

Moral and mental health challenges faced by maternity staff during the Covid-19 pandemic

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Abstract

The current COVID-19 pandemic places maternity staff at risk of engaging in clinical practice that may be in direct contravention with evidence, professional recommendations, or, more profoundly, deeply held ethical or moral beliefs and values, as services attempt to control the risk of cross-infection. Practice changes in some settings include reduction in personal contacts for tests, treatments and antenatal and postnatal care; exclusion of birth partners for labour and birth; separation of mother and baby in the immediate postnatal period; restrictions on breastfeeding; and reduced capacity for hands-on professional labour support through social distancing and use of personal protective equipment. These enforced changes may result in increasing levels of occupational moral injury that need to be addressed both, at an organisational, as well as at a personal level.

The current Coronavirus 2019 (COVID-19) outbreak poses an important threat to public health but also unique challenges to healthcare workers, for many reasons. The best way of treating the infection is yet unknown, and healthcare workers fear for their own safety, the safety of their patients, and that of their loved ones (Maunder, 2009). They are required to adapt their practices, often without much time for reflection or evidence gathering. Research on previous epidemics/pandemics shows the toll that caring for patients can have on the mental health of staff, such as elevated levels of psychological distress, insomnia, alcohol/drug misuse, and symptoms of posttraumatic stress disorder (PTSD), depression, anxiety, burnout, anger, and higher perceived stress (Vyas, Delaney, Webb-Murphy, & Johnston, 2016). These mental health problems may negatively impact the way in which professionals interact with their patients, including avoidance of infected patients (Fiksenbaum, Marjanovic, Greenglass, & Coffey, 2006; Marjanovic, Greenglass, & Coffey, 2007).

While the evidence clearly shows a negative impact on the mental health of healthcare workers in general, no specific data exists regarding its impact on staff caring for childbearing women and their families. This group is particularly relevant, as pregnant women are usually healthy, and medical interventions are usually kept to a minimum in maternity care. Face-to-face psychological support is as important as physical checks, and good quality maternity care requires a trusting relationship between professionals and families. Good eye contact, touch, and tone are critical elements of care, particularly during labour. During a pandemic, the restriction of face-to-face antenatal and postnatal care, the need for personal protective equipment (PPE) that limits personal engagement, and the restriction on supportive touch may be as distressing for staff to carry out, as it is for women and families to experience.

In the UK, there has been a mixed organisational response to COVID-19 in maternity services. Some hospitals have closed community services and moved all care to centralised hospitals. In Ireland, almost all maternity care services are centralised within hospital networks, so closure of community provision is not an issue. However, face-to-face contacts have reduced, as a significant proportion of antenatal care is now managed through virtual consultations and antenatal education is being delivered online. Across both countries, limits have been placed on the number of tests and treatments available in some settings, in both ante and postnatal care, and birth companionship and postnatal visiting have been restricted.

As part of an EU-funded COST Action CA 18211 network, the authors set up a website (CA18211, 2020) in response to calls from midwives and obstetricians on the frontline to have a one-stop shop to access central resources and to capture how maternity care is being affected by the current Covid-19 crisis. Examples submitted by maternity workers to the website include a forced separation of mothers and babies for up to 14 days if mothers are confirmed or suspected of being COVID-19 positive, a lack of opportunity to support mothers with breastfeeding, and the prohibition on the admission of birth partners during labour or during the postpartum hospital stay. Even more traumatic stories are emerging from some countries, of women told they must have their labour induced or have a caesarean section against their will, in contradiction to their human rights to consent to such interventions or not (Birthrights, 2020). Some women have to do this without companionship, where few staff are available, and in hospitals full of patients with severe COVID-19 symptoms, being worried that they and/or their baby may become infected. All of these practices are potentially both physically and psychologically damaging for mothers and babies. All are in direct contravention of COVID-19 recommendations from relevant organisations, such as the World Health Organisation,

International Confederation of Midwives, and International Federation of Gynecology and Obstetrics.

When local organisational imperatives and clinical practice are in direct contravention with evidence, professional recommendations, or, more profoundly, deeply held ethical or moral beliefs and values, this can give rise to increasing levels of occupational moral injury (Litz et al., 2009). In extreme cases, staff can feel that they have become the instruments of inhumane treatment of women and babies – the active perpetrators of psychological and physical harm, in complete violation of their moral norms and practice standards. Central to the concerns of many maternity workers is the disruption of their relationship with the women caused by the introduction of pandemic-related measures. This is exacerbated by the fact that, in parallel with a sense of moral injury, for many staff, there may also be a sense of relief that they are protected from infection by the use of PPE and other security measures that have been imposed. Because of the unprecedented and relentless work pressure, even a strong sense of ethical and moral duty can, understandably, be dulled, leading to emotional distancing for self-preservation. However, later reflection on the attitudes and behaviours that result from such necessary disciplining may re-traumatise health care providers and make them more vulnerable to developing mental health problems, such as PTSD, depression, and suicidal ideation (Williamson, Stevelink, & Greenberg, 2018). In turn, this may lead to reduced working hours and increased turnover (Mauder et al., 2006).

Several approaches may help maternity staff to counteract the negative effects of the current pandemic on their morale and mental health. Managers should ensure that time and space is given to help staff reflect on and make sense of the morally difficult decisions they must take. One such approach may be Schwartz rounds (Flanagan, Chadwick, Goodrich, Ford, &

Wickens, 2020) organised by team leaders, which could also be carried out in a virtual format. Schwartz rounds follow a structured format that allows healthcare professionals to discuss and reflect on the emotional work-related challenges of their day-to-day practice, in a safe and confidential space (Flanagan et al., 2020). In addition, a peer support programme that is available to all staff could be offered, including a discussion about moral injury and early warning signs to look out for (Greenberg, Docherty, Gnanapragasam, & Wessely, 2020). Staff reporting high and persistent levels of psychological distress or mental health problems should be identified early and offered appropriate specialist support.

In conclusion, the unique challenges that the current COVID-19 pandemic poses place maternity staff at risk of engaging in changed practices that may be in direct contravention with evidence, professional recommendations, or, more profoundly, deeply held ethical or moral beliefs and values. This may result in increasing levels of occupational moral injury that need to be addressed, both at an organisational, and at a personal level. Health services should begin offering psychosocial support for staff to protect their mental wellbeing if they are to continue to provide high quality care.

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