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The collective experience of moral distress: a qualitative analysis of perspectives of frontline health workers during COVID-19

Sophie Lewis[1*] , Karen Willis[2] and Natasha Smallwood[3]

Abstract

Background Moral distress is reported to be a critical force contributing to intensifying rates of anxiety, depression and burnout experienced by healthcare workers. In this paper, we examine the moral dilemmas and ensuing distress personally and collectively experienced by healthcare workers while caring for patients during the pandemic.

Methods Data are drawn from free-text responses from a cross-sectional national online survey of Australian healthcare workers about the patient care challenges they faced.

Results Three themes were derived from qualitative content analysis that illuminated the ways in which moral dilemmas and distress were relationally experienced by healthcare workers: (1) the moral ambiguity of how to care well for patients amid a rapidly changing work environment; (2) the distress of witnessing suffering shared *between* healthcare workers and patients; and (3) the distress of performing new forms of invisible work in the absence of institutional recognition. These findings reveal that moral distress was a strongly shared experience.

Conclusions Findings advance understandings of moral distress as a relational experience, collectively felt, constituted, and experienced by healthcare workers. Considering how to harness collective solidarity in effectively responding to moral distress experienced across the frontline healthcare workforce is critical.

Keywords Moral distress, Patient care, Frontline healthcare, Burnout, COVID-19

*Correspondence:
Sophie Lewis
sophie.lewis@sydney.edu.au
[1]Faculty of Medicine and Health, School of Health Sciences, University of Sydney, Sydney, New South Wales, Australia
[2]College of Health and Biomedicine, Victoria University, Melbourne, Australia
[3]Department of Allergy, Immunology and Respiratory Medicine, Central Clinical School, The Alfred Hospital, Monash University, Melbourne, Australia

Background

The COVID-19 pandemic provides a unique lens through which to explore the dimensions of moral dilemma and moral distress as personally and collectively experienced by healthcare workers [1]. Moral distress occurs when a healthcare worker is impeded from engaging in morally or ethically appropriate actions by internal or external factors [2, 3]. It can arise when a healthcare worker witnesses or participates in acts about which they feel powerless to change that threaten their moral integrity or core values [1, 4–5]. Repeated experiences of moral distress can result in moral residue (the accumulation of unresolved moral tensions over time) that erodes healthcare workers' ability to cope with morally distressing

experiences in the future [6]. Throughout the pandemic, the moral distress of feeling unable to provide patients with the care they need has reportedly been one of the critical forces contributing to escalating rates of anxiety, depression and burnout experienced by healthcare workers [7–10].

Moral distress is likely to occur in situations where healthcare workers encounter moral dilemmas or tensions, such as when health policies or protocols are introduced that constrain patient care, where patients are experiencing unnecessary suffering, where there is disruption or conflict in professional relationships, where healthcare workers feel stuck between institutional requirements and the needs of their patients and where there is inadequate staffing and limited resources and support [11–14]. The unpredictability of the virus, uncertainty about provision of care, feelings of helplessness and fear, disconnectedness from family, and the chaotic and fast pace of information dissemination, decision-making and crisis planning, have all created moral tensions for healthcare workers, and resultant moral distress during COVID-19 [15]. Infection control mandated practices and personal protective equipment (PPE) disrupted many important (unspoken) ways of showing care and compassion (e.g., through touch and facial expressions), with considerable impact on how patients and healthcare workers experienced care and caring [16–18]. The absence of family to care for patients (due to visitor restrictions) unsettled person/family-centric approaches to care [19], placed greater burden on healthcare workers to fill informal care gaps, and produced new kinds of grief and distress for patients [20], and for healthcare workers witnessing patient suffering [14, 18, 21].

Research conducted during the pandemic on moral distress has been mostly quantitative and has primarily framed moral distress as a personal emotional experience and occupational hazard [22–23]. Proposed solutions have focused on developing mental toughness and moral resilience that help individuals to cope with their distress (see for example, 24). However, understanding moral distress and developing effective solutions to the collective distress experienced across the healthcare workforce, requires in-depth exploration of how healthcare workers' moral agency, identity, and responsibilities, have been disrupted or compromised [7, 25–28]; and how moral distress is shared with other healthcare workers and patients [15].

In thinking about moral distress as not solely an experience of an individual 'moral agent' but as arising within a network of caring relationships, ethics of care scholarship has utility [29–30]. An ethics of care perspective focuses attention to the caring relationship including the interdependencies and involvement of multiple actors in negotiating morally distressing situations [29–30], and how moral distress can be experienced by all parties in the care relationships, including patients and health professionals [31–32]. Moreover, the experience of moral distress is multidimensional: it can take many forms, arise in variously morally troubling situations, and be experienced differently across contexts and people [25, 33–34]. Thus, it can be difficult to recognise. Some of the ways in which moral distress manifests, like anxiety, anger, frustration, sadness, and guilt are more easily perceptible. Others, like feeling insignificant, worthless, and belittled, are much less noticeable, and may go unrecognised. A lack of recognition can mean individuals are left to endure their distress alone, further contributing to feeling devalued, unheard, and uncared for [35].

In this paper, our aim is to examine the moral dilemmas and ensuing distress healthcare workers reported while caring for patients during the pandemic. We thus contribute to understandings of moral distress as a relational experience, as it is personally and collectively felt, constituted, and experienced by healthcare workers [36].

Method

Data were drawn from open-ended responses collected from the Australian COVID-19 Frontline Health Workers Survey (https://covid-19-frontline.com.au/). This mixed-method nationwide single-point survey was conducted from August to October 2020 coinciding with Australia's second wave of the pandemic. The survey explored the psychosocial effects of COVID-19 on the Australian frontline health workforce. Further information about the overall study design and methods are reported elsewhere, including quantitative data reporting on moral distress [37].

Participants who self-identified as frontline healthcare workers, including nurses, doctors, allied health staff, medical laboratory, and other roles, were recruited through health organisations, professional associations or colleges, universities, government contacts, and national media. After providing informed consent, participants either directly completed the online survey or via a purpose-built website. Ethics approval was provided by [Hospital ethics committee removed for blind review]. Participants provided consent online. Information for participants was provided on the survey website, indicating that data would be stored securely and would be anonymised in reporting. As the survey was about the psychosocial impact of COVID-19, links to mental health resources were also provided on the survey website. A total of 7846 complete survey responses were received. Most participants were female (6344, 81%) and just over half (4110, 52%) were younger than 40 years. Participants included nurses (3088, 39%), doctors (2436, 31%), allied health workers (1314, 17%), and other roles in health (523, 7%) or administration (485, 6%). They worked in

primary care or community care roles (1250, 16%), medical speciality areas (1205, 15%), emergency departments (1146, 15%), anaesthetics or surgical areas (824, 11%) or intensive care (745, 10%). Most worked in metropolitan locations (6373, 81%), while 1473 (19%) worked in regional or remote areas. Over two-thirds of participants experienced mental illness symptoms during the pandemic, including anxiety (60%), burnout (71%) and/or depression (57%). More than three-quarters reported that the pandemic had impacted on their relationships with family, friends and colleagues.

The survey included four free text questions in addition to quantitative questions and psychometric measures. In this article, we draw on data from participants' responses to the free text questions. We took a qualitative descriptive approach as we wanted to examine participants' experiences of moral distress in great depth, paying close attention to the nuances of their experiences, how moral distress was experienced in relation to other healthcare professionals, and contingent on work contexts [38]. This provided an opportunity for participants to reveal additional insights about their experiences of work and life during the pandemic. Qualitative data collected through open-ended survey responses are often critiqued for their purported inability to capture in-depth data (in contrast to interview data, for example). However, open-ended survey questions enable the capture of rich and intricate data and facilitate access to hard to reach, time poor, and/or geographically dispersed populations. In responding to the free text open ended questions, participants were able to write as little or as much as they wished, in each free text question. Many participants wrote extensive and rich accounts of their feelings, perspectives, and experiences. This approach allowed us to capture insights from a large, diverse, and often extremely time-poor cohort of health professionals, including diverse groups of healthcare workers (e.g., nurses, allied health staff, doctors, administrative staff) working in diverse settings (e.g., public and private hospitals, primary and community care) across metropolitan, rural and remote localities nationwide. This approach [39] maximised opportunities for all frontline healthcare workers, including those who are traditionally overlooked or marginalised in research studies, to participate and share their accounts and have their voices heard, facilitating the potential to capture a diversity of experiences [40–41]. The second of the four free text questions asked: "What did you find to be the main challenges that you faced during the COVID-19 pandemic?" and received a total of 6684 participant responses. Responses for this question form the basis for our analysis of participants' patient care experiences and the moral distress that arose.

In line with the approach of qualitative description emphasising staying close to the data [42], qualitative content analysis was used to analyse the data [43–44]. Codes were generated both deductively and inductively. Based on initial reading of the first 100 responses, and informed by a review of the literature, a code book was developed by two authors. This code book categorised responses broadly in terms of personal, work and social factors, with key codes identified in each (e.g., the code 'patient care' was used to code data about caring for patients and families, including references to moral distress and/or moral injury (e.g., watching patient suffering and visitor restrictions). Additional codes were developed inductively as analysis proceeded. Up to three codes were applied to each free text response. Codes were discussed and refined during weekly discussions to establish inter-rater reliability and consensus. After initial coding was completed, the data within each code were sorted and compared identifying patterns and differences in ideas and concepts to develop themes [45]. A total of 685 responses were coded as patient care. Two authors systematically analysed the data coded as patient care using Excel, as this code included all the data related to moral distress that healthcare workers reported while caring for patients, the main focus of our research question. Analysis involved both repeatedly and independently reading these responses and meeting regularly to discuss and refine the key ideas and patterns within the data. Differences in coding and/or contradictions in the data were discussed through weekly meetings between the two authors, and any differences in interpretation were resolved through reaching consensus in these analytic discussions [46]. Through the analytical process, data were organised into three descriptive categories about moral distress: (1) providing 'good' care during substantial disruption; (2) watching patients/families suffer; and (3) invisible and unrecognised work. We then returned to the literature on moral distress to further refine these categories and develop substantive themes. The prominent themes that relate to patient care experiences and the moral distress that arose are presented below. We have included information about occupation, gender, and age range in the presentation of the findings.

Results

The data presented encapsulates healthcare workers' descriptions of their experiences of providing patient care, and the moral distress they described in doing so. Three prominent themes were generated through our analysis. These themes, related to (1) 'the challenges of caring well during rapid change' (2) 'witnessing suffering' and (3) 'invisible and thankless work', build on each other to illuminate how moral distress is experienced by healthcare workers, in relation to each other, and within intricate healthcare structures [47].

Caring well during rapid change

Healthcare workers described the moral ambiguities as they tried to care well for patients while also adhering to a rapidly changing work environment, with new risks and risk minimisation protocols. Illustrative of the challenges of balancing risk management vis-à-vis patient welfare during high uncertainty and rapid change is the excerpt below from a hospital-based nurse. She describes the felt institutional pressure to prioritise the care and wellbeing of her patients, and how this was in tension with other important values and responsibilities, such as the protection of family and her own sense of personal safety. Her excerpt demonstrates the distress arising when healthcare workers experience conflict between what is in the best interests of patients, organisations, families, and themselves. Importantly, she illustrates the interpersonal dynamics of moral distress as she describes the guilt of not being able to do more:

> *The daily changes to the workplace, the uncertainty, and the anxiety of all our patients who are immuno-compromised. They were afraid, we can't tell them it will be fine, and the anxiety is contagious. We were being forced to prioritise our patient's wellbeing over our own and the pressure and guilt is real. The guilt over not being able to 'act up' and volunteer to be redeployed to a COVID ward because of my family was awful. (Nurse, medical speciality, female, 31–40)*

A senior doctor similarly described the division between hospital executives and clinical staff. Her excerpt reveals the moral and emotional complexity experienced by healthcare workers: the struggles of keeping up with constant change and information overload, being unable to provide patients with good quality care, and the frustration and disillusionment of not being heard or valued.

> *There was greater divide between administration/executive and clinical staff, and this led to frustration, a sense of not being listened to and being undervalued in the workplace. Difficulty keeping up with the frequent changes to systems and processes (e.g., PPE use as per DHHS and the hospital). There were too many places to find information and it was not always very coordinated. [...] It felt like some patients had delays in appropriate diagnosis [and] treatment due to being labelled as COVID or suspected COVID. (Senior doctor, intensive care, female, aged 31–40)*

The sense of personal duty to 'protect everyone' was positioned by participants as an individual moral dilemma between, on the one hand, work demands and the needs of their patients and colleagues, versus on the other hand, the needs of themselves and their families:

> *I felt so much responsibility to protect everyone it was debilitating.' (Nurse, surgical, female, age 20–30).*
> *[The] dilemma of having to choose work i.e., client/patient/colleague needs versus personal and family needs and safety.' (Psychologist, community care, male, age 31–40).*

Their distress was compounded by feeling unsupported by their organisation in making decisions about patient care, and fear of being held personally accountable for any possible adverse patient outcomes. The following quotes from community and hospital-based nurses and a paramedic capture many of the moral elements of distress – guilt, fear of judgement and blame, and even belittlement:

> *This pandemic has changed the way we practise holistic primary healthcare. It has depersonalised it. [...] being overwhelmed with dread that you may have just exposed yourself, your colleagues, your other patients, and your community to a deadly virus causes insurmountable stress, judgement and lack of certainty that is hard to buffer in every day. Suddenly healthcare staff who are used to working in environments of unknown certainty are thrown into an intolerable environment. This environment is risky, thankless, messy, uncomfortable, and worst of all vilified publicly when we make an error. (Nurse, primary care, female, age 31–40)*
> *When you make the decision to see a patient, you are making the decision alone as the managers above you are not clinically trained. It has been really hard to weigh up the risks at times and feel guilty that you can't service these patients as you normally would, and yet the hospital holds you responsible if something goes wrong. (Nurse, community care, female, age 41–50)*
> *...lack of support from my employer feeling alone and abandoned, if I make a mistake you're chastised and made an example of in front of others, belittled, you're left feeling worthless. (Paramedic, male, age 41–50)*

A reported 'culture of blame' within some organisations toward healthcare workers who became infected posed an additional threat to some participants' moral integrity:

> *... blaming healthcare workers who become positive rather than supporting them, assuming they got it from community transmission despite them work-*

ing on HOT wards 4 days a week. (Nurse, rotational pool, female, age 20–30)

In the perceived absence of institutional leadership and resources, participants' sense of personal responsibility was often accompanied by stress, guilt, and helplessness about 'not doing enough' or 'letting others down', further indicating their feeling of constrained moral agency, as they recounted the main challenges posed by the pandemic.

Increased demand for mental health services that are not adequately funded and feeling helpless and unable to do anything for these patients. (Junior doctor, emergency department, female, age 20–30)
Not being able to provide patients with the quality and intensity of care that they need. Fear of decline and deterioration in patients because we can't assess or care for them in the same way (i.e., telehealth less effective, can't offer home visits, services being unavailable - such as exercise groups, hydro, specialised clinics being shut or running less frequently). Fast tracking of patient discharge from hospital due to demand for beds or patients' mental health in hospital (lack of visitors, fear of getting COVID) meant patients were less prepared to cope at home and families did not have the training or resources to support them - this meant we were put under more stress to try to keep them safe at home when we are already lacking resources. (Physiotherapist, community care, female, age 31–40)
Not feeling that I am able to do my job properly and watching clients who are vulnerable suffer as a result. (Physiotherapist, community care, female, age 51–64)
Not being able to fulfil my full role due to only being able to see high priority clients (Occupational therapist, community care, female, age 20–30).

Participants described feeling belittled, unimportant, and condemned by their organisation. Some of the less visible manifestations of moral distress are illustrated in the following extract from a radiographer who described trying to keep up with rapidly changing protocols and provide good patient care with limited organisational support as demoralising.

Rapidly changing protocols, inconsistency across different areas of the hospital - nurses are based in one ward but we [radiographers] go across ED, ICU, COVID wards, non-COVID wards and the processes are different everywhere we go. It's demoralising and scary to be told you're not safe when you're doing

exactly what you did for the last patient. (Radiographer, female, age 31–40)

And, as the extract below from a respiratory scientist highlights, not only was there the moral distress associated with feeling devalued and unheard, but the distress they experienced occurred alongside the distress experienced by the patients being cared for.

Beginning of COVID was managerial incompetence and dismissal of respiratory scientists' genuine concern about exposure and our general welfare. This 'business as usual' mentality was frightening and frankly disgusting. We felt unsupported, dismissed, ill equipped and uninformed in the most dangerous experience of our professional lives. We did not sign up for this. In general living, it felt like the goal posts of daily life kept moving, sometimes dramatically each day, with more restrictions. It was difficult to keep track of what we could and should do / not do everyday. It was draining, exhausting, and frightening. I'm sad for our patients who are extremely anxious, as part of the most at risk and vulnerable in the community. Many patients, and their families, have been deprived of face to face or physical contact with their loved ones in their dying days. I'm sad for these patients and concerned about their loved ones now and going forward. (Respiratory scientist, female, age 31–40)

Others wrote about their fear that trauma and burnout would have an enduring impact on their core professional identities and values, including their capacity for empathic and compassionate care.

I'm scared of the long terms effect of COVID-19 on my mental health and professional identity as a nurse. I'm finding it hard to distinguish burn out with PTSD symptoms and fear that the long journey in recovering from Covid will impact my mental health more negatively. (Nurse, emergency, female, age 20–30)
The impact of COVID has affected my empathy and burnout, I feel like best practice is unachievable and that there are so many barriers to providing care. (Physiotherapist, general medicine, female, age 31–40)

Witnessing suffering
Another prominent theme generated was that moral distress emanated from being a bystander to the pain and suffering of others – patients, family members, hospital visitors, and colleagues. This distress was not

experienced by healthcare workers in isolation from each other but collectively experienced across a network of professional and patient relationships. Many participants wrote about the distress of being unable to provide comfort and reassurance to patients. Distress was intensified when patients were frail or otherwise vulnerable.

> *Not being able to touch the patients or smile or hold their hands or sit with them or reassure them with a kind face - That is VERY difficult for me and one day soon I HOPE this will change. (Nurse, emergency department, female, age 51–64)*
> *Watching patients suffer, unable to breathe with little comfort measures in place. (Nurse, hospital aged care, female, age 51–64)*
> *…seeing deteriorating patients and being unable to help. (Junior doctor, emergency department, female, age 20–30).*
> *The distress of dealing with isolated frail aged clients who are experiencing significant decline in function with loss of opportunity for incidental contact with people and exercise. (Allied health practitioner, community care, female, age 65–70)*

Witnessing the distress, grief, and loneliness of critically unwell or dying patients being separated from their families was particularly morally troubling for those working in intensive and palliative care. The moral distress circulating between healthcare workers and patients was most evident in end-of-life situations, where healthcare workers felt the heightened moral duty and burden of caring for patients dying alone, and where patients were unable to act in accordance with their core values about how they wished to die [15]. The excerpts below show the interconnectedness of moral distress in patient-professional relationships.

> *The absence of loved ones has been professionally really hard and feels wrong and in my opinion is wrong and the benefit far outweighs the risk in so many instances when there has not been COVID cases or high suspicion of any in the Unit. The mental health effects on ICU or ward patients is huge and may not be felt for some time. (Nurse, intensive care, female, age 51–64)*
> *Palliation of patients under COVID precautions. We expect a high mortality rate in ICU but being unable to have family present and unable to hold a patient's hand directly has been very distressing. (Junior doctor, intensive care, female, aged 41–50)*
> *Not letting family members see their loved ones has taken a significant toll on me. I cry for those families every day. (Administrative staff, medical speciality, female, age 31–40)*

> *The emotional stress caused by family members not being able to visit critically unwell or palliative patients has been distressing, both due to the emotions caused by such a situation but then also the aggression at times by family members. (Nurse, emergency, female, age 20–30)*

Illustrative of how moral distress was situational, the moral distress of preventing dying patients from seeing their families was experienced by the following participant, working in hospital administration, in relation to her own experience of having no contact with her dying father due to her high risk of transmitting the virus:

> *Because I am a healthcare worker, I was unable to visit my dying father. Now, every day, I am telling family members they can't visit their loved ones. I am concerned events like this will create irreparable trauma to people on one scale or another […] I feel stress now at a constant and high level and I'm not sure how this will affect me. (Administrative staff, female, age 31–40)*

A nurse in residential aged care similarly wrote about the morality of institutionally enforced 'COVID solitary confinement' in aged care, and the many adverse effects on residents' psychological, social, and physical well-being. This excerpt draws attention to the dilemma of how patient safety and care were being constituted, the social harms of measures to keep patients 'COVID safe', and how PPE created obstacles to displays of care and connection:

> *Watching residents in residential aged care facilities decline functionally physically and cognitively not due to COVID but simply to COVID solitary confinement and the withdrawal of services such as GP and locum services, physio, podiatry, wound consultants, leisure activities, access to the sun, access to anything other than bed baths for weeks on end and access to family. Let's not forget the simple therapeutic benefit of a smiling face not hidden by a mask or skin on skin contact of a caring hand. (Nurse, residential aged care, male, age 51–64)*

That is, moral distress was not experienced in isolation by individual health care workers, but also in relation to the actions (and inactions) of others as well as in relation to the moral distress experienced by patients and family members.

Other participants wrote about the moral distress they felt witnessing other healthcare workers withdrawing or withholding what in participants' view was necessary care – illustrating the interconnectedness of moral

distress, and how it is experienced in relation to the actions (and inactions) of others:

> *Other healthcare workers from other areas refusing to provide medical care to individuals due to their perceived risk of acquiring COVID-19. (Junior doctor, infectious diseases, female, age 31–40)*
> *I could no longer help people which is what I do for a job. So many restrictions and doctors/services refusing to see patients. I am deeply concerned that patients are delaying or not receiving appropriate care which is making for poorer outcomes. (Nurse, community care, female, age 31–40)*

Invisible and thankless work
Finally, participants reported distress related to the unrelenting invisible work that was demanded of them in trying to meet the care needs of their patients, but that in their view was often taken for granted or unacknowledged by their organisation, the media, and the wider community. A perceived lack of institutional recognition for their labour coupled with insufficient resources to fulfil their caring obligations, further intensified their distress.

First, visitor restrictions that were imposed by workplaces created new emotional labour for participants who were tasked with managing the distress of patients and families being separated from each other; and trying to provide the emotional care that patients were no longer receiving from their families and friends.

> *Patients' emotional needs increased [because] no family or visitors allowed. [This placed a] huge strain on nurses. (Nurse, surgical, female age 31–40)*
> *The visitor bans have been very challenging leaving healthcare workers to have to deal with the trauma of people being scared and alone in hospital. (Nurse, emergency, female, age 20–30)*

This additional emotional work was often accompanied by the distress of feeling unable to fill the informal care gap caused by visitor restrictions. Participants' sense of powerlessness is evident in the following extract from a nurse working in intensive care who writes about the impossible burden and moral obligation she feels trying to act as nurse, friend, and family to her critically unwell and isolated patients:

> *Research shows patients in ICU do better when their family is at their side. The psychological burden on me as a nurse has significantly increased. I now have to be the patient's nurse, friend, main contact, possibly their only interaction that whole day. Despite*

> *knowing allowing visitors in is very risky, it's hard to tell families they can't visit their loved one who is critically ill. Then they call all the time (of course), but I can't spend all shift on the phone to them. (Nurse, intensive care, female, age 20–30)*

The lack of organisational accountability and backing in relation to visitor restrictions was a key source of tension described by participants. Many wrote about feeling unprotected, let-down and unsupported by senior management. The below extracts indicate that senior management shifted responsibility for enforcing policies and managing patient and family distress onto individual healthcare workers.

> *Department of Health puts out guidelines, but it is clinicians like me who have to break bad news to patients about things like visitors etc. I have to manage patient expectations and address grief, mental distress & loss. The moral injury from this is going to last a lifetime. (Obstetrician, female, age 41–50)*
> *Caring for patients dying alone is awful. Managing family distress and feeling blamed for this is awful. (Junior doctor, respiratory medicine, female, age 20–30)*

Participants felt the personal toll of bearing the brunt of patients' and families' grief and anger, in relation to visitor restrictions. Participants tasked with a gatekeeping or leadership role wrote about the distress of being caught in the middle of the organisation and patients/families. They wrote about being held responsible for enforcing visitor restriction policies (even when they were not enthusiastically supportive), leading to difficult conversations with families. They frequently wrote about being the object or outlet for patients' and visitors' frustration and suffering.

> *I'm working as an advanced trainee in an inpatient palliative care unit with harsh visitor restrictions (no-one allowed in or out unless "very end of life"). The levels of anxiety, distress and anger from patients and families are so high. I know people are so upset and scared, but it's a lot to manage when you're bearing the brunt of it all day. Nursing and admin staff defer decisions and explanations to me. None of my consultants are here Monday-Friday 8 – 6 like I am. They all work part-time so I feel they get a break. I would desperately benefit from some time off the ward [...] just to get a break from the high levels of emotional distress that patients and other staff are exposing me too. It's getting too much. (Junior doctor, palliative care, female, age 20–30)*

Aged care is often forgotten but we have a very high emotional toll from caring for very vulnerable patients with high mortality rates and high emotions from their families that is understandable and unrelenting. As a registrar I am there on the ground every day and take the brunt of this as the most senior available person. I see the distress of my colleagues and we end up being each other's counsellors when we have little reserves left. (Junior doctor, hospital aged care, female, age 20–30)

As a result, participants' own emotional wellbeing often suffered.

The mental/emotional impact of patients not having their families around during their admission and using all my energy to look after patients while struggling myself. (Nurse, surgical, female, age 20–30).

Participants also wrote about the difficulties of working in an environment of collective anxiety and moral distress, as well as the challenges of supporting their colleagues who were experiencing distress, while they were also feeling anxious, distressed, and overwhelmed by their workload.

As the consultant on a large team, managing the team's anxiety and stress has been a huge challenge. (Senior doctor, emergency, female, age 31–40)
Trying to deal with the escalation in distress in staff, patients, and families without having the time or emotional energy to provide the support I thought they deserved. (Senior doctor, palliative care, female, age 41–50)

Participants talked about how their own distress was closely connected with the distress and suffering of their peers – from close colleagues to those working overseas that they had never met. As the below quotes also show, institutions like the media and government had an important role in shaping these participants' experiences.

The media attention around the pandemic and particularly around my hospital has been a bit of a letdown. I could see how people could rapidly become desensitized. The saturated attention on the 'glamorous' areas of the hospital pulled at my sense of worth as a nurse, having personally encountered the plight of my fellow colleagues battling covid in areas of nursing that may not appeal to the public eye. (Nurse, surgical, female, age 31–40)
I experienced great grief listening to the experiences of my colleagues worldwide with illness and death. There appeared a lot of talk about protecting front-line staff but small follow through. Many of us were "silenced" for having opinions other than the status quo. This isolated me even more. (Nurse, respiratory medicine, female, age 51–64)

Some described the pressure to portray a public appearance of 'calm positivity', while they ignored or concealed their own needs or tried to manage their distress in private:

… needing to hold everyone else's emotion while having no way to take care of my own needs. (Psychologist, mental health private inpatient, female, age 20–30)
Maintaining my own calm and managing my own anxieties (lead by example) whilst trying to lead others and help them manage their anxieties. Trying not to get caught up in other people's anxiety and at times panic. (Junior doctor, intensive care, female, age 41–50)

Others, wrote about how PPE worked against some of the ways that healthcare workers empathised and showed solidarity to their colleagues:

[I'm] hating the lack of smiles and empathy relayed through facial expression hidden behind the masks - no subtle positive reinforcement ("knowing") from colleagues. (Physiotherapist, emergency department, female age 51–64).

Finally, healthcare workers, like the following palliative care physician, wrote about the harm created when organisations did not acknowledge the increased invisible workload and collective distress experienced by the frontline workforce, and instead pressured individual workers to 'do more':

Workplace/management acknowledgement and understanding of the increased moral and emotional distress workers are dealing with and toll it is taking […] Before trying to bully staff into doing more (often with less resources) they could take stock and find out if the staff are even coping with current workload and stressors, and not blame or judge if the worker is not coping. This would actually require them to talk with the staff members though. (Senior doctor, palliative care, female, age 41–50)

Knowing that their peers shared their experience, and having their experience validated by others, was identified as helpful in coping with distress.

Having feelings validated by others; it's strangely comforting that others are feeling the same as me even though the feelings are really deflating and uncomfortable. (Dietician, female, 20–30)

Having people listen without judgement or giving advice is great. Having work colleagues who are going through the same thing helps (collective moral injury etc.). (Sonographer, female, age 31–40)

Discussion and conclusions

The COVID-19 pandemic shone a light on issues and tensions in healthcare provision that have existed for many decades – the cracks in the system, the casualisation of the workforce, healthcare workers traumatised by crises and wedged between the needs of their patients and medical hierarchies, the powerlessness, underpay and under-recognition of the value of much of healthcare work [48]. The pandemic added to these tensions with rapid change and unrelenting expectations being placed on healthcare workers to do more, which became, for many, a critical source of distress. The challenges described by participants in our research reflect dramatic shifts in relations and practices of care, contributing to complex experiences and forms of moral distress. The moral challenges and tensions linked to this distress blurred the lines between the individual and work, with choices and decisions about work intimately linked to perceptions of collective risk (to self, patients and families). 'Caring well' became fraught as healthcare workers grappled within this rapidly changing context. The absence of family to care for patients (due to visitor restrictions) unsettled person/family-centric approaches to care and placed greater burden on healthcare workers to fill informal care gaps.

Moral distress is clearly linked with the witnessing of suffering, and the many changes in how care was provided meant that healthcare workers experienced moral distress particularly as they cared for vulnerable and dying patients, many of whom died alone. Visitor restrictions were a source of great distress to many healthcare workers, as they grappled with increased workload while attempting to take on the additional care load. The experiences recounted in themes one and two, flowed into the distress associated with the additional invisible and emotional work that emanated from rapid change, and changing protocols. A key driver of distress was the lack of recognition, as individuals and as a workforce, for their labour and their moral distress, which served to reinforce and intensify the experience. Importantly, it appears that lack of recognition also works against people reaching out for support. What is also evident, is that recognition and validation play a role as antidotes for personal and collective distress. Lack of recognition for both their labour and their distress intensified and reinforced the issue for these participants.

Consistent with research showing that the individualisation of moral distress both conceals its underlying institutional drivers and its impacts on healthcare workers, individually and collectively [48], these findings reveal that far from being an individual experience, moral distress was a strongly shared experience. We contribute to scholarship on the collective experience of moral distress, by further illustrating how moral distress is a relational and situational experience that emanates within caring relationships, such as when a health professional feels unable to fulfil their caring obligations and the patient's care needs are not met [29–32]. Revealing of the interconnectedness of moral distress, rather than merely being an internal feeling related to the actions of each individual healthcare worker in isolation, moral distress was contingent on the actions (and inactions) and feelings of others (colleagues and patients), moving across these interactions [15]. The pandemic drew attention to the ways in which institutional responses for managing distress (e.g., counselling, wellness apps) may be deficient in addressing collective distress. The push towards requiring individuals to self-identify distress and take measures to build moral resilience could have the unintended consequence of blaming the individual healthcare worker [48].

Altruistic and benevolence approaches to care are undervalued, and yet harnessing collective solidarity might be important in responding to moral distress. Moral distress is clearly linked with burnout and also poses a key risk for workforce retention and patient safety. With burnout explained and focused at the individual level – as rundown, exhausted doctors and nurses, rather than using the language of collective trauma and distress, the imperative for organisational change becomes lost. As the pandemic continues and health services remain at breaking point, we can ill-afford to lose valuable and morally invested clinicians, a point also noted by West and colleagues [49].

These findings also reveal the incremental and enduring nature of moral distress associated with being in an environment of repeated exposure to situations in which their moral integrity was compromised. Many participants referred to not knowing how distress would affect them individually and collectively over the longer term. In the context of COVID-19 and in future crises, we must consider how exposure to morally distressing situations can have a long-lasting effect, personally and collectively, and can become integrated into the thoughts and views of the self. This is a particular critical consideration as the pandemic has exposed health professionals to repeated episodes of moral distress over time, and its association with burnout [10, 50].

Author contributions
KW and NS designed the study. SL and KW analysed the data. All authors contributed drafting, editing and approving the final manuscript.

Data availability
The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
Ethics approval was provided by Melbourne Health Human Research Ethics Committee (HREC/67074/MH-2020). Participants provided consent online. Information for participants was provided on the survey website, indicating that data would be stored securely and would be anonymised in reporting.

Consent for publication
Not applicable.

Competing interests
The authors declare that they have no competing interests.

List of abbreviations
Not applicable.

References

1. Godshall M. Coping with moral distress during COVID-19. Nurs. 2021;51(2):55–8.
2. Jameton A. Nursing practice: The ethical issues. Englewood Cliffs: Prentice-Hall; 1984.
3. Jameton A. A reflection on moral distress in nursing together with a current application of the concept. J Bioethical Inq. 2013;10(3):297–308.
4. Corley MC. Nurse moral distress: a proposed theory and research agenda. Nurs Ethics. 2002;9(6):636–50.
5. Salari N, Shohaimi S, Khaledi-Paveh B, Kazeminia M, Bazrafshan MR, Mohammadi M. The severity of moral distress in nurses: a systematic review and meta-analysis. Philos Ethics Humanit Med. 2022;17(1):1–14.
6. Dunham AM, Rieder TN, Humbyrd CJ. A bioethical perspective for navigating moral dilemmas amidst the COVID-19 pandemic. J Am Acad Orthop Surg. 2020;28(11):471–76.
7. Dzeng E, Wachter RM. Ethics in conflict: moral distress as a root cause of burnout. J Gen Intern Med. 2020;35(2):409–11.
8. Haar J, O'Kane C. A post-lockdown study of burnout risk amongst New Zealand essential workers. Soc Sci Med. 2022;306:115157.
9. Smallwood N, Pascoe A, Karimi L, Willis K. Moral distress and perceived community views are associated with mental health symptoms in frontline health workers during the COVID-19 pandemic. Int J Environ Res Public Health. 2021;18(16):8723.
10. Wilson CA, Metwally H, Heavner S, Kennedy AB, Britt TW. Chronicling moral distress among healthcare providers during the COVID-19 pandemic. Int J Mental Health Nurs. 2022;31(1):111–27.
11. Digby R, Winton-Brown T, Finlayson F, Dobson H, Bucknall T. Hospital staff well-being during the first wave of COVID-19: Staff perspectives. Int J Mental Health Nurs. 2021;30(2):440–50.
12. Dimino K, Horan KM, Stephenson C. Leading our frontline HEROES through times of crisis with a sense of hope, efficacy, resilience, and optimism. Nurse Lead. 2020;18(6):592–6.
13. Trachtenberg S, Tehan T, Shostak S, Snydeman C, Lewis M, Romain F, et al. Experiences of moral distress in a COVID-19 intensive care unit: A qualitative study of nurses and respiratory therapists in the United States. Nurs Inq. 2023;30(1):e12500.
14. Kuek JTY, Ngiam LXL, Kamal NHA, Chia JL, Chan NPX, Abdurrahman ABHM, Krishna LKR. The impact of caring for dying patients in intensive care units on a physician's personhood: a systematic scoping review. Philos Ethics Humanit Med. 2020;15:1–16.
15. Vittone S, Sotomayor CR. Moral distress entangled: patients and providers in the COVID-19 era. HEC Forum. 2021;33(4):415–23.
16. Durkin J, Jackson D, Usher K. Touch in times of COVID-19: Touch hunger hurts. J Clin Nurs. 2021;30(1–2):e4–5.
17. Gordon JM, Magbee T, Yoder LH. The experiences of critical care nurses caring for patients with COVID-19 during the 2020 pandemic: A qualitative study. Appl Nurs Res. 2021;59:151418.
18. Rao H, Mancini D, Tong A, Khan H, Gutierrez BS, Mundo W, Cervantes L. Frontline interdisciplinary clinician perspectives on caring for patients with COVID-19: A qualitative study. BMJ open. 2021;11(5):e048712.
19. Munshi L, Evans G, Razak F. The case for relaxing no-visitor policies in hospitals during the ongoing COVID-19 pandemic. CMAJ. 2021;193(4):E135–7.
20. Wallace CL, Wladkowski SP, Gibson A, White P. Grief during the COVID-19 pandemic: considerations for palliative care providers. J Pain Symptom Manage. 2020;60(1):e70–6.
21. Azoulay E, De Waele J, Ferrer R, Staudinger T, Borkowska M, Povoa P, Cecconi M. Symptoms of burnout in intensive care unit specialists facing the COVID-19 outbreak. Ann Intensive Care. 2020;10(1):1–8.
22. Malliarou M, Nikolentzos A, Papadopoulos D, Bekiari T, Sarafis P. ICU nurse's moral distress as an occupational hazard threatening professional quality of life in the time of pandemic COVID 19. Materia Socio-Medica. 2021;33(2):88.
23. Thomas TA, Davis FD, Kumar S, Thammasitboon S, Rushton CH. COVID-19 and moral distress: A pediatric critical care survey. Am J Crit Care. 2021;30(6):e80–98.
24. Rushton CH. Moral resilience: a capacity for navigating moral distress in critical care. AACN. 2016;27(1):111–9.
25. Morley G, Ives J, Bradbury-Jones C, Irvine F. What is 'moral distress'? A narrative synthesis of the literature. Nurs Ethics. 2019;26(3):646–62.
26. Kherbache A, Mertens E, Denier Y. Moral distress in medicine: an ethical analysis. J Health Psychol. 2022;27(8):1971–90.
27. Varcoe C, Pauly B, Storch J, Newton L, Makaroff K. Nurses' perceptions of and responses to morally distressing situations. Nurs Ethics. 2012;19(4):488–500.
28. Varcoe C, Pauly B, Webster G, Storch J. Moral distress: tensions as springboards for action. HEC Forum. 2012;24(1):51–62.
29. Gilligan C. a Different Voice: Psychological Theory and Women's Development. 2nd ed. Cambridge: Harvard University Press; 1993.
30. Held V. The Ethics of Care: Personal, Political, and Global. Oxford: Oxford University Press; 2006.
31. Walsh JP. Care, commitment and moral distress. Ethical theory moral Pract. 2018;21(3):615–28.
32. Collins S. The Core of care ethics. New York: Palgrave Macmillan; 2015.
33. Fourie C. Who is experiencing what kind of moral distress? Distinctions for moving from a narrow to a broad definition of moral distress. AMA J Ethics. 2017;19(6):578–84.
34. Morley G, Bradbury-Jones C, Ives J. Reasons to redefine moral distress: a feminist empirical bioethics analysis. Bioethics. 2021;35(1):61–71.
35. Hanna DR. Moral distress: the state of the science. Res Theory Nurs Pract. 2004;18(1):73–93.
36. Deschenes S, Kunyk D. Situating moral distress within relational ethics. Nurs Ethics. 2020;27(3):767–77.
37. Author blinded for peer review.
38. Bradshaw C, Atkinson S, Doody O. Employing a qualitative description approach in health care research. Global Qual Nurs Res. 2017;4:1–8.
39. Toerien M, Wilkinson S. Exploring the depilation norm: A qualitative questionnaire study of women's body hair removal. Qual Res Psychol. 2004;1:69–92. https://doi.org/10.1191/1478088704qp006oa
40. Braun V, Clarke V, Gray D. Innovations in qualitative methods. In B. Gough, editor, The Palgrave handbook of critical social psychology. Palgrave Macmillan; 2017: 243–266.

41. Braun V, Clarke V, Boulton E, Davey L, McEvoy C. The online survey as a qualitative research tool. Int J Social Res Methodol. 2020;24(6):641–54. https://doi.org/10.1080/13645579.2020.1805550

42. Neergaard MA, Olesen F, Andersen RS, Sondergaard J. Qualitative description—the poor cousin of health research? BMC Med Res Methodol. 2009;9:52. https://doi.org/10.1186/1471-2288-9-52

43. Bengtsson M. How to plan and perform a qualitative study using content analysis. Nurs Plus Open. 2016;2:8–14. https://doi.org/10.1016/J.NPLS.2016.01.001

44. Morgan D. Qualitative content analysis: A guide to paths not taken. Qual Health Res. 1993;3:112–21. https://doi.org/10.1177/104973239300300107

45. Bradley E, Curry L, Devers K. Qualitative data analysis for health services research. Health Serv Res. 2007;42:1758–72. https://doi.org/10.1111/j.1475-6673.2006.00684

46. Elo S, Kaariainen M, Kanste O, Polkki T, Utriainen K, Kyngas H. Qualitative content analysis: A focus on trustworthiness. SAGE Open. 2014;4(1):11772158244014522633.

47. Rodney PA. What we know about moral distress. AJN. 2017;117(2):S7–10.

48. Molinaro ML, Polzer J, Rudman DL, Savundranayagam M. I can't be the nurse I want to be: Counter-stories of moral distress in nurses' narratives of pediatric oncology caregiving. Soc Sci Med. 2023;115677.

49. West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences and solutions. J Int Med. 2018;283(6):516–29.

50. Epstein EG, Delgado S. Understanding and addressing moral distress. Online J Issues Nurs. 2010;15(3).

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