examined more fully as we enter the full recovery phase of the disaster.

The pandemic offers a glimpse into the reality of human finitude. At the center of our grief is a stark realization that death is often closer than we want to admit and is out of our control. Many of us have lost our "assumptive worldview" as we are forced to reconcile how life is now with the way it used to be, or the way we think it should be. The much touted idea of a future new "normal" seems flawed in that many losses can never be recovered. We are currently betwixt and between, or living in what anthropologists call liminal space. We are not who we were before the pandemic, but we are not quite who we will be when it is over either.

IV. Pandemic as portal: learning and growing amidst uncharted pandemic stressors

We have an opportunity to see the pandemic as a passageway to a better future. What will we learn from this public health disaster? We are positioned to reimagine public health in the United States with an eye towards understanding the social determinants of health and removing institutional bias in healthcare delivery. We could examine the many ways that health (mis)information is circulated, and the ways that trust in medical care is hampered especially in communities of color. We could plan for fully integrated mental healthcare that doesn't stigmatize those seeking help. We may learn more about the nuances of moral distress, perhaps distinguishing between that which is intrinsic to end-of-life care, and that which results from organizational failures. According to a US government Substance Abuse and Mental Health Services Administration model (DeWolfe), disasters typically follow a trajectory of heroic response, disillusionment, and gradual reconstruction, accompanied by emotional highs and lows. In this year of vaccine, there is hope for recovery. But what will healthcare clinicians need to continue working through the end of the pandemic without injuries to their own mental, physical, and spiritual health? How will they recover from the multiple losses sustained and flourish as human beings? Perhaps we need to ask these questions of clinicians now and listen carefully.

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Ethics Committees for Community Based Services – A Unique Focus

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Co-Chair, OhioHealth EACCBS

Ethics committees have existed primarily in the acute care environment since their inception. The American Medical Association's Code of Medical Ethics Opinion 10.7 is titled "Ethics Committees in Health Care Institutions" [1]. Most definitions of ethics committees refer to "hospital" as the locus of services. The most common topics for ethics consultation requests reported in the literature relate to hospital-based issues, often of a time-sensitive nature. In his article on the emergence of hospital ethics committees, Aulisio [2] points out that there were almost no ethics committees as recently as 40 years ago. Rapid expansion in the hospital environment has occurred as a result of key clinical cases and changing expectations of accrediting bodies. An article focused on nurses' roles in addressing ethical challenges provides three examples, all hospital based [3]. More recently, some nursing homes have established ethics committees. Addressing healthcare related ethical challenges outside of the institutional setting is not prominent in the literature.

Increasingly, though, there are indications that ethics committee work is expanding to more proactive roles in addressing issues such as population health, social determinants of health, and community-based care. In her presentation on the importance of ethical committees in the evolving healthcare environment, Glover [4] speaks to issues such as price of medications and patient choices related to adherence to plans of care based on cost. The current pandemic has changed the way health care is delivered; telehealth is one key example. Emerging issues such as COVID-19 vaccine availability and distribution are creating opportunities for consideration of ethical challenges that go beyond hospital walls and typical institutional ethics committee areas of focus.

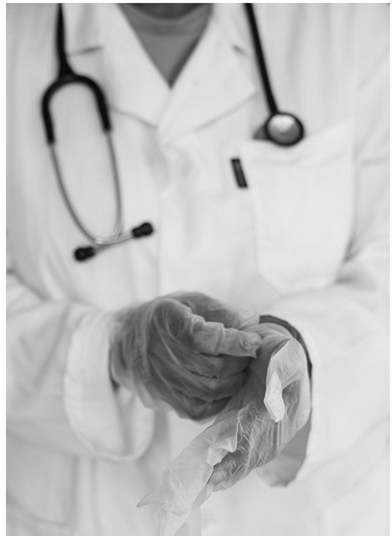
OhioHealth, a large faith-based healthcare system in central Ohio, was a pioneer in establishing a community-based services ethics advisory committee in 2004. The Ethics Advisory Committee for Community Based Services (EACCBS) at OhioHealth has been a key component of OhioHealth ethics consultation services since 2004. Service lines supported by EACCBS include home care, inpatient and home hospice, home medical equipment, infusion therapy, and the Gerlach Center for Senior Health. Prior to 2004, ethical dilemmas arising within these services were addressed by one of the hospital ethics committees within the OhioHealth system. As home care and hospice services grew, the physician director of the hospice program, who sat on the hospital ethics committee, realized that the hospital ethics committee was not adequately prepared to address the unique needs of patients and families in the community-based care setting. She approached the OhioHealth leadership team with a proposal to start a community-based services ethics committee, which was strongly supported. The committee was formed as a unique entity within the ethics committee structure at OhioHealth and has continued to thrive as it meets unique needs of staff, patients, and families. As part of its 10th anniversary celebration, the committee was honored to present a concurrent session at the 2014 American Society of Bioethics and Humanities conference, focusing on the unique role of a community-based services ethics committee.

Current interprofessional committee membership includes a clinical ethicist, physicians, nurses, social workers, therapists, and chaplains. The membership is almost equally divided between OhioHealth at Home associates and community members. Many of the issues above have been addressed by this committee, with a very different perspective than hospital-based ethics committees. Additionally, co-chairs of the EACCBS serve on the system's Joint Ethics committee and have been able to offer a more holistic consideration of ethical challenges in complex cases related to transitions between hospital and home care or hospice services. Following are some of the unique features noted as a result of this committee's work.

Hospital ethics committees often deal with end-of-life challenges, surrogate decision making, and similar issues related to differences in values between patients/families and clinicians. Consult requests in community-based services, in contrast, often focus on ethical dilemmas of

staff who have values conflicts between patient/family choices in their homes and the prescribed plan of care. Common areas of concern in community-based services are safety of patients and/or family members (sometimes involving children) in the home, safety of staff in a patient's home, patient autonomy, substance use disorders impacting patients and families, and environmental conditions. The focus of the clinician as a guest in the patient's home presents unique challenges when ethical dilemmas arise. The role of the interprofessional team is critical in the community-based services setting – chaplains, respiratory therapists, oxygen delivery personnel, physical therapists, nurses, and others are often involved, individually or in teams, in providing care in the home. Each brings a different perspective related to needs of patients/families, resources available in the home or the community, and receptivity of the patient/family to healthcare providers as "guests" in their home.

One example involved a patient with chronic obstructive pulmonary disease on home oxygen. The patient was a long-time smoker and chose to continue the smoking habit. Because this individual lived in an apartment building, there was concern about not only his safety but that of other residents in the building. Factors considered by the committee were patient safety, autonomy, and confidentiality; prevention of harm to the patient and others; and the ongoing need for medical treatment. With ethics committee deliberation and consultation with the care team and patient, the outcome was that the patient moved from an upper story apartment to one on the ground floor with a patio. When a desire to smoke arose, the patient discontinued the oxygen and stepped onto the patio to smoke. Patient autonomy was respected, safety to the patient and others was protected, and necessary medical care was able to be continued. The collaborative consultation process and the resulting positive outcome provided staff with best practice options in additional situations of non-compliance with treatment recommendations.



In the hospital setting, there is often a sense of urgency related to addressing ethical dilemmas and supporting clinicians in making time-sensitive decisions. In the community-based setting, there is less urgency but equal significance in terms of quality of life, safety, and autonomy in decision making. Engaging a clinical ethicist in consultations in a timely manner promotes the value of addressing ethical dilemmas and supports care teams who are struggling with challenging situations.

Staff turnover in the home care environment is high, creating challenges in educating staff and managers in best ways to address ethical challenges and moral distress. With productivity an issue, taking time to thoroughly analyze situations and seek ethics committee/consultant guidance sometimes takes a back seat to "quick fix" interventions or avoidance. Staff transitioning to the home care environment from an institutional setting often find it challenging to adapt to functioning in a setting that is controlled by the patient and family rather than the patient being expected to follow hospital requirements, leading to moral distress.

In order to contribute to case reviews, policy development and review, and education, a community based ethics committee needs to be aware of issues that might not arise, or might occur in a different context, than for patients in hospitals or long term care facilities. Examples include informed consent, elder abuse and child abuse resources and reporting requirements, self-neglect, cultural aspects of health and care, spirituality, futile treatment, privacy & confidentiality, and use of social media.

As care delivery continues to shift to the community environment, a community-based ethics advisory committee is well positioned to address unique needs of patients, families, and to address community health issues. Recognizing the uniqueness and challenges faced by patients and families in their homes enables a community-based committee to focus on issues that would otherwise not be addressed in a typical hospital-based ethics committee.

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INTERVIEW

Kathy Grannan,
RN-C, MSN, CNL

Last year, members of the Bioethics Network of Ohio elected Kathy Grannan, RN-C, MSN, CNL, to a three-year term as a member of BENO's board of trust. Kathy has been a BENO member and attended the annual conference for many years but has never before served on BENO's board of trust. Kathy brings to the BENO board a wealth of experience in nursing across numerous care environments.

The interview that follows is a chance to get to know Kathy in more depth than the ballot statement allowed; it also gave me the opportunity to reflect on a very strange time in healthcare with a very interesting person.
– Alan Murphy

Alan Murphy: BENO's 2021 annual conference is moving online to guard against interference by the ongoing COVID-19 pandemic. While recognizing that we'll all miss the chance to see one another in person, what most excites you about this first – perhaps only! – online annual conference?

Kathy Grannan: I am excited about the online access to the BENO conference at a time when so many ethical issues plague health care. Allocation of resources, safety versus autonomy, ethnic disparities, and many more issues plague both professional and personal lives for many in health care. Conference attendance may actually increase with the ease of access that the online option provides, through the accommodation of location and timing. Social distancing easily accomplished, and no mask needed! I look forward to seeing faces: old members and new alike.

AM: You've nominally retired after a long and accomplished career in healthcare. What in your considerable experience in healthcare has been most valuable to you as you approach healthcare ethics? Which of your views in healthcare ethics have changed the most over the course of your career?

KG: Regarding ethical perspectives, perhaps the most valuable aspect of my 43 years in nursing is the diversity of my work experience. I characterize this in two ways: diversity of health care concerns, and the interdisciplinary nature of my work. The diversity of perspectives encountered in my work in 10 different specialty areas; inpatient, outpatient and community health care settings, and administrative roles have required problem solving skills and broad understanding of complicated circumstances. My roles in nursing governance, education and a broad spectrum of committee work has provided an in-depth look at many health care issues and increased my capacity to understand "the gray areas" of health care issues. Perhaps the view that has changed the most, and is still not finished changing, is the reconciliation of the mission of healthcare versus the business aspects of providing care. Keeping both aspects of that equation healthy is a constant and evolving struggle. As a new nurse (in 1976) I was fairly singularly focused on patient advocacy. My years of experience have taught me to balance patient needs with the health of the organization to accomplish goals.

AM: You're a new BENO board member but very far from new to healthcare ethics in Ohio. Your career as I've known it focused on out-patients in central Ohio. Healthcare ethics is a visible presence in in-patient environments across Ohio, but remains less conspicuous in the out-patient environment. What needs in healthcare ethics do you think out-patient care has that in-patient healthcare ethics might overlook? What do you think are the best opportunities an organization like BENO has to support healthcare ethics in the out-patient environment?

KG: What an excellent question! When we first formed OhioHealth's Community Services ethics committee, we knew there were concerns that inpatient settings would never encounter. Issues surrounding patient autonomy and compliance are completely different when professionals meet patients on their own turf. Safety concerns for both patients and health care workers are dramatically different. Disparity in healthcare and access to resources becomes much less gray when you are standing in the midst of a dangerous or impoverished situation. BENO could be a real asset to the large number of healthcare professionals who face these issues without the support of an ethics resource versed in outpatient care concerns. We could consider a blog, a section of the *BioQuarterly* with references to case studies or research on outpatient care, and sharing insights from our unique outpatient ethics committee with other hospital systems with outpatient services.

AM: A lot of your BENO board member colleagues, and a lot of *BioQuarterly's* readers, work primarily in in-patient environments and have been embroiled in figuring out how to operate during a public health crisis without parallel in recent memory. There are so many patients and so many projects we have only because of COVID-19. I worry that I am becoming a little myopic as I turn from one COVID-19 issue to another, minute to minute, hour to hour, day to day. I expect that, with your background and current circumstances, you have a valuably different view of the pandemic. As the pandemic enters its second year, what do you think those of us wrapped up with COVID-19 on the inpatient side of things are most in danger of missing about the pandemic's significance for healthcare ethics?

KG: Tracking ethical issues surfaced by the pandemic in some ways resembles chasing a moving target. The fires you are trying to stamp out in inpatient care are directly linked to outpatient and community issues. Addressing pandemic ethical issues in the community may allow for fewer hospitalizations and wiser allocations of resources. Examples on the outpatient side might include identifying candidates and determining most effective use of antibody infusion options; facilitating safe and timely outpatient administration without putting other infusion patients at risk; equitable allocation of PPE for community essential workers such as healthcare professionals in congregate settings and first responders, equitable allocation of vaccines, and even oxygen as hospital capacities are reached. Each of these issues requires making choices influenced by budgetary concerns, staffing, educational needs and the meshing of professional and political perspectives.

AM: US healthcare ethics has been preoccupied with the COVID-19 pandemic this year. What healthcare ethics issues other than the pandemic do you think need the most attention, and why?

KG: The pandemic has shed more light on the issue of disparities in health care, but the topic is truly a much broader issue than the pandemic perspective reveals. The body of

research in this area is growing and I feel this would be a timely topic for the present and the future. Political perspectives aside, if healthcare professionals take on the reality of these disparities, who better to objectively address the problems that underlie these disparities? Directly connected to that are the ethical issues surrounding "affordable" health care. I would really enjoy a frank discussion on healthcare costs, payment structures, insurance status, and consumer attitudes about paying for healthcare. A panel of professionals representing healthcare administration, insurance, CMS, single payer advocates, and social work professionals in touch with under-insured populations would be a lively session! My third choice is another that the pandemic has shed light on but again the topic exceeds the pandemic perspective. Moral distress amongst healthcare workers may be at an all-time high at present, but the benefits of a discussion on this topic carry beyond our current circumstances. Ethics committees constantly interface with healthcare workers facing tough, even life threatening situations, where patient or personal safety is at issue. An in-depth look at levels of responsibility (patient, professional, institutional, societal, and faith community) for all involved in such situations, accompanied by a view toward professional resilience, would be a laudable topic. It might provide personal insight and some broad perspective ideas.

AM: Since you mention the growing body of research on disparities in healthcare, do you have any recent articles or books you'd especially recommend to *BioQuarterly's* readers, who no doubt encounter those realities every day but may not be as familiar with the relevant literature as you are?

KG: Articles regarding healthcare disparities research are as diverse as the populations they hope to improve care for! Examples of subject matter include studies of the social determinants of equity; the possible overuse of health care; the impact of the ACA and the transformation of payment and delivery systems on equity; the role of cultural competence and communication on equity; even the study of ethnicity's role in clinical trial design and drug response. Wasserman and colleagues offer an overview of research and gaps in knowledge since the initial Institute of Medicine's 2004 report on disparities [1]; Zimmerman and Anderson offer updates on progress in addressing disparities [2]. And Wilkinson and colleagues describe some strategic proposals to address inequities [3]. Readers may also note that the reference lists for these articles contain links to more specific aspects that may prove useful for their professional role.

AM: You also mentioned moral distress as a major concern, one exacerbated by the pandemic but which will surely outlast it. Moral distress is described a lot of different ways, but one of the most commonly-cited definitions, originating with Andrew Jameton, characterizes moral distress as the affective state arising from "know[ing] the morally correct action to take but [being] constrained in some way from taking this action." [4] Many of the things that prevent clinicians from doing what they feel they ought to do are very specific to individual situations. Sometimes, the constraint on the clinician is a result of institutional policy or practice. And perhaps too often, the constraint is societal (e.g., models of healthcare reimbursement), which private organizations can influence but not control. What role do you think a statewide, educational, healthcare ethics organization like BENO can have in addressing moral distress?

KG: BENO's major focus is to serve as an educational resource for healthcare professionals where ethical issues are concerned. Our current outreach includes an annual conference on current ethical issues, a resource linkage through our website, a quarterly publication with insight into current issues. Each of these formats provides an opportunity to provide professionals with case studies and current literature, naming issues of moral distress and examples of effective coping strategies, as well as the opportunity for professionals to share strategies.

AM: 2020 was a very strange, very strained year. As we went through a holiday season without parallel in my memory and as the pandemic has spilled over into 2021, I know I've struggled sometimes to appreciate what I have to be grateful for, even while I know that appreciating what good we have is important for resilience in the face of moral distress. As you think over the pandemic, what have you found to be grateful for?

KG: The silver linings in a year such as 2020 aren't always easy to see. As a human being, I celebrate respectful collaboration wherever I can find it, such as in scientists working together globally to address pandemic concerns, a peaceful record voter turnout, and a greater number of people than ever recognizing the impact of economic and cultural disparities and wanting to bring about change. Personally, I celebrate new perspectives on solitude and some of the unexpected perks that come with a shrunken "to do" list brought about by pandemic restrictions. I am learning more about "being in the moment". I am grateful for the beauty of creation all around me, the love of family and friends, and a warm brownie fresh out of the oven!

AM: And as we continue into 2021, what do you hope for in US healthcare? I imagine resolution, or at least stabilization, of the COVID-19 pandemic has to be on your mind; certainly it is on mine. But assuming we get something like that by the end of 2021 – which I grant is an optimistic sort of thing to assume – what else would you hope for?

KG: One of the greatest hopes I have in 2021 is that the lessons learned from this pandemic about preparedness will translate into an international plan without hesitation. I have been involved in planning discussions for pandemics in the past, but those fell short of what was needed for 2020. I also hope these lessons become part of healthcare professional education including the degree programs, primarily in the areas of understanding how to cope with personal risk in each role and some insight into maintaining resilience. An additional hope is for increased awareness of cultural disparities within our workplaces and a commitment to cultural competence to diminish inequity.

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