Racial Inequities and Moral Distress: A Supplement to *Moral Stress Amongst Healthcare Workers During COVID-19*

A Guide to Moral Injury

Centre of Excellence - PTSD
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Contents

Key messages

- Racialized communities have been disproportionately effected by the COVID-19 pandemic. Our recent publication *Moral Stress Amongst Health Care Workers During COVID-19: A Guide to Moral Injury*, excluded this vital lens.
- In additional to systemic discrimination within our society and the Canadian healthcare system, the COVID-19 pandemic has created and perpetuated stressors that can further weigh on racialized healthcare workers. We created *Racial Inequities and Moral Distress: A Supplement to Moral Stress Amongst Healthcare Workers During COVID-19: A Guide to Moral Injury* to name this issue.
- Lived experiences of racism and discrimination can collide with the moral stress of working in healthcare and put racialized healthcare workers at an increased risk of experiencing moral distress and moral injury, as the COVID-19 pandemic converges with events that highlight persistent racial injustice.
- While some healthcare workers may experience pride, gratitude, and a sense of purpose from being able to support their communities during COVID-19, others may experience an additional burden on their mental health and well-being.
- The Centre for Excellence on PTSD and other Related Mental Health Conditions is seeking community partners to co-determine and co-develop next steps in protecting racialized and non-racialized healthcare workers from the potential long-term mental health implications of moral distress and moral injury during and after COVID-19.

Introduction

This document is a supplement to Moral Stress Amongst Healthcare Workers During COVID-19: A Guide to Moral Injury. Its aim is to raise awareness and inform essential workers and healthcare leaders about intersecting health inequities and stressors that disproportionately affect racialized people in Canada and that may uniquely inform their experience of the COVID-19 pandemic.

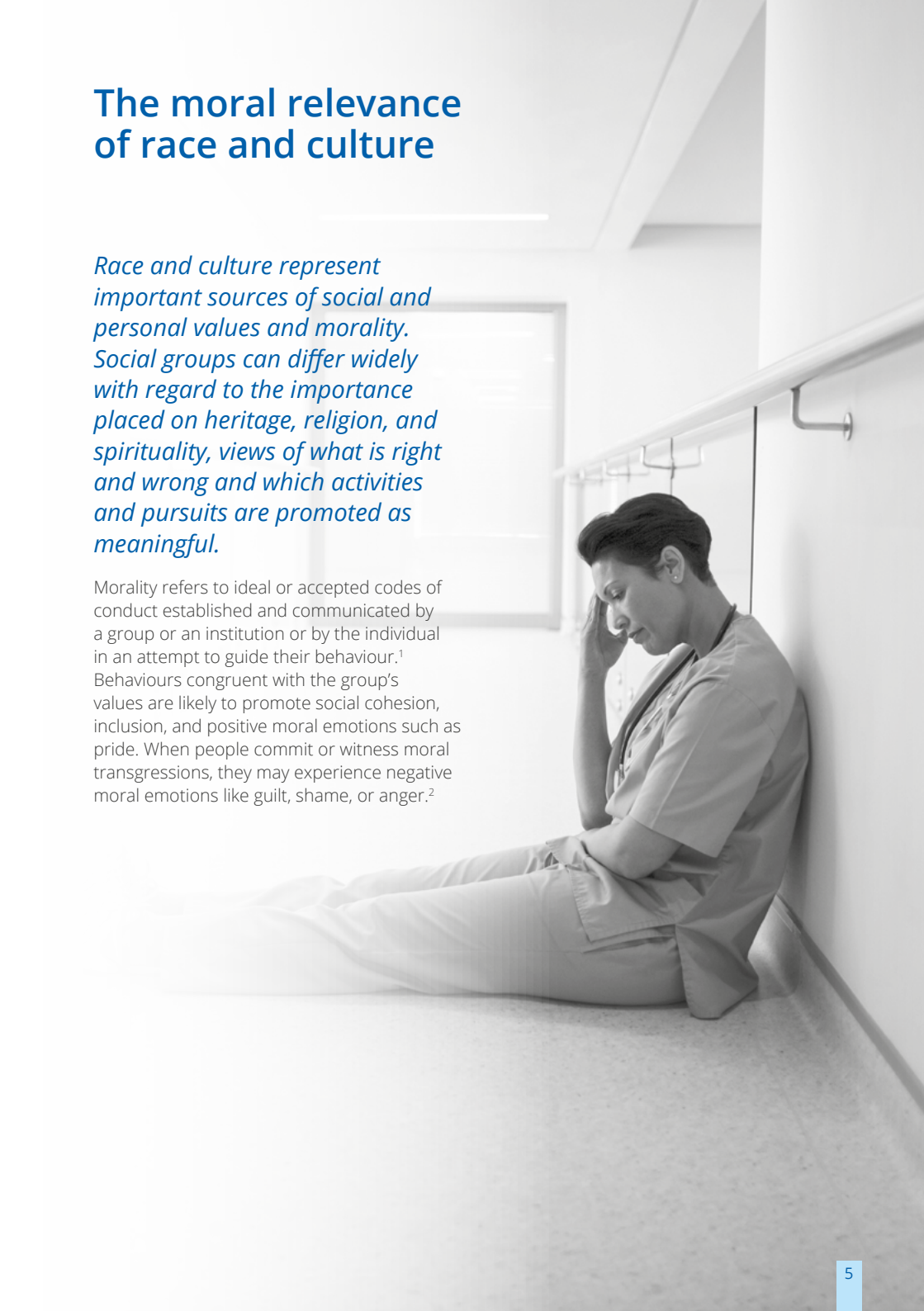
While the *Guide to Moral Injury* focuses generally on the increased risk of moral stressors implicit in healthcare service delivery during the COVID-19 pandemic, it did not address how the diverse identities of healthcare workers may inform or compound that distress. With this supplement, we aim to recognize and prompt discussion about the impact of racial disparities on mental health and in the healthcare sector. This supplement has been developed by synthesizing findings from academic and grey literature and firsthand accounts of racialized healthcare workers. The Centre of Excellence on PTSD and Related Mental Health Conditions is committed to centring equity and inclusion in its work. As such, we are soliciting feedback and exploring ways to support and amplify the voices of people with lived and living experience to further this necessary discussion.

This supplement explores how race and culture intersect with morality and are axes of identity relevant to the experiences of moral distress and moral injury. It also discusses how racism, as a determinant of health, has influenced health outcomes during the COVID-19 pandemic. In addition, it suggests that health disparities and inequities may cause and/or exacerbate moral distress in racialized healthcare workers during the COVID-19 pandemic, and provides preliminary insight into how researchers may begin to better understand and address the association between racism and moral distress.

The moral relevance of race and culture

Race and culture represent important sources of social and personal values and morality. Social groups can differ widely with regard to the importance placed on heritage, religion, and spirituality, views of what is right and wrong and which activities and pursuits are promoted as meaningful.

Morality refers to ideal or accepted codes of conduct established and communicated by a group or an institution or by the individual in an attempt to guide their behaviour.[1] Behaviours congruent with the group's values are likely to promote social cohesion, inclusion, and positive moral emotions such as pride. When people commit or witness moral transgressions, they may experience negative moral emotions like guilt, shame, or anger.[2]



On a societal level, morality has historically been wielded against people and groups who have been marginalized in Western societies. Marginalized people and groups have been, and continue to be, unfairly represented as immoral or morally inferior. For example, Western societies perpetuate misconceptions that people who are poor, people who use drugs, and people with histories of criminal justice involvement experience the struggles they do because they are unwilling to lead moral lives.[3]

A dominant discourse that positions racialized people and/or cultural markers of difference as immoral has resulted in "perpetual subjugation and harassment by government officials" and police,[4] and has justified oppression and assimilation.[5] Racialized people or groups that have been positioned as a threat to established norms and practices are continually monitored, managed, and held "in check" by policies, institutions, and structures that, directly and indirectly, uphold those norms and preserve symbolic boundaries.[6] The classification of who "belongs" on what side of the boundary is interlinked with race and racism because racial hierarchies inform the determination of which individuals and groups uphold and exemplify upright cultural values. Consequently, the values that connect marginalized people to their identities and communities are often devalued and suppressed.

The norms and practices of the dominant culture are also the frame through which its systems are established, managed, and preserved, given that the administration of those systems is typically overseen by those who are part of the dominant culture. This is frequently to the detriment of racialized people and groups.[7] The proliferation of discrimination and manifestation of racism in every major societal institution is referred to as systemic racism.[8]

In Canada, systemic racism has had devastating social, cultural, economic, and health consequences for racialized people who routinely face barriers and inequities in terms of access to meaningful employment and education, adequate housing, and mental healthcare as well as higher rates of problematic substance use and criminal justice involvement.[9] The dehumanizing and delegitimizing effects of racism can influence people's moral experiences of self and community and can contribute to psychological distress, which might include moral distress and moral injury.[i]

[i] *As research on moral injury in health care remains nascent, so, too, does the exploration of the ways in which race may be a mediating factor in experiences of moral distress and moral injury. Further research is needed to understand whether and how race informs understandings of moral distress and moral injury as well as how racialized health care workers may be distinctly impacted by morally distressing experiences.*

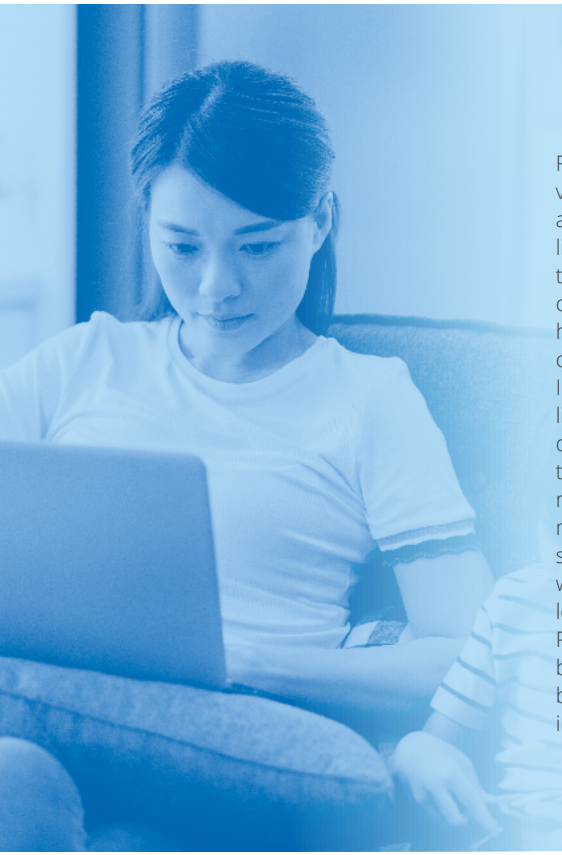
COVID-19, systemic racism, and psychological distress

The COVID-19 pandemic has laid bare the impact that systemic racism and racial discrimination have on the physical and mental health of racialized people.

At the start of the pandemic, people around the world quickly learned that everyone is at risk of contracting the virus. Although COVID-19 in this way "does not discriminate,"[10] it has revealed that discriminatory structures, attitudes, and policies have created different starting lines in the pandemic for racialized people and communities.[11] In particular, longstanding health disparities and inequities have made it more challenging for racialized people to resist exposure to and contraction of COVID-19, which has meant worse outcomes in those communities.[ii]

In Canada, rates of infection have coincided with race, as more racialized people live in neighbourhoods with the highest rates of COVID-19.[12] In the US, Black and Latinx communities in particular are experiencing higher rates of infection and mortality;[13] this is also the case for Black, Asian and minority ethnic groups in the UK.[14]

[ii] *Until health officials agreed to collect and publish race-based data, neighbourhood maps of Toronto and Montréal comparing annual household income with COVID-19 infection rate were used to demonstrate the correlation between the two. Data released in July 2020 revealed that Black people comprised 21% of Toronto's reported COVID-19 cases but only 9% of its population, and that 51% of reported cases in the city were from people living in low-income households, while only 30% of the population is considered low income. Click here for the complete dataset from the City of Toronto.*



Racialized people have been made more vulnerable to the virus because historical and persistent systemic inequity creates lived realities that increase exposure to the virus and the likelihood of developing chronic conditions, such as diabetes and hypertension, which contribute to COVID-19 complications.[iii] In Canada, Black and Indigenous people and newcomers are more likely to experience poverty, live in high-density neighbourhoods and/or in situations that make physical distancing challenging, if not impossible.[iv] Racialized people are also more likely to work in jobs deemed "essential services" on the front lines of the pandemic—warehouse and courier/delivery services, long-term care homes, and grocery stores.[15] People who work these jobs are unlikely to be able to work remotely; these jobs tend to be low-paying and may not come with health insurance.[v]

[iii] *As Neeraj Bhala et al. (2020) point out, racialized and ethnic groups are heterogeneous and as such have diverse risk factor profiles that are informed by social and economic disadvantages and that may influence COVID-19 outcomes. Black, Indigenous and Latinx people are also more likely to live in food deserts, in areas where they are exposed to pollution, and in areas with neglected infrastructure, all of which can contribute to or exacerbate the symptoms of chronic conditions, and leave people immunocompromised. See: Bhala, Neeraj, Gwenetta Curry, Adrian R. Martineau, Charles Agyemang, and Raj Bhopal. 2020. "Sharpening the Global Focus on Ethnicity and Race in the Time of COVID-19." The Lancet 395 (10238): 1673-1676; Fang, Lei, George Karakiulakis, and Michael Roth. "Are Patients with Hypertension and Diabetes Mellitus at Increased Risk for COVID-19 Infection?" The Lancet Respiratory Medicine 8 (4): e21.*

[iv] *This includes people who are incarcerated, who are more likely to identify as Black or Indigenous. COVID-19 outbreaks in Canadian and US prisons have been substantial, but access to testing, cleaning supplies and PPE has been inadequate. In facilities in Ontario and Quebec, detained migrants and incarcerated people have been "quarantined" in solitary confinement units, which led to hunger strikes and protests. See: Henriques, Brittany, "Coronavirus: Four Men Continue Hunger Strike at Immigration Monitoring Centre in Laval," Global News, March 28, 2020, https://globalnews.ca/news/6746367/coronavirus-immigrants-hunger-strike-laval/; Hasham, Alyshah, "Inmate hunger strike at Ontario jail ends after five days," TheStar.com, June 22, 2020, https://www.thestar.com/news/gta/2020/06/22/inmate-hunger-strike-at-ontario-jail-ends-after-five-days.html*

[v] *These jobs are also feminized: they are largely done by women, and devalued and undervalued because they are done by women.*

COVID-19 has also "uncovered social and political fractures within communities, with racialized and discriminatory responses to fear disproportionately affecting marginalized groups."[16] For example, political discourse and publicity surrounding the virus' origin in China prompted a surge of anti-Chinese displays of racism worldwide, including the defacement of public property and assaults and hate crimes against individuals of Chinese and East Asian origin.[17] Statistics Canada data released in July 2020 found that, since the start of the pandemic, "the proportion of visible minority participants (18%) who perceived an increase in the frequency of harassment or attacks based on race, ethnicity or skin colour was three times larger than the proportion among the rest of the population (6%)."[18] Although these attacks have been motivated by fear and misinformation about the origin and spread of coronavirus, they are enabled by longstanding xenophobic attitudes towards Chinese and Southeast/East Asian Canadians.[vi]

Concurrently, recent fatal incidents of police violence against Black people, which were reported during the pandemic and viewed around the world, have compounded the crises caused by the pandemic. This longstanding, historical injustice, amplified as such by the Black Lives Matter movement, has prompted reckoning with the "complex struggle over the pandemic, racial injustice, and police brutality."[19] The unconscionable deaths of George Floyd, Ahmaud Arbery, Breonna Taylor, Regis Korchinski-Paquet, Ejaz Choudry, and others, have reignited conversations about longstanding racism and racial discrimination in policing, and has prompted recognition of this moment as a "double pandemic."[20] The Commissioner of Health of the City of New York, Dr. Oxiris Barbot, used the term "collective moral injury" to describe the "lasting emotional and spiritual impacts on a community when authorities commit actions that violate core moral values."[21] In turn, as they grapple with the unprecedented circumstances of COVID-19 in a society undergirded by systemic racism, racialized people are at increased risk of negative legal, physical and mental health consequences.[22]

When it comes to mental health, narratives and emergent data demonstrate that the mental health of Black and Indigenous people in Canada has been made worse by the double pandemics of COVID-19 and racial injustice. Black people in Canada are sharing their experiences of individual and collective exhaustion and collective trauma.[23] Mental health professionals are raising awareness that young, Black clients are expressing "devastation they feel is a cumulation of a lifetime of repeated traumatic experiences based on race, and this has profound effects on their mental health and sense of self."[24]

[vi] *Following the SARS outbreak in Toronto in 2003, Chinese, Southeast/East Asian and Filipina communities experienced racist backlash in the form of alienation, discrimination and racist remarks. See: Leung, Carrianne. 2008. The Yellow Peril Revisited: The Impact of SARS on Chinese and Southeast Asian Communities." Resources for Feminist Research 33 (1-2): 135.*

Indigenous leaders and activists have emphasized that in many Indigenous communities, fears of an outbreak, isolation, existing mental health issues in the community, and barriers to care are worsening mental health during COVID-19.[25] Recent Statistics Canada data demonstrates that, since the start of physical distancing, Indigenous peoples are more likely than non-Indigenous people to report fair or poor mental health, more likely to report symptoms consistent with anxiety, and more likely to describe their mental health as somewhat worse or much worse.[26] Indigenous leaders and activists have also emphasized that the pandemic may increase the risk of and rates of violence for Indigenous women and girls asked to self-isolate in unsafe living situations.[27]

Risk of moral distress and moral injury in racialized people working in healthcare

During COVID-19, healthcare workers already grappling with the daily stressors of their work are now facing heightened challenges of care provision in the pandemic. As the pandemic collides with national reckonings with systemic racism, racialized healthcare workers may be at increased risk of experiencing psychological and moral distress.

Racism in medicine and healthcare has long been identified as a reality and a stressor for racialized healthcare workers.[28] It compounds the typical stressors of care provision and contributes to distress, reduced morale, self-doubt, burnout, and mental health problems, including anxiety and depression.[29] It may come from patients and clients or from colleagues.[30] Racialized healthcare workers may face skepticism about their training or competence, belittlement of the way they speak, work, and/or dress, questions about their ethnic or racial background, and denigration of their religious beliefs or cultural practices.[31] They also report witnessing colleagues make discriminatory comments about racialized patients.[32]

Harassment and racial discrimination may be subtle. Covert forms of racism may take the form of microaggressions, "brief and commonplace daily verbal, behavioural, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory or negative racial slights and insults to the target person or group."[33] A recent study of the impact of racial microaggressions on racialized medical, nursing and physician assistant students found that they left students feeling devalued, inferior, and isolated, and had a negative impact on students' academic performance and well-being.[34] Although awareness about microaggressions is increasing in organizations and social settings, their intangibility and commonplaceness makes them difficult to identify and respond to.

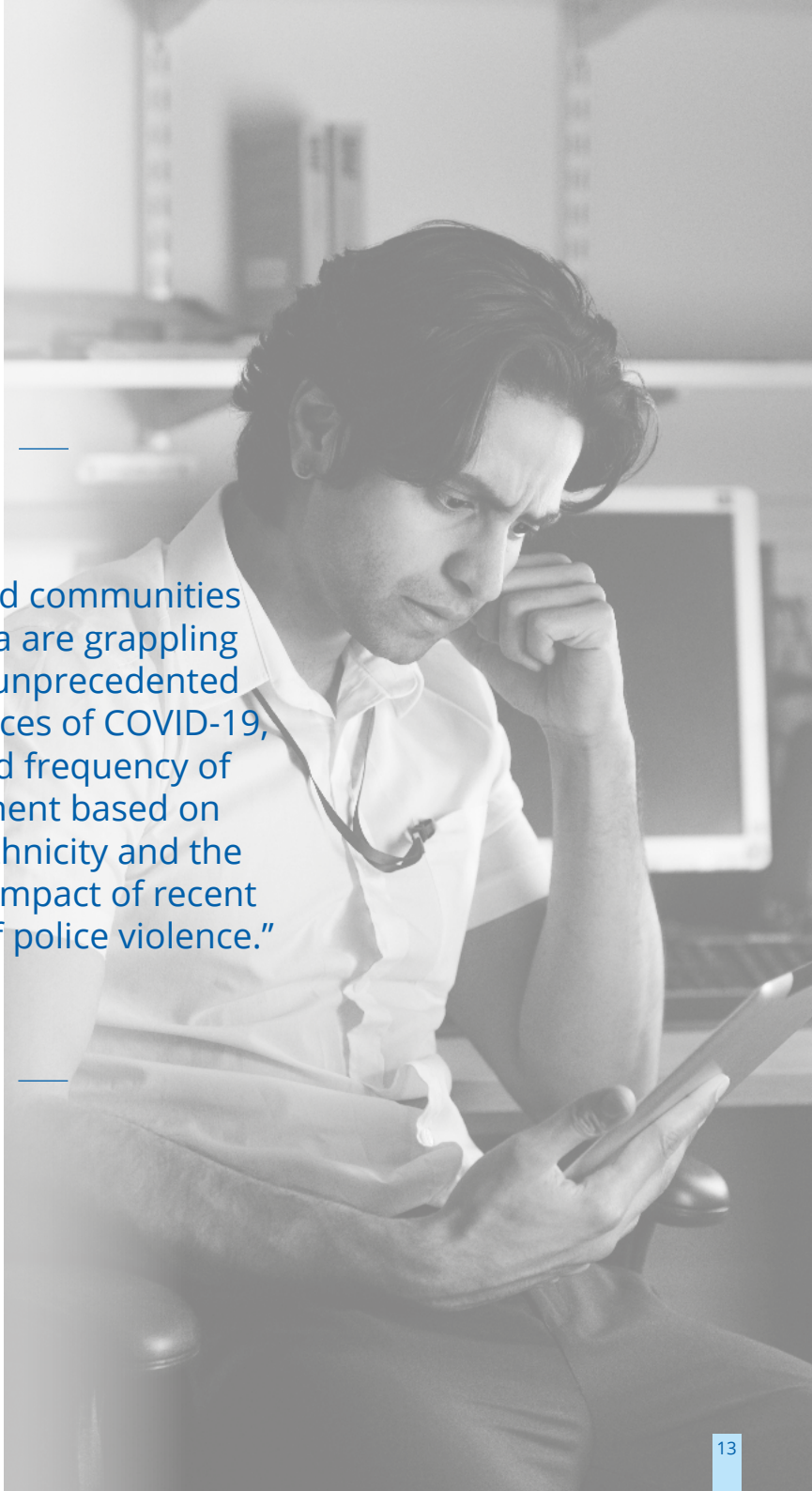
For a variety of reasons, including rank or tenure in the organization and/or fear of retaliation, workers may not feel empowered to speak out about or speak up against such indignities.[35] When patients express racist behaviour, healthcare workers may experience a conflict between preserving their humanity and providing care.[36] Colleagues and administrators may ignore, dismiss, or explain away such occurrences. Consequently, healthcare workers may experience role conflict and a sense of betrayal, which may serve to compound moral distress.[37]

The healthcare field remains fraught with an underrepresentation of racialized people in leadership positions.[38] This may increase a sense of isolation as they may feel they lack allies or supports they need as they struggle to preserve their humanity and care for others. At the same time, racialized healthcare workers may also be called upon, formally or informally, to educate their team or organization about systemic racism and how it affects racialized people. This may place on them additional stress that can lead to representation burnout, the "feeling of exhaustion that comes from being the *only* person of a particular identity in an environment."[39]

Thus, during COVID-19, racialized people may be at an increased risk of moral injury as they face multiple, concurrent moral stressors both at work and in their communities. In the day-to-day, they may be overburdened in their work and have to make difficult moral decisions related to patient care (e.g., who receives treatment) in healthcare environments facing resource and capacity shortages. The intersection of inequitable outcomes in COVID-19 and systemic racism may prompt critical reflection on how healthcare is informed by and perpetuates inequities.[40] They may feel compelled to protect themselves and/or vulnerable clients and patients from the harms of racism and racial discrimination[41] but the environment in which they work may not empower them to do so.[42]

Given that people of colour are disproportionately affected by COVID-19, racialized healthcare workers may also struggle with distress stemming from a sense of identification with patients who may remind them of loved ones.[43] Additionally, in response to renewed national attention to racism, they may experience moral distress in response to recent racist incidents, triggers of past or recent instances of discrimination, or fear of being targeted or discriminated against within and outside their workplaces.

All of this may leave racialized healthcare workers feeling ineffectual, hopeless, and/or morally distressed in their work. Some researchers and practitioners are concerned that the nascent physical and mental health risks of dealing with COVID-19 and the persistent experience of systemic racism will be a breaking point for already-stressed racialized healthcare workers, threatening the sustainability of a diverse workforce.[44]



"Racialized communities in Canada are grappling with the unprecedented circumstances of COVID-19, increased frequency of harassment based on race or ethnicity and the collective impact of recent incidents of police violence."

Managing risk of moral injury and offering support to racialized healthcare workers

Across Canada, health authorities, associations, and organizations are increasingly paying attention to inequities in healthcare and working to foster cultures of inclusion.

Associations and organizations are compiling and sharing resources about how implicit bias, health inequities, and racism impact treatment pathways and outcomes.[45] Organizations are adopting equity, diversity, and inclusion plans to foster supportive environments for staff and clients and to meet the needs of diverse communities.[46] Healthcare professionals are increasingly participating in critical education and training such as cultural competency and safety as well as implicit bias training.[47]

These efforts can be complemented by providing attention to the potential for moral distress and moral injury in racialized healthcare workers during the COVID-19 pandemic. A commitment to managing this risk and supporting racialized workers is essential to their well-being and, by extension, the systems they are a part of and the populations they serve. Awareness and integration of how the intersection of class, ability, age, gender, sex, and identification with the LGBTQ+ community inform workplace experiences is also critical to supporting staff and promoting healthy work environments.

It is clear that structural solutions are necessary to promote well-being and mitigate the risk of moral distress and moral injury among racialized healthcare workers. Key principles that can cultivate supportive environments, and by extension mitigate moral distress, include education, reflection, empowerment, and allyship.[48] Together with the information provided in this supplement, these principles can provide a lens through which the recommendations in the *Guide to Moral Injury* can be read for organizations looking to raise awareness about how race and racism might uniquely inform moral stress.

Please share your thoughts and experiences with us

We welcome any insight and/or testimony you may be willing to share about your own experiences and/or those of your team members. We also welcome feedback on the *Guide to Moral Injury* and this supplemental document, both of which can be found at moralinjuryguide.ca. We are particularly interested in learning about ongoing and novel efforts organizations, communities, and individuals are making to mitigate the impact of moral distress in the healthcare context during the COVID-19 pandemic. Such information helps us improve our knowledge of key and emerging issues, promote a greater understanding of moral distress in healthcare, and helps inform our recommendations for supporting well-being during this difficult time.

The Centre of Excellence on PTSD and Related Mental Health Conditions is committed to being a leader in equitable and inclusive research and knowledge mobilization practices and is taking a partnership approach to community-based work. We know that population-based research and initiatives can be more relevant and meaningful and have more of an impact in communities when they are responsive to the community's unique needs and values, informed by lived and living experience, and done in authentic collaboration with communities.

Beginning with the foundational work of the *Guide to Moral Injury* and this supplement, we are seeking to cultivate relationships and partnerships with associations, organizations, community leaders, and people with lived and living experience to co-design a project (or projects) that will enhance understanding of this emergent issue in healthcare in Canada.

As part of this process, we are open to invitations to partner, collaborate with or support associations and community organizations interested in enhancing our collective understanding of this emergent issue in healthcare in Canada. Please contact us at info-coe@theroyal.ca.

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For advice on the services available to you and your staff, please contact your local hospital or healthcare agency's staff wellbeing and support services.

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