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Moral distress in medicine: An ethical analysis

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Abstract

Moral distress is a negative emotional response that occurs when physicians know the morally correct action but are prevented from taking it because of internal or external constraints. Moral distress undermines a physician's ethical integrity, leading to anger, poor job satisfaction, reduced quality of care and burnout. Scarce literature exists on the ethical aspects of moral distress in medicine. We conducted an ethical analysis of moral distress as experienced by physicians and analysed it from the literature using two predominant ethical theories: principlism and care ethics. Finally, we consider the emergence of moral distress in medicine during the COVID-19 pandemic.

Keywords

medicine, health care, moral distress, principlism, care ethics, COVID-19

Introduction

When a healthcare professional knows what they ought to do morally, but is prevented from doing it, either because of internal or external constraints, moral distress can occur (Fourie, 2015; Ulrich and Grady, 2018). Jameton and Jackson (1984) were the first to describe the notion of moral distress in the context of nurses' ethical responsibilities before, during and after nuclear war. They and others characterise moral distress as a negative emotional response to one's personal moral failure in practising one's profession (Jameton and Jackson, 1984; MacCarthy and Gastmans, 2015). Originally, the phenomenon had a strong *psychological* connotation (sense of powerlessness, feelings of anger, guilt, shame, remorse, etc.). However, moral distress is now understood to be *multidimensional*, and is a phenomenon that can affect people in *various professions*. Varcoe et al. (2012: 59) advanced a more refined definition of moral distress: 'It is a *relational* experience shaped by multiple contexts, including the socio-political and cultural context of the workplace environment'. This was a watershed moment in the characterisation of moral distress, because it distinguished it clearly from other types of distress, contextualised it, and emphasised the relational nature of it.

Moral distress differs from other types of distress, such as work-related stress, emotional stress, or compassion fatigue (Varcoe et al.,

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2012). Although the presence of these other types of stress can compound the manifestation of moral distress, the difference is fundamental. With moral distress, sufferers may also feel that they have lost some of their personal and professional integrity, have been compromised as a moral agent in practicing in accordance with accepted with accepted values and standards, or have abandoned their ethical principles (Lamiani et al., 2017; MacCarthy and Gastmans, 2015; Thomas and MacCullough, 2015; Trautmann, 2015).

For decades, research on moral distress focussed predominantly on nurses' experiences. Gradually, it was recognised that it also affects other healthcare professionals (e.g. physicians, pharmacists, psychologists, etc.) and other people involved in difficult situations (e.g. patients, family, etc.). Studies show that nurses experience significantly higher levels of moral distress than physicians (Aacharya et al., 2011; Abbasi et al., 2014; Austin et al., 2017; Bernhardt et al., 2010; Dodek et al., 2016, 2019; Hamric et al., 2012; Jameton and Jackson, 1984; Lamiani et al., 2018; MacCarthy and Gastmans, 2015; Mehlis et al., 2018; Thomas and MacCullough, 2015; Thomas et al., 2016; Trautmann, 2015; Walsh, 2018). Due to the ubiquitous medical hierarchy, nurses' authority is limited, and they are more likely to experience moral distress because of their subordinate position (Atabay et al., 2015; Axelsson et al., 2019; Dodek et al., 2016; Dzeng et al., 2015; Hamric et al., 2006; Iglesias et al., 2012; MacCarthy and Gastmans, 2015; Rosenwohl-Mack et al., 2020).

During the past decade, accumulating evidence shows that physicians increasingly experience moral distress (Abbasi et al., 2014; Allen et al., 2013; Austin et al., 2017; Axelsson et al., 2019; Dodek et al., 2016, 2019; Førde and Aasland, 2007; Henrich et al., 2017; Howe, 2017b; Iglesias et al., 2012; Kälvemark et al., 2004; Lamiani et al., 2017, 2018; Mehlis et al., 2018; Nejadsarvari et al., 2015; Oliver, 2018; Traudt and Liaschenko, 2017; Whitehead et al., 2015). This situation has occurred because physicians are often exposed to factors that can stunt their ability to act according to their own professional and ethical values. Some of these factors include failure to provide completely satisfactory treatment, lack of time, patients waiting too long, lack of resources and organisational barriers (Abbasi et al., 2014; Bernhardt et al., 2010; Førde and Aasland, 2007, 2013; Henrich et al., 2016; Iglesias et al., 2012; Rosenwohl-Mack et al., 2020). These constraints can lead to physicians experiencing moral distress and feeling that their professional and personal integrity are threatened. This in turn can lead to job dissatisfaction, negative self-image, burnout and considerations of job abandonment (Dzeng et al., 2015; Førde and Aasland, 2013). These issues regarding different aspects of moral distress in medicine raise several important questions that are amenable to a fresh ethical analysis.

In this paper, firstly, we examine how physicians experience moral distress. We focus on empirical studies on the prevalence of moral distress in medicine, its causes and consequences, as well as various coping strategies. Secondly, we reflect on these results by applying the perspectives of two predominant theories in contemporary biomedical ethics: principlism and care ethics. Thirdly, we consider the emergence of moral distress in medicine during the COVID-19 pandemic. Finally, we conclude by offering preliminary recommendations for dealing with moral distress in medical practice, medical ethics education and further warranted research.

Background

Prevalence of moral distress in medicine

Existing quantitative research on moral distress reveals that over one half of physicians report experiencing moderate to high levels of moral distress (Abbasi et al., 2014; Allen et al., 2013; Austin et al., 2017; Dodek et al., 2016; Førde and Aasland, 2007; Iglesias et al., 2012; Kälvemark et al., 2004; Lamiani et al., 2017; Whitehead et al., 2015). Moral distress has been reported in

all clinical settings, showing no differences between sexes or sociodemographic variables. With increasing age, however, moral stress is experienced more frequently, but less intensively. Work experience is not associated with more or less moral distress (Abbasi et al., 2014; Allen et al., 2013; Dodek et al., 2016; Førde and Aasland, 2007; Iglesias et al., 2012; Kälvemark et al., 2004; Lamiani et al., 2017; Thomas et al., 2016; Whitehead et al., 2015). Having a higher moral sensitivity – defined by Lutzen et al. (2006: 189) as, 'one's awareness of her own sense of responsibility, moral load, and moral capability' – is correlated with higher intensities but lower frequencies of moral distress (Lutzen et al., 2006; Nejadsarvari et al., 2015).

The highest levels of moral distress are reported for healthcare professionals in intensive care units, palliative care units, and emergency wards (Dodek et al., 2016; Whitehead et al., 2015). These professionals experienced the highest frequency of moral distress but at a relatively low intensity (Whitehead et al., 2015). Healthcare professionals in paediatric wards report experiencing the converse (i.e. low frequency, high intensity) (Abbasi et al., 2014; Dodek et al., 2016; Whitehead et al., 2015).One study reported higher levels of moral distress in general practitioners compared to hospital doctors (Førde and Aasland, 2013).

Table 1 summarises some characteristics of moral distress in medicine, as we determined from the above-mentioned articles.

Causes

Many complex factors contribute to moral distress in physicians (Abbasi et al., 2014; Austin et al., 2017; Bernhardt et al., 2010; Dzeng et al., 2015; Førde and Aasland, 2007, 2013; Henrich et al., 2016; Iglesias et al., 2012; Rosenwohl-Mack et al., 2020; Rushton and Westphal, 2004; Rushton et al., 2013; Thomas et al., 2016; Whitehead et al., 2015). Some of the factors reported in the primary literature refer to *external constraints*, such as lack of time, resources and financial constraints. Physicians report feeling distressed, because administrative and documentation work 'steal' important time away from patients. Also, drug and medical-equipment shortages are prominent triggers for moral distress, because equal and adequate care for all patients cannot be provided (Abbasi et al., 2014; Axelsson et al., 2019; Bernhardt et al., 2010; Dodek et al., 2016; Førde and Aasland, 2007, 2013; Henrich et al., 2016, 2017; Iglesias et al., 2012; Rosenwohl-Mack et al., 2020; Rushton and Westphal, 2004). Medical ethics and deontology uphold the opposite values.

Inadequate communication, low tolerance for criticism and meagre collaboration among colleagues are other external constraints that contribute to physicians' moral distress. This in turn causes ethical challenges, uncertainty, and discord about patients' conditions and prognoses among team members (Abbasi et al., 2014; Bernhardt et al., 2010; Førde and Aasland, 2007; Rushton and Westphal, 2004; Thomas et al., 2016; Whitehead et al., 2015). A final important constraint is rooted in physician-organisation relations, specifically that of employer's policies and priorities. Physicians' own professional values are often congruent with their employer's, but these can conflict sometimes with care needs or can compromise care. These policies include excessive administrative guidelines, national or local overregulation and legislation of care practices, provision of futile care as required by medical procedures, receiving intense pressure from insurers or employers to reduce costs, or increasing unfairness and demand imposed by certain patients at the expense of other weaker patients, who cannot stand up for themselves (Abbasi et al., 2014; Austin et al., 2017; Axelsson et al., 2019; Berlinger, 2016; Dodek et al., 2016, 2019; Førde and Aasland, 2007, 2013; Howe, 2017b; Iglesias et al., 2012; Lamiani et al., 2018; Rosenwohl-Mack et al., 2020; Rushton, 2016; Traudt and Liaschenko, 2017; Whitehead et al., 2015). These external constraints can all contribute to the occurrence of moral distress.

At an individual level, several *internal factors* can also contribute to physicians' moral distress. Experiencing ethical issues early on in

Table 1. Moral distress in medicine – characteristics in terms of its prevalence, causes, consequences and coping strategies.*

Prevalence	Present in all clinical settings Correlation with high moral sensitivity Most specifically present in intensive, palliative, emergency, and paediatric care GPs > Hospital doctors
Causes	- *External constraints* • Lack of time due to increased administrative and documentation duties • Lack of resources such as shortage of drugs and medical equipment • Inadequate communication among colleagues • Low tolerance for critique within the team • Little collaboration among colleagues • Organisational policies that compromise professional values - *Internal constraints* • Perceived powerlessness • Lack of moral sensitivity • Lack of capacity for ethical reflection • Self-doubt, lack of knowledge, fear, etc. • Personality traits and individual coping strategies - *Clinical situations* • Prolonging the dying process by having to provide futile care • Failure to have an end-of-life conversation • Witnessing provision of false hope to patients and their family • Having to provide care that is not in the best interest of the patient
Consequences	- *Emotional reactions* • Guilt • Frustration • Helplessness • Anger - *Physical symptoms* • Fatigue • Exhaustion • Sleeping problems • Heart palpitations • Headaches • Neck and abdominal pain - *Existential Level* • Burnout • Poor job satisfaction • Poor satisfaction with the quality of care - *Changed behavior* • Avoiding patients • Depersonalisation • Derealisation
Coping	- *Negative coping* • Distancing • Derealisation • Hiding or compartmentalising emotions • Avoiding patients

(Continued)

Table 1. (Continued)

	- *Positive coping → individual level* • Active coping • Constructive planning • Restraint and acceptance - *Positive coping → organisational support* • Investment in a healthy ethical climate • Creating a culture of ethical reflection and discussion • Stimulating open dialogue among colleagues and with patients • Investing in medical ethics education for the staff • Applying the AACN's 4A's framework

*Source: Authors' own elaboration based on an analysis of the primary literature.
GP: general practitioner; AACN: American association of critical care nurses.

one's professional career and one's subsequent coping (or lack thereof) have an impact on the frequency and intensity of moral distress. Perceived powerlessness, lack of moral sensitivity or capacity for ethical reflection, self-doubt, lack of knowledge, or even fear can also trigger moral distress, depending on a physician's personality traits and individual coping strategies (Axelsson et al., 2019; Bernhardt et al., 2010; Lamiani et al., 2017; Nejadsarvari et al., 2015; Rushton and Westphal, 2004; Rushton et al., 2013).

Since moral distress originates from both internal and external constraints, both are involved in making certain *clinical situations* more susceptible to the emergence of moral distress. These situations include extending the dying process with futile treatment; failure to engage in end-of-life conversations with the patient and their family; witnessing someone else give false hope to a patient and their family; and being required to provide care that is not in the best interest of the patient. Physicians attributed such situations to a lack of continuity of care, harmful treatment situations or being forced to work with colleagues who do not meet minimal competency standards (Abbasi et al., 2014; Allen et al., 2013; Austin et al., 2017; Axelsson et al., 2019; Bernhardt et al., 2010; Dzeng et al., 2015; Epstein and Hamric, 2009; Henrich et al., 2016; Iglesias et al., 2012; Lamiani et al., 2018; Rosenwohl-Mack et al., 2020; Whitehead et al., 2015).

Consequences

Physicians' emotional reactions associated with moral distress may prominently include guilt, frustration, helplessness and anger (Bernhardt et al., 2010; Dzeng et al., 2015; Henrich et al., 2017; Rushton and Westphal, 2004). Physical symptoms, such as fatigue, exhaustion, sleeping problems, heart palpitations, headaches, neck and abdominal pain may also occur, although these latter symptoms have been only reported in studies of nurses (Rushton and Westphal, 2004; Rushton et al., 2016). Ultimately, moral distress can lead to burnout, poor job satisfaction and dissatisfaction with the quality of care provided (Abbasi et al., 2014; Austin et al., 2017; Dodek et al., 2016; Henrich et al., 2017; Lamiani et al., 2017; Monrouxe et al., 2015; Rushton and Westphal, 2004). Experiencing moral distress correlates with reduced quality of care, in terms of patient safety and effectiveness of care (Abbasi et al., 2014; Henrich et al., 2017; Monrouxe et al., 2015; Oliver, 2018). At a behavioural level, experiencing moral distress can cause physicians to avoid patients and can lead to depersonalisation and derealisation (Dzeng et al., 2015; Henrich et al., 2017; Lamiani et al., 2018; Oh and Gastmans, 2015). In physicians, no clear evidence exists that suggests moral distress leads to job abandonment (Lamiani et al., 2017).

Repeated and unevaluated instances of moral distress can cause a gradual 'crescendo effect' over time (Figure 1), in which the sufferer

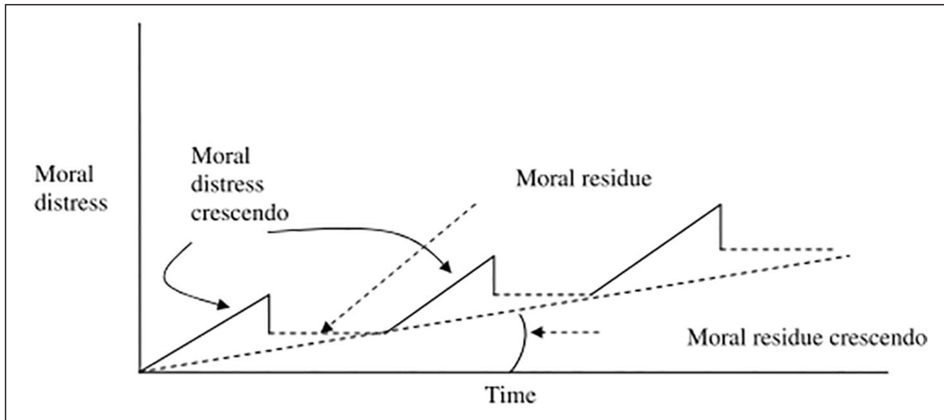

Figure 1. Crescendo effect. From Epstein and Hamric (2009), with permission.

experiences a build-up of moral residue (Epstein and Hamric, 2009; Hamric, 2012; MacCarthy and Gastmans, 2015). Moral residue contributes to new and higher baseline levels of distress. When moral distress is not resolved, the cumulative effect ensures that additional morally distressing situations can evoke even stronger reactions (Epstein and Hamric, 2009). The question naturally arises about how one suffering from moral distress deals with the situation.

Coping

Distancing, derealisation, hiding or compartmentalising emotions and avoiding patients are examples of negative coping mechanisms (Howe, 2017b). Positive coping mechanisms can be engaged at the individual or organisational level. To reduce moral distress, individual coping strategies, such as active coping, constructive planning, restraint and acceptance, are important but not sufficient to deal with the situation (Howe, 2017b; Kälvemark et al., 2004; Zavotsky and Chan, 2016).

To lower moral distress, one essentially needs organisational support. Evidence suggests that organisations that promote a healthy ethical climate are successful at reducing moral distress. An ethical climate clearly outlines what comprises correct behaviour. Importantly, an organisation that aims to have an ethical climate also clearly defines how ethical issues should be handled. Such a climate does not regard moral distress as a threat, but instead welcomes its challenges by creating a culture of ethical reflection and discussion within an open and tolerant atmosphere (Atabay et al., 2015; Denier et al., 2019; Hamric and Wocial, 2016; Howe, 2017a; Rosenwohl-Mack et al., 2020; Sauerland et al., 2014; Whitehead et al., 2015).

Good communication strategies, such as stimulating frank dialogue among colleagues or giving patients a say in possible outcomes, may reduce moral distress. One way to do this is by discussing ethical dilemmas with them. Participants in several studies also mentioned that venting, discussing the situation with compassionate colleagues, or debriefing within the team were effective ways to cope with negative emotional responses to moral distress (Austin et al., 2017; Howe, 2017b; Mehlis et al., 2018; Ulrich et al., 2010).

Besides these coping strategies, studies indicate that medical-ethics training is effective in reducing moral distress (Abbasi et al., 2014; Berger, 2014; Lamiani et al., 2017; Rhodes, 2017; Ulrich et al., 2010). The American Association of Critical Care Nurses' 4A's framework represents an effective strategy. The 4A's programme is a cyclic process, consisting of four stages (Ask, Affirm, Assess and Act), to

help a sufferer lower moral distress. The aims of the four stages are to help sufferers (1) become aware of their moral distress and its effects, (2) make a commitment to address moral distress, (3) to be ready to make an action plan and (4) preserve their integrity and authenticity (Rushton and Westphal, 2004).

Taken together, this empirical evidence considered in the first part of this paper shows that moral distress is a common and multifaceted phenomenon in medical practice. Physicians who experience moral distress have many challenges in adhering to core aspects of providing 'good medical care' in the *ethical* sense of the word. Put differently, moral distress essentially challenges physicians' ethical obligation to actually provide good medical care. The implications of such an ethical challenge, then, is that it is necessary to investigate moral distress from an ethical point of view. Specifically, this means that we have to address the question by deciding which ethical theories to apply and decide which principles and frameworks can lead one to reach a better understanding of the core values at stake. Also, we would need to study the way in which these theories, principles, and frameworks are related to each other and to study the various dimensions of the process of ethical reflection and action in this field.

In the next sections, we carry out an ethical analysis based on two of the most influential theories in contemporary biomedical ethics. Firstly, we will apply the four principles of biomedical ethics. Then, we will look at ethical aspects of moral distress in medicine from the care-ethics perspective. The overall aim is to identify ethical aspects that are fundamentally related to the phenomenon of moral distress in medicine. Finally, we provide an integrated ethical framework for understanding, assessing, and dealing with moral distress in medicine.

Ethical analysis

The principle-based approach

The most widely used approach to ethical analysis in medicine is based on Beauchamp and Childress' four principles of biomedical ethics: (1) respect for autonomy; (2) non-maleficence; (3) beneficence; and (4) justice (Beauchamp and Childress, 2001; Cooper, 1991; Taylor, 2013). Below, we apply these principles to the experience of moral distress in medicine. Table 2 summarises our analysis of the ethical principles, causes, and challenges in this regard.

Autonomy. Respect for autonomy is a pivotal criterion in contemporary healthcare and primarily refers to *respect for the autonomy of the patient* (Beauchamp and Childress, 2001). This requires that healthcare staff allow the patient to be autonomous in thought, intention, and action when making decisions regarding their healthcare procedures based on personal values and beliefs (Beauchamp and Childress, 2001; Murgic et al., 2015). In order to make a reasonable decision, the patient must understand the likelihood of success and be made aware of all the risks of the treatment, according to the principle of informed consent (Murgic et al., 2015).

Research on moral distress in medicine, especially how it arises in intensive care, palliative care, and in paediatric and emergency wards, has shown that respecting patients' autonomy in real life is not always easy or possible to achieve (Abbasi et al., 2014; Dodek et al., 2019; Rosenwohl-Mack et al., 2020; Whitehead et al., 2015). This is particularly true when difficult choices have to be made between various treatment options, when the respective outcomes are uncertain and difficult to assess, when highly complex medical procedures have to be explained, and when strong emotions cloud the patient's judgement. These and other situations make it clear that a physician's expertise is always needed within the context of a shared decision-making process. The goal in such a process is to help the patient achieve a reasonable decision through active participation and dialogue with the physician (Scheibler et al., 2003). But again, evidence suggests that not every patient can express his or her autonomous choice in the same way and with the same clarity. In practice, articulate and more self-reliant patients are being prioritised at the expense

Table 2. Ethical principles, causes of and challenges in moral distress in medicine.*

Principles of biomedical ethics†	Causes of and challenges in moral distress
1. Respect for autonomy	**Patient**
	- Unable to express/clarify autonomous choices
	⇨ *Prioritising stronger and more confident patients at the expense of weaker ones*
	Physician
	- Increased workload pressure
	- Increased work complexity
	- Ethical dilemmas
	- Administrative burdens
	- Constant evolution of guidelines
	⇨ *Less time available for direct patient care and shared decision-making*
2 and 3. Non-maleficence and beneficence	- Uncertainty of balance between benefits and harms due to:
	• Unintended outcomes
	• Unforeseeable effects
	⇨ *Fear of providing futile/aggressive care*
4. Justice	- Shortage of drugs and medical equipment
	- Pressure on equal and adequate care for everyone
	- Economic reasoning and prioritisation
	- Gap between healthcare needs and available resources
	⇨ *Obliges physicians to work more efficiently according to cost-benefit ratio instead of medical reasoning*

*Authors' elaborations.
†Beauchamp and Childress' four principles of biomedical ethics (Beauchamp and Childress, 2001; Cooper, 1991; Taylor, 2013).

of less confident ones; this is morally distressing, as reported by approximately half of physicians (Førde and Aasland, 2007; Iglesias et al., 2012). Examples include situations with the elderly, who in many circumstances may happen to be given less priority (Førde and Aasland, 2007, 2013; Iglesias et al., 2012). This also occurs because of care complexity and less acute or self-reliant presentation.

Besides patient autonomy, there is also *professional autonomy of the physician*. This has been characterised by Skår (2010: 2226) as 'having the authority to make decisions and the freedom to act in accordance with one's professional knowledge base' (Beauchamp and Childress, 2001; Førde and Aasland, 2013). From the literature, we learn that when a physician's autonomy becomes vulnerable, this can lead to feelings of powerlessness, lack of moral sensitivity or capacity for ethical reflection, self-doubt, lack of knowledge or even fear (Axelsson et al., 2019; Bernhardt et al., 2010; Lamiani et al., 2017; Nejadsarvari et al., 2015; Rushton and Westphal, 2004; Rushton et al., 2013). All of this can erode professional morale, which is an important antecedent of moral distress (Førde and Aasland, 2007, 2013; Iglesias et al., 2012; Kälvemark et al., 2004).

Moral distress can also arise when external constraints occupy the time intended for direct patient care (Førde and Aasland, 2007, 2013; Iglesias et al., 2012). Increased workload pressure, increased work complexity, ethical dilemmas, administrative and documentation duties, as well as evolving guidelines can be triggers. In Kälvemark et al. (2004: 1079), a physician describes the dilemma of external constraints: 'I don't experience that the problem [i.e. moral distress] occurs when I actually have my patients . . . [The problem] is when I don't have

the time for them. Everything else takes so much time. That is the problem'. On top of that, physicians' documentation of all outcomes and decisions is obligatory. But when the documentation chart fails to take into account (social) circumstances that do play a role in clinical decision-making, on paper, this might make physicians feel nervous about their performance (Bernhardt et al., 2010; Borry et al., 2004).

Non-maleficence and beneficence. The principle of non-maleficence asserts an obligation not to inflict harm intentionally, and derives its strength from the Hippocratic principle of 'primum non nocere' (Beauchamp and Childress, 2001; Crawshaw et al., 1994). As Aacharya et al. (2011: 8) describe, the principle of beneficence is 'a moral obligation of contributing to the benefit or well-being of people and thus is a positive action done for the benefit of others instead of merely refraining from harmful acts' (Beauchamp and Childress, 2001).

Physicians need to assess both principles together, with the aim of producing net benefit over harm. Again, reality shows that medical decisions do not take place in splendid isolation (Lutzen et al., 2006). Unintended outcomes and unforeseen events do happen (Borry et al., 2004). Harm can be done unintentionally, and not all outcomes are as beneficial as hoped for or intended. In this regard, Borry et al. (2004: 85) stress that from an ethical point of view, 'decision-making can only be regarded as acceptable if the decision is supported by good arguments, though it would be ethically irresponsible not to take account of the (un)foreseeable effects of one's actions'. This uncertainty can make medical decision-making morally distressing, as demonstrated by empirical research (Fourie, 2017).

Examples of uncertain situations include those involving end-of-life situations where physicians have to decide whether or not to withhold, continue or withdraw an invasive treatment. In several studies, the majority of the physicians reported experiencing moral distress in end-of-life care because of the uncertainty of balancing benefits and harms (Abbasi et al., 2014; Dzeng et al., 2015; Whitehead et al., 2015). As aptly described by a physician from the study of Henrich et al. (2016: 59): '[. . .] the truth of the matter is that there are certainly cases where we predict people aren't going to do well, and [then] they do better than we expect. And that just makes it that much harder when you have someone whom you think you are doing too much to, but you don't really know for sure'. This situation refers to the fear of having to provide care that may not be in the best interest of the patient or having to provide futile care (Abbasi et al., 2014; Dzeng et al., 2015; Henrich et al., 2016; Whitehead et al., 2015). Futile care can be defined as care that does not improve patient outcome; rather, instead of benefit, it places an even greater burden on the patient (Dzeng et al., 2015; Shaner, 2016). Crawshaw et al. (1994: 952), vis-à-vis the Hippocratic oath, describe futility as having 'to treat those who are overmastered by their disease, realising that in such cases medicine is powerless'.

Withholding treatment can be morally worse than not trying (Dzeng et al., 2015; Shaner, 2016). In many cases, an accurate prognosis can only be made after starting the treatment. Patients, their family, and physicians feel less stressed and more in control if they can reverse or otherwise change a decision after the treatment already has started. However, physicians find it morally distressing when the family requests continued or demands aggressive care, even after physicians have recommended switching to comfort care (Henrich et al., 2016). Such insistence on giving futile care may occur because of unrealistic expectations and lack of acceptance of the patient's medical condition, as described by Henrich et al. (2016: 59): 'Family says everything has to be done. Doesn't matter what, at what cost to the patient, to hospital, to you, everything has to be done. And that's really what sometimes is very difficult to deal with'. The same kind of morally distressing experience happens when physicians observe their colleagues or superiors giving patients and their families false hope (Austin et al., 2017; Epstein and Hamric, 2009; Lamiani et al., 2018).

Justice. The fourth principle is justice (Beauchamp and Childress, 2001; Denier, 2007; Taylor, 2013). Taylor (2013: 2) describes the principle of justice as follows:

> '[Justice is] generally considered to have two components: equitability and distributive justice. *Equitability* means that persons in like circumstances should be treated similarly. In healthcare, this concept means that persons with similar medical conditions should receive the same quality of medical care regardless of nonmedical factors, such as wealth, social standing, or self-confidence. In other words, equal care should be realized for equal needs. *Distributive justice* means that, in view of the unavoidable reality that we do – and always will – have limited resources to devote to healthcare, we are morally obligated to distribute those limited resources fairly among patients. This does not mean that each person or group must get an equal share of the scarce resources (equality), but rather a fair share based on appropriate criteria and principles (equity)'.

How do these ideas about the principle of justice relate to findings in the literature? Physicians experience moral distress when less priority is given to frail and dependent elderly patients, because such an attitude seems disconnected from the principle of justice, being unjust and unfair (Førde and Aasland, 2007, 2013; Iglesias et al., 2012). A similar kind of situation occurs when there is shortage of drugs and medical equipment, which means delivering equal and adequate care to everyone is impossible (Abbasi et al., 2014; Axelsson et al., 2019; Bernhardt et al., 2010; Dodek et al., 2016; Førde and Aasland, 2007, 2013; Henrich et al., 2016, 2017; Iglesias et al., 2012; Rushton and Westphal, 2004). Obviously, then, situations in modern medicine arise when the principle of justice and physicians' fidelity to their Hippocratic oath are pitted against each other.

Research shows that during the past decades, physicians have experienced fundamental changes in the healthcare system. The sheer number of medical treatments and approaches and people's expectations of healthcare and medicine have exploded. New technologies and increased health and psychosocial needs of patients have increasingly pushed healthcare costs upward in all Western healthcare systems (Abdool et al., 2016; Kälvemark et al., 2004); some of this pressure is due to the combination of lifestyle changes and increased life expectancy. This contemporary problem creates a relative shortage of services and goods that are both complex and stretching across several domains of medicine. More than ever before, the gap between needs and available resources has accelerated. In order to reduce costs, government, institutional management and insurance companies may oblige physicians to work more efficiently to achieve a better cost-benefit ratio for the former three parties. This reasoning may force physicians to deny care to certain categories of patients for purely economic reasons, hardly consistent with the principle of justice. As illustrated by Kälvemark et al. (2004: 1079): '[. . .] you feel terrible toward the patient [. . .] when you can't offer someone a hospital bed . . . they can be ever so ill and you can't offer them what you really think they need. [. . .] those who can't pay'.

Such denial of care for economic reasons puts physicians in a stressful bind: trying to provide the best healthcare for people in need, whilst at the same time, keeping costs down and resources spared. This situation has been reported to create moral conflict (Henrich et al., 2016). For physicians, using economic reasoning in the context of good healthcare is bad medical practice (Garbutt and Davies, 2011). When forced into economic prioritisation, from a physician's point of view, expensive or scarce resources should be used on cases with the greatest medical urgency. From a medical point of view, priority must be given to patients who would benefit the greatest medically (Krütli et al., 2016). When economic concerns dominate their decision-making, physicians report feeling frustrated, powerless and morally distressed (Abbasi et al., 2014; Førde and Aasland, 2007, 2013; Henrich et al., 2016; Iglesias et al., 2012; Whitehead et al., 2015).

Table 3. Five stages of care ethics – their corresponding moral qualities and meaning.*

Stage of care	Moral quality	Meaning	
Caring about	Attentiveness	Recognising unmet need(s) for care	Affected when less time available for patient care
Taking care of	Responsibility	Actually doing something about the existing need(s)	
Actual caregiving	Competence	Meeting the patient's need(s) adequately and professionally	
Care receiving	Responsiveness	Observing whether and to what extent the patient is indeed affected by the care received, possibly noticing newly emerging needs	
Relationship between caregiver and care-receiver (caring relationship)			
Caring with	Plurality, communication, trust respect, solidarity	Actual presence of a fair and just culture of care within the institution and society as a whole	General context and conditions of care

*Source: Authors' own elaborations of Tronto's originally described stages (Edwards, 2009; Jecker and Reich, 2004; Taylor, 2013; Tronto, 1993).

In conclusion, the results from our four-principles ethical analysis reveal some insights into the ethical tensions that are present in physicians' experiences of moral distress. A glaring drawback, however, is that we arrive at a disjointed overall view on how the *relational dynamics* of the *care process as a whole* addresses moral distress in medicine. To overcome this failing, we next consider another perspective – the care ethics perspective – which offers important additional insights and a more comprehensive ethical view on moral distress in medicine. A care-ethics approach augments the four-principles ethical analysis in that it focusses on the *caring relationship* between physicians and patients, understood as a dynamic back-and-forth process unfolding over time.

Care ethics approach

Care ethics is an ethical theory that originally evolved from the Kohlberg-Gilligan debate on moral psychology. It was developed more explicitly in the 1980s, most notably in the work of Gilligan and Noddings. Their studies on women's approach to ethics and moral dilemmas (Collins, 2015; Edwards, 2009) led to an ethical perspective based on interpersonal relationships and actual practices of taking care of one another. According to this theory, care has an important ethical value, not only within our own particular daily lives but also within the broader societal context of education and social policy. As such, the care ethics perspective has become very influential within contemporary ethical theory and practice, one applied in multiple domains for moral decision-making. Today, it is most commonly recognised in the works of Joan Tronto (Edwards, 2009; Jecker and Reich, 2004; Taylor, 2013; Tronto, 1993). In her theory, five stages of care are identified, each aligning with a corresponding moral quality (Tronto, 1993, 2013). Together, the stages aid understanding of the ethical meaning of moral distress in medicine, as it unfolds in the relational dynamics of the care process. Table 3 provides an overview of Tronto's five stages, their corresponding moral qualities, and meaning.

Five stages of care. The first stage of the care process is 'caring about' and begins with noticing unmet caring needs. It involves recognising the existence of a particular need and being concerned about the vulnerable condition of the one experiencing that need. The corresponding moral quality is *'attentiveness'*; that is, the capacity to be alert to one's surroundings by genuinely taking into account another person's

perspective (Edwards, 2009; Sevenhuijsen, 2014; Tronto, 1993). We ask ourselves: ‘What does the patient really need?’

The second stage is ‘taking care of’, which includes accepting responsibility to actually satisfy those existing need(s), to take action (i.e. *take care of* the situation). The corresponding moral quality is *‘responsibility*’ (Sauerland et al., 2014; Zavotsky and Chan, 2016). One does not ignore others’ needs but instead accepts responsibility to solve the problem. Improving the patient’s condition is recognised as paramount.

The third stage of caring involves ‘actual caregiving’. It means adequately satisfying the patient’s need(s). This, of course, requires one to possess the necessary professional competence. *Competence* is the moral quality most closely aligned (Tronto, 1993). One does not provide care in a casual way but professionally and competently.

Once the actual care is provided, there is typically a response from the care-receiver. Achieving good care requires feedback from patients and verification that their needs are actually met appropriately. This comprises Tronto’s fourth stage called ‘care receiving’. Observing the patient’s response and assessing how they are affected requires the moral quality of *‘responsiveness’* (Sevenhuijsen, 2014; Tronto, 1993). An important aspect of good care is actually responding to the effect the care has on the care-receiver.

Taken together, these first four stages proceed iteratively, with the care relationship between caregiver and care-receiver adjusting with each cycle. The dynamic is a relational process of first attentively ‘caring about’ unmet needs, and then accepting one’s responsibility to ‘take care of’ the unmet needs. The caregiver also needs to be attentive to new care needs that might emerge for which the caregiver would want to be attentive, after which the process repeats.

As mentioned, moral distress can originate exactly when constraints are insinuated into this iterative and dynamic relational care process. When experiencing moral distress, physicians repeatedly point to stress caused by appropriation of patient time via external constraints. This loss of time essentially ‘short-circuits’ physicians from morally entering into the care relationship, one characterised by qualitative, safe and effective care guided by shared decision-making (Førde and Aasland, 2007, 2013; Iglesias et al., 2012; Kälvemark et al., 2004; Scheibler et al., 2003). How so? Necessary patient consultation time is pitted against the moral quality of ‘attentiveness’; assessing needs and choosing appropriate care and treatment is pitted against the moral quality of ‘taking responsibility’; acting in a professional manner is pitted against ‘competence’; and assessing whether the given care and treatment truly helps the patient is pitted against ‘responsiveness’.

The final stage, ‘caring with’, is more contextual and requires that caring needs and the various ways they are met are consistent with democratic commitments to justice, equality, and freedom for all stakeholders (Tronto, 2013). This involves an overarching reflection, providing a way to analyse when, how, and by whom caring is done within society in general (Tronto, 2013). Being attentive to this final stage of care requires a commitment to the key moral qualities of every citizen: *plurality, communication, trust, respect* and *solidarity* (Tronto, 2013). These moral qualities enable people to take collective responsibility (*solidarity*) in creating a fair and just context, to think seriously about the nature and variety of existing care needs and aim to achieve a sort of general *trust* for a climate of good care for everyone in need. This all takes place in a context of democratic debate, open *communication*, and *respect* for a *plurality* of ideas and well-considered judgements. In short, this final stage of care refers to the broader dimension of care as it takes place within general society and its various institutions.

Research also shows that central causes of moral distress are situated against the broader social and institutional milieu, within which physicians have to operate; this represents the fifth stage of ‘caring with’. Within the social setting, the nature of the healthcare system, in general, makes certain healthcare services available to all, while other services are

available only to those who can afford them. This kind of inherent organisation can create moral distress in physicians, because patients with equal medical needs have unequal access (Førde and Aasland, 2007, 2013; Iglesias et al., 2012; Kälvemark et al., 2004).

Interacting with this structural inequity is the exponentially increasing corpus of medical knowledge and treatment options. This expansion of possibilities has elevated people's expectations towards physicians' capabilities for delivering high levels of care and compounds the pressure on professionals to provide a kind of headstrong care that may be unnecessary or to provide futile care (Abbasi et al., 2014; Dzeng et al., 2015; Henrich et al., 2016; Whitehead et al., 2015). Combined with the overall cost-reducing climate of medical institutions, physicians report feeling pulled in opposite directions. On the one hand, they aim to provide the best healthcare. On the other hand, they are beholden to the government, their institution, or insurance company to always lower the cost-benefit ratio. In such cases, they feel powerless and morally distressed (Abbasi et al., 2014; Førde and Aasland, 2007, 2013; Henrich et al., 2016; Iglesias et al., 2012; Whitehead et al., 2015).

Thus, the evidence shows that it is important for physicians to be able to work in an organisation that has a healthy care ethics approach and welcomes the ethical challenges of contemporary healthcare. Specifically, they create a culture of ethical reflection and discussion among colleagues, patients, and institutional representatives within an open and tolerant atmosphere (Atabay et al., 2015; Denier et al., 2019; Hamric and Wocial, 2016; Howe, 2017a; Sauerland et al., 2014; Whitehead et al., 2015). In short, a care ethics approach is promoted in which interpersonal relationships are emphasised. Such a relational approach has the potential to act directly on easing the pressure points among stakeholders and perhaps lower the drivers of moral distress in physicians.

Relational dynamics of care. Including the relational aspect of care ethics represents an important addition and improvement over the narrower perspective of principlism, as it provides (1) room for interaction and reciprocal care; (2) context within which the physician can function as a skilled companion to the patient and the family; and (3) a care process that is founded on the values of shared decision-making and person-centred care.

Firstly, the care ethics perspective takes as its starting point the concern of people for each other and is driven to action by a motivation to care. It is inspired by the interconnectedness of reciprocal caring relationships and the iterative dynamics of the care process (Collins, 2015; Schuchter and Heller, 2017; Walsh, 2018). Taylor (2013: 7) summarises: 'It incorporates the complex web of relationships in which the patient is embedded, and considers the perspectives of all those who truly care for the patient'. As such, the relationship between caregiver and care-receiver is of key moral importance (Schuchter and Heller, 2017; Walsh, 2018).

In working towards the goal of reducing the prevalence of moral distress in physicians, we believe it is important to add a care-ethics perspective to current ethical discussions that use only a principle-based approach. As mentioned, moral distress arises when multi-sourced pressure is applied to a healthcare professional who is guided by the four canonical moral principles (autonomy, non-maleficence, beneficence and justice). Schuchter and Heller (2017: 54) explain that a sole moral-based approach is limited in the care dialogue: 'The solution to a moral problem does not lie in judging actions on the basis of moral principles, but in intensifying relationships and enhancing empathetic involvement'. Investing in the care relationship and seeing it as a binding factor creates mutual trust and commitment. This gives physicians room to deal with their moral distress and the strength to continue rather than give up.

Secondly, also related is the ethical perspective of *skilled companionship*. This perspective states that a good healthcare professional skilfully diagnoses not only a physical or psychological condition and provides appropriate treatment, but also adopts, as a fundamental

tenet, viewing the patient's well-being holistically. By being a partner with patients and their families, considering how they cope and reflecting on how their condition affects their lives and well-being, physicians also function as skilled companions (Dierckx de Casterlé, 2015). Dierckx de Casterlé (2015: 3328) defines the skilled companionship approach as: 'Achieving the full capacity of companionship lies in being able to discover the uniqueness of a person, to sense his needs, and to really help this person'. Achieving this kind of competent companionship (Dierckx de Casterlé, 2015), we believe, will work towards lowering external pressures on physicians that drive their feelings of moral distress.

Thirdly, relational dynamics is also strongly related to aspects of *shared decision-making* and *person-centred care*. As we showed from the evidence on moral distress, it is clear that the physician's expertise is always needed for shared decision-making. The goal in shared decision-making is to reach a well-balanced decision, one arrived at by the patient through active participation and dialogue with the physician (Scheibler et al., 2003). It is essential for realising person-centred care. Research on moral distress in medicine makes clear how crucial it is for physicians to engage in these relational aspects of healthcare, with shared decision-making helping to realise person-centred care.

In this paper, we identified and analysed the ethical dimensions of moral distress in physicians using the two predominant theories in biomedical ethics. Firstly, on the basis of a literature analysis, we gained important insights about the way in which the four principles of biomedical ethics are limited when applied to the issue of moral distress in modern medicine. The insights gained by the four-principles approach are still important. However, when applied in isolation, they produce a somewhat fragmented view, because they cannot flesh out the whole picture of moral distress as experienced by physicians, its causes and consequences, and how to successfully cope. For example, consider the justice principle in the context of institutional cost pressures and scarce medical resources. Physicians are being torn in opposite directions: They are trying to give equal treatment to all patients (justice principle), but because of lack of resources and external cost pressures imposed on them, they are forced to provide unequal treatment. While we gained insight into one cause of moral distress in physicians by analysing the situation using the four biomedical principles, we found no solution with these principles on recommending a way to cope and reduce moral distress. Consequently, we found it may be fruitful to analyse the situation from the perspective of care ethics.

By means of its five stages of care, our care ethics analysis produced new insights into the relational dynamics of care and the way in which it is present (or absent) in physicians' experiences of moral distress in medicine. By adding this care ethics perspective to the principle-based approach, we reached a more comprehensive view of the various ethical challenges of moral distress in medicine and possible solutions for reducing it.

Moral distress in responding to COVID-19

The year 2020 wreaked havoc in medicine and healthcare around the world. As a final reflection on moral distress in medicine, it is instructive to consider the impact the COVID-19 pandemic is having in 2020–21.

Since the outbreak of COVID-19, healthcare professionals increasingly have had to face morally challenging situations. Clinicians suddenly had to answer many unprecedented questions about how to deliver good care in emergency situations where material and personnel resources were scarce. As of February 2021, large-scale research results are not yet available on moral distress in medicine related to the COVID-19 pandemic. Most recent publications on the topic do show, however, that many signs of moral distress, moral residue and moral injury are clearly present in healthcare workers (Archard et al., 2020; Coulthard, 2020; Dawson, 2020; Dawson et al., 2020; Dunham et al., 2020; Meager et al., 2020; Szczerbińska, 2020; White and Lo, 2020).

Essentially, the origins of the moral distress are rooted in tension between the 'standard' clinical-ethics focus that operated before the pandemic and a public-health ethics focus that began to operate soon after the pandemic was recognised (Berlinger et al., 2020; Dunham et al., 2020). Normally, clinicians operate within the framework of clinical ethics. Their duties and responsibilities relate to a typical clinical encounter, one comprising clinician, patient and sometimes family. This emphasis suddenly shifted in early 2020.

As discussed above, physicians, as patient advocates, aim to respect autonomy in medical decision-making, prioritise non-maleficence, and beneficence and focus on the most vulnerable patients (Berlinger et al., 2020; Dunham et al., 2020). In a global emergency health crisis, like the COVID-19 pandemic, some of these principles are at odds with each other.

Pandemic healthcare environments present challenges to this clinical-ethics value framework that can only be met by shifting perspective to a public-health ethics approach. As Dunham et al. (2020: 5) state: 'The standard question of what *I* ought to do is modified to what *we*, as population, ought to do'. The shift from patient-centred practice to pandemic-focussed public health considerations creates great tension in physicians, especially for clinicians unaccustomed to working under emergency conditions with scarce resources (Berlinger et al., 2020; Dawson, 2020; Dawson et al., 2020). However, *individual-clinical ethics* and *public-health ethics* sometime conflict. The former is concerned with what is best for the individual patient, while the latter is concerned with the collective good.

Tension also arises between physicians' fidelity to *best medical practices* (Hippocratic Oath) and managing *scarce resources* (ICU beds, personal protective equipment, ventilators, etc.). Tension arises between physicians' *expert practice* (the moral responsibility of professional expertise) and their having to *practice at the edge of or beyond their competencies* because of redeployment needs. Tension exists between one's *professional duties* (the duty to serve) and *duties on the personal level*, to one's family and oneself (practice safely to protect one's own health and that of one's family). Finally, tension develops between good medical practice in line with *consistent and transparent guidelines* for clinical practice and 'crisis medical practice'. This resulted from the *vague and constantly changing* nature of the many recommendations and guidelines that were modified during the unfolding COVID-19 crisis as knowledge of the virus accumulated. This latter situation caused much confusion and diverse interpretations (Berlinger et al., 2020; Dawson, 2020; Dawson et al., 2020; Dunham et al., 2020). In short, all of these tensions has led to moral distress at an unprecedented level.

Although these early publications provide important first insights into the experience of moral distress in medicine since the COVID-19 pandemic, much research still needs to be done, especially regarding prevalence, coping, and structural mitigation of moral distress in healthcare practice (Gustavsson et al., 2019). Past, present and future ethical challenges in responding to this pandemic did and will require increased attention from many perspectives and on many levels of our healthcare systems and practices worldwide (Archard et al., 2020; Coulthard, 2020; Dunham et al., 2020). However, from our analysis and brief consideration of the tensions emerging in the COVID-19 pandemic, it seems reasonable as a first step to target individual moral conflicts rather than many simultaneously. This approach may allay some of the tensions underlying moral distress. We also speculate that such an approach may be applicable to intense medical environments that are present during war or outbreaks in locales with severely limited resources.

Concluding remarks

In this paper, we conducted an ethical analysis of moral distress as experienced by physicians. In organising this analysis, we used the two predominant ethical theories: principlism and care ethics. Our analysis revealed that many factors can determine the presence, frequency and

intensity of moral distress in medicine. We also showed that moral distress, moral residue, and moral injury can be mitigated when various conditions are met. We now want to draw attention to three possible strategies for dealing with moral distress in medicine, in particular, for physicians in intensive care units, palliative care and emergency wards, follow by a final remark on the COVID-19 Pandemic and the need for further research.

Firstly, a useful tool to handle moral distress is the American Association of Critical Care Nurses' 4A's framework (Allen et al., 2013; Rushton and Westphal, 2004; Trautmann, 2015). In applying the 4A's – Ask, Affirm, Assess, and Act – self-reflection (Ask) begins the process and helps the sufferer to see that moral distress is present. The next steps of self-affirming and self-assessing help the sufferer move towards the final step of taking action to preserve professional integrity and authenticity (Rushton and Westphal, 2004). The 4A's is an ongoing process of continuous re-evaluation that is effective for nurses in crisis; however, it may be useful for physician sufferers as well. Somewhat related evidence shows that moral resilience can be cultivated on a personal level using a simple exercise: before retiring for the night, writing down three good things that happened during the day (Dunham et al., 2020; Rippstein-Leuenberger et al., 2017).

Secondly, on a structural level, healthcare organisations might be able to contribute to lowering moral distress in medicine by creating a favourable institutional ethical climate, one with serious ethics education, tools, and guidelines for ethical discussion and reflection, and that promotes continuous ethical reflection and dialogue within teams. A caring attitude and a healthy ethical climate where collaboration and an open discussion are promoted systematically is a necessary contextual factor (Atabay et al., 2015; Denier et al., 2019; Hamric et al., 2012; Sauerland et al., 2014). Ethical frameworks for healthcare institutions and teams have been shown to be critical in responding to moral dilemmas and ethically challenging circumstances (Berlinger et al., 2020; Dawson, 2020; Dawson et al., 2020; Dunham et al., 2020).

Thirdly, robust medical-ethics education is imperative for dealing with moral distress. Educators need to inculcate moral courage and wisdom, helping physicians to remain faithful to their moral framework, while simultaneously meeting challenges both in normal and exceptional circumstances. Such training may help physicians to deal more effectively with moral distress (Abbasi et al., 2014; Berger, 2014; Lamiani et al., 2017; Rhodes, 2017), allowing many more physicians to attain a higher professional and personal quality of life (Austin et al., 2017).

Finally, it remains to be stressed that our analysis of moral distress in responding to COVID-19 is based on the first and most recent publications in this field, of which there are, to date, only very few available. Nevertheless, our search has shown that the COVID-19 pandemic indeed caused a lot of moral distress among physicians, and this from the very start of the outbreak. We have been able to discuss the evidence available until now, but we realize that there are many more factors that contribute to the experience of moral distress in responding to COVID-19. Accordingly, there is a great need for further elaboration and research in this domain. It is to be expected that more literature about this topic will appear in the near future.

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