Healthcare Workers' Moral Distress during the COVID-19 Pandemic

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During the COVID-19 pandemic, healthcare workers (HCWs) did not have the opportunity to provide high-quality and standard healthcare services. Research conducted during the pandemic has revealed widespread mental health problems among HCWs. Moral distress was noted as one of the critical issues that limited the performance of HCWs in providing quality care.

moral distress ethical dilemmas healthcare workers (HCWs) COVID-19

1. Introduction

A disease originating in China and named after 2019, i.e., COVID-19, emerged as a threat to global health (Wang et al. 2020). After its rapid spread to several countries in January 2020, the World Health Organization (WHO) declared the disease COVID-19 a public health emergency of international concern, which became a global pandemic on 11 March 2020 (Cucinotta and Vanelli 2020). Within a few weeks of declaring the COVID-19 pandemic an international disease, it became clear that conventional public health practices would not be able to contain it (Latif et al. 2020; Luengo-Oroz et al. 2020). Massive restrictions were introduced, including remote work, social distancing, staying at home, mandatory wearing of masks, and continuous testing. Significant restrictions were introduced in the provision of scheduled and ambulatory health care services. The COVID-19 pandemic attracted enormous attention from HCWs and public health professionals, as well as experts from various scientific disciplines, who produced more than 400,000 publications about the coronavirus in 2020 (Esteva et al. 2021). The statistics of 19 May 2021 showed that the COVID-19 pandemic was a global disease to be measured in the lives of more than 3.4 million deceased people (Kim and Burić 2020). The world crisis turned into an emergency in the healthcare sector. Moral distress became a significant phenomenon among HCWs (Silverman et al. 2021; Liu et al. 2012).

Jameton (1984) was the first to describe a concept of moral distress in the context of nurses' ethical responsibilities before, during, and after a nuclear war. The above-mentioned ones, as well as some other authors, described moral distress as a negative emotional response to a personal moral failure while practicing in one's professional field (Jameton 1984; McCarthy and Gastmans 2015). This concept related not only to nurses or veterans, but its definition and application were also widely discussed among physicians and residents (Farrell and Hayward 2022). The above-mentioned phenomenon was common to many healthcare institutions and at multiple organizational levels, and that, in turn, had negative consequences both among HCWs and healthcare organizations (Oh and Gastmans 2015).

At the individual level, moral distress led to emotional burnout, lack of empathy, compassion fatigue, feelings of powerlessness, and dissatisfaction with professional performance. On the other hand, at the organizational level, the quality of the service provided by healthcare deteriorated, which was associated with a catastrophic lack of time and resources. An increase in employee turnover was observed (Ahokas and Hemberg 2022; Fagerdahl et al. 2022; Hegarty et al. 2022; Zerach and Levi-Belz 2022; Asadi et al. 2022). The number of cases in which ethical issues had to be addressed increased. Healthcare organizations often lacked standardized guidelines on how to deal with ethical dilemmas. Recent studies (Donkers et al. 2021; Petrisor et al. 2021; Silverman et al. 2021; Hegarty et al. 2022; Lemmo et al. 2022) demonstrated the relationship between ethical dilemmas experienced by healthcare professionals and moral distress. Since the start of the COVID-19 pandemic, moral and ethical dilemmas in healthcare have risen to the top of medical priorities.

The biggest challenges for care professionals were a lack of experience in working with the COVID-19 pandemic, a lack of personal protective equipment, as well as social distancing (Dudzinski et al. 2020; Nyashanu et al. 2020). Several issues involving ethical dilemmas (Farrell and Hayward 2022) were illuminated. Ethical dilemmas occurred in situations where a complex decision that consisted of choosing between two mutually exclusive or equally complex moral options had to be made (Morley et al. 2019). HCWs faced ethical dilemmas, which included a lack of personnel resources, distribution of artificial respiratory ventilators, insufficiency of personal protective equipment, and the use of experimental therapy (Donkers et al. 2021). Although scientists provided extensive information on the spread and course of the disease, decision-making remained in the hands of doctors (Farrell and Hayward 2022). HCWs experienced ethically and morally stressful situations every day. They had to deal with increasing infection rates and workloads inadequate for existing resources (Riedel et al. 2022; Alonso-Prieto et al. 2022; Zerach and Levi-Belz 2021). While working in the clinical environment, HCWs still had to face several moral and ethical dilemmas that increased moral distress (Menon and Padhy 2020), contributed to emotional burnout, and had an impact on the effectiveness of their work (Donkers et al. 2021; Smallwood et al. 2021; Kok et al. 2023; Koonce and Hyrkas 2023). Therefore, both ethical dilemmas and basic principles of morality were at odds with each other during the pandemic.

The COVID-19 pandemic served as one of the factors that also created psychological problems and contributed to the development of moral distress (Williamson et al. 2020). HCWs experienced a high level of moral distress (Zerach and Levi-Belz 2022), and therefore, various support mechanisms were developed. Very often, HCWs used the consultations offered by psychologists, the assistance of social workers, pastoral counseling, and the help of psychotherapists. Often, an immediate supervisor served as an advisor and a person who listens to and supports (Kok et al. 2023; Hines et al. 2021).

The above-mentioned clearly showed that the COVID-19 pandemic caused significant mental and physical health problems for HCWs (Donkers et al. 2021; Hegarty et al. 2022; Lemmo et al. 2022; Petrisor et al. 2021; Silverman et al. 2021). It is necessary to pay increased attention to the mental health of HCWs. Clear guidelines should be developed on how HCWs should act in emergency epidemic situations, minimizing the impact of moral distress on HCWs as much as possible. Therefore, it is crucial to conduct a scoping review of studies carried out to understand the phenomenon of moral distress among HCWs during the COVID-19 pandemic and to summarize possible

intervention methods for reducing the moral distress of HCWs. The obtained data will provide an opportunity to develop a set of preventive measures for medical institutions with the purpose to reduce mental health problems caused by moral distress among HCWs.

2. Level of Moral Distress during the COVID-19 Pandemic

Different levels of moral distress were found among health care workers.

A study conducted by Donkers et al. showed that the moral distress level among nurses was higher than that among the support staff (Donkers et al. 2021). In its turn, the results of the research carried out in Iran showed that the moral distress level of nurses was low (Asadi et al. 2022). Performing in-depth analysis and dividing respondents by their marital status helped the researchers to find out that the moral distress level was higher among unmarried employees. The results of the study clearly showed that marital status served as one of the promoters of moral distress, thus influencing the level of the latter. Those who were not married experienced higher moral distress (Asadi et al. 2022). In their turn, the Kok et al. research results showed no significant difference in moral distress levels between doctors and nurses (Kok et al. 2023). A study conducted in Israel showed high levels of moral distress (Zerach and Levi-Belz 2022), confirming the mental health problems of HCWs. Active monitoring of mental health is required.

3. Risk Factors of Moral Distress during the COVID-19 Pandemic

Risk factors for moral distress related to ethical dilemmas, lack of resources, and actions that did not correspond to the moral values of healthcare workers.

HCWs reported that they experienced moral distress due to a variety of reasons, including unpredictable and extreme changes, which had a very significant impact on the ability of HCWs to serve patients and provide quality healthcare services (Fagerdahl et al. 2022). They failed to provide patient-oriented, empathetic care. HCWs faced various moral and ethical dilemmas while following the established pandemic management protocols (Alonso-Prieto et al. 2022). Another reason was the risk of infection. HCWs were afraid of infecting their families and people close to them (Alonso-Prieto et al. 2022; Zerach and Levi-Belz 2021). HCWs also reported moral distress relating to a lack of resources (58.3%); wearing personal protective equipment (31.7%), which limited their ability to care for patients; family exclusion, which contradicted their values (60.2%); and the fear of deceiving colleagues if they were infected and had to quarantine (55.0%) (Smallwood et al. 2021; Zerach and Levi-Belz 2021). Hard work, where their actions did not correspond to their moral values, was also noted (Zerach and Levi-Belz 2021; Hegarty et al. 2022). A study conducted in Iran showed a significant correlation between moral distress and marital status (p = 0.001) and rotation among posts (p = 0.01). Nurses whose workplaces practiced staff rotation among posts experienced greater moral distress (Asadi et al. 2022). The obtained results allowed us to conclude that working in a changing professional work environment might contribute to the development of moral distress of HCWs. A study

conducted in the United States showed that moral distress was caused by moral and ethical dilemmas, pervasive uncertainty, unclear duties, isolation, burnout, fear for personal safety and health, risk of infecting family and friends, financial concerns, self-doubt, and dissatisfaction with an acutely introduced telehealth system (Patterson et al. 2021). The results of Ahokas and Hemberg's qualitative study identified several risk factors causing moral distress during the COVID-19 pandemic. One of them was a lack of time. HCWs were forced to prioritize between groups of patients and choose which patient to devote more time to. It caused massive moral distress among HCWs. The COVID-19 pandemic served as an even greater reason for time shortages, which accordingly increased the moral distress of HCWs and affected the quality of patient care (Ahokas and Hemberg 2022). A lack of resources was mentioned by HCWs as the next risk factor. HCWs pointed out that one of the biggest resource deficiencies related to a qualified staff, which would facilitate the sharing of responsibilities and a reduction in morale distress (Hegarty et al. 2022). HCWs' ability to emphasize ethical values was limited because economic factors were the most important (Ahokas and Hemberg 2022). A study conducted in Israel identified the inability to provide reasonable health care due to a lack of time, which simultaneously imposed a feeling of responsibility for patients' sufferings or loss of life, as one of the risks (Zerach and Levi-Belz 2022). In their turn, Lemmo et al. identified the following risk factors for moral distress: moral constraints, tension, conflict, dilemmas, moral uncertainty, and moral compromise (Lemmo et al. 2022).

4. Moral and Ethical Dilemmas during the COVID-19 Pandemic

The moral and ethical dilemmas experienced by healthcare workers during the COVID-19 pandemic related to the personal moral values of the workers and external constraints.

Ethical dilemmas experienced by healthcare workers related to a lack of resources. In practice, it was manifested as an insufficient number of beds in the COVID-19 wards and intensive care units, as well as a lack of HCWs. Institutions with fewer employees began to lose more labor force, and the level of absence due to sick leave increased as well. Infected HCWs were isolated. The remaining ones had to work with incompetent colleagues, take care of an inadequately large number of patients, face a lack of communication with managers, and deal with vaguely defined regulations and guidelines that were changing daily (Donkers et al. 2021). Very often, regular changes in guidelines created situations where HCWs had to make urgent moral and ethical decisions (Hegarty et al. 2022). A lack of medication and the impossibility to confront other HCWs and move freely and fast in emergencies made the staff feel constrained, as they were unable to properly provide care. Nurses noted that they experienced situations where they felt unable to do the right thing or were unable to prevent actions that were considered morally wrong due to institutional, contextual, or personal barriers (Lemmo et al. 2022). HCWs were often forced to act beyond their competence, leading some of them to believe that they had put patients at risk due to inadequate infection control procedures (Lemmo et al. 2022). HWCs felt angry with the government for mismanaging the COVID-19 guidelines and underfunding services. Employees were tasked to compensate for systemic errors by working excessive amounts of overtime. This led to cynicism towards organizational attempts to address staff well-being and was seen as a failure to deal with the root cause of the problem and did not reduce

the moral distress caused (Hegarty et al. 2022). HCWs experienced feelings of guilt when they felt personally responsible for not meeting society's expectations, which mainly related to failings in the provision of patient-oriented health care. HCWs expressed a certain degree of guilt regarding their involvement. They felt like accomplices in the system's failures because they were not adequately trained in how to deal with a situation of the mass epidemic to satisfy public needs and provide high-quality care (Hegarty et al. 2022).

Insufficient clinical knowledge in working during the COVID-19 pandemic served as another cause of moral and ethical dilemmas. HCWs had to experience situations where they felt unprepared and incompetent while dealing with the SARS-CoV-2 epidemic. For this reason, HCWs lost many patients in a very short period. The consequences of the virus manifested differently from patient to patient, so a different treatment, which had not been tested until then, was needed. HCWs had to experience new moral and ethical situations. Performing work duties in conditions of the pandemic massively contributed to the development of moral distress among HCWs (Lemmo et al. 2022). It served as both internal and external factors of ethical dilemmas.

During the COVID-19 pandemic, all HCWs were obliged to use personal protective equipment. Working in special protective clothing prevented emotional contact between HCWs and patients. Infected patients were isolated. Any visits to hospitalized patients were prohibited. HCWs had to forbid visits from relatives. Ward staff experienced moral and ethical situations where they were unable to facilitate communication between dying patients and their family members or to support patients to die in a dignified manner because there were too many patients requiring attention (Hegarty et al. 2022). The above-mentioned aspects represent another situation of ethical dilemmas experienced by healthcare workers.

5. Harm to HCWs Caused by Moral Distress

The harm of moral distress experienced by healthcare workers related to the deterioration of mental health, psychosocial problems, and burnout.

Looking at the effects of moral distress on healthcare workers, problems such as increased stress, anxiety, and irritability were noted. Many HCWs marked a sense of helplessness, as well as a difficulty in falling asleep and a lower quality of sleep (Alonso-Prieto et al. 2022; Zerach and Levi-Belz 2021). HCWs reported that the moral distress they experienced either increased or decreased their ability to empathize with others. Both the increased and decreased ability to empathize were interpreted in a negative light (Alonso-Prieto et al. 2022). Such psychosocial health problems as exhaustion and sleep disorders were also mentioned (Donkers et al. 2021). One of the studies showed a positive correlation between moral distress and psychosomatics and concerns about the risk of being infected (Maffoni et al. 2022). Moral distress caused difficulties for employees at both individual and organizational levels, where moral distress was associated with increased levels of anxiety, depression, and risk of burnout (Smallwood et al. 2021; Donkers et al. 2021). The study conducted by Kok et al. proved that moral distress was associated with burnout, emotional exhaustion, and depersonalization in 22.7% of cases (Kok et al. 2023). The obtained results showed a positive correlation between moral distress and emotional exhaustion and depersonalization, as well as increased emotional exhaustion, which hurt the relatives of HCWs (Kok et al. 2023).

In its turn, the study conducted in England showed a negative effect of moral distress on the mental health of HCWs. Deterioration in mental health was associated with accumulated moral distress at work, exacerbated by life stressors. Most often, moral distress manifested as increased anxiety, which caused sleep disorders for several people. Anxiety was observed in several employees who used stress-related sick leave. One of the HCWs suffered from panic attacks during night shifts, which disappeared when she left her job (Hegarty et al. 2022). Moral distress of HCWs was associated with a deterioration of mental health that was further aggravated by constant stressors.

A study conducted in Italy identified six moral distress detriments that HCWs suffered from. Employees experienced a sense of powerlessness, a lack of resources, and an inability to change the course of events determined by the spread of infection. Feelings of undervaluation were present when employees were unable to express their professional opinion about the treatment process. A great sense of uncertainty and confusion contributed to the difficulty in discussing decisions that seemed extremely important to HCWs (Lemmo et al. 2022). In some cases, nurses felt angry when decisions made by doctors contradicted their opinion. Moreover, such anger was described as a reaction to doctors who seemingly did not consider nurses' opinions. The sadness experienced related to a need for making choices between patients to be treated and those to be allowed to die. The feeling of guilt, in its turn, occurred in situations of moral uncertainty. The feeling of helplessness was created by situations where HCWs felt completely helpless facing death (Lemmo et al. 2022). All the above-mentioned permeated the moral realm, causing HCWs to face stress, burnout, and moral discomfort.

6. Intervention Methods to Reduce Moral Distress

Informal resources, such as self-care resources and support from colleagues, family members, or friends, were the most frequently cited ways of reducing moral distress, followed by professional or formal sources of support, such as discussions with supervisors or the use of counselling support (Alonso-Prieto et al. 2022; Zerach and Levi-Belz 2021). Very often, HCWs used counselling offered by psychologists, the help of social workers, pastoral counselling, and the support of other members of the mental health support team. In addition, an "open" culture where managers were welcoming was mentioned. Employees had an opportunity to share questions, feelings, and emotions of a professional nature, as well as an opportunity to discuss and dispute harm caused by the COVID-19 pandemic, human mortality, and moral distress experienced (Donkers et al. 2021; Ahokas and Hemberg 2022). Also, a study carried out by Kok et al. proved that support from immediate supervisors reduced moral distress and emotional exhaustion (Kok et al. 2023). Regular monitoring of employees' well-being was also considered important. Talking to experts, colleagues, or a therapist helped prevent the adverse effects of moral distress on the mental health of HCWs (Ahokas and Hemberg 2022). Facing emergencies in the healthcare sector, for instance, a pandemic, it was important to draft a professional and organizational support plan in due time. Such action helped strengthen both the internal and external resources of HCWs. It helped to avoid emotional burnout (Gustavsson et al. 2020). Several HCWs noted that ability to express feelings of anger, guilt, and frustration openly was important to reduce moral distress. It helped to normalize their level of moral distress. Others used "black humor" (Hegarty et al. 2022). Those who did not have an opportunity for clinical supervision attended reflective practice groups. Sometimes, line managers, providing reassurance and support, fill in this role. Engaging in activities outside work

such as physical exercise, cooking, reading, meditation, spending time with family, etc., was helpful. These activities provided a temporary escape from difficult thoughts and helped to separate work and private lives (Hegarty et al. 2022; Klitzman 2022).

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