Moral Distress and Dilemmas Experienced by Healthcare Professionals during Care of Patients with COVID-19

Kobra Rashidi
Department of Nursing, Lorestan University of Medical Sciences, Khorramabad, Iran.
Fateme Goudarzi
Department of Nursing, Lorestan University of Medical Sciences, Khorramabad, Iran
Mohsen Fadavi
Medical Ethics Department, Faculty of Traditional Medicine, Shahid Beheshti University of Medical Sciences, Tehran, Iran
Forouzan Akrami (froozan_akrami@yahoo.com)
Postdoctoral Researcher, Medical Ethics and Law Research Center, Shahid Beheshti University of Medical Sciences, Tehran, Iran. https://orcid.org/0000-0002-5001-0085

Research Article

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Abstract

Background

Emerging COVID-19 pandemic has posed numerous ethical challenges to the healthcare. This study aimed to explain ethical challenges experienced by healthcare professionals giving care for COVID-19 patients during early phases of the pandemic.

Method

This qualitative study was conducted by content analysis approach. 22 semi-structured in-depth interviews were done with 18 healthcare professionals working in medical centers and hospitals of public or private sectors, in Tehran, capital of Iran, from July to October 2020.

Results

The ethical challenges categorized into 4 categories (and 11 sub-categories) including: poor professional care, preference of public interests over individual care, difficult decision-making, and moral distress.

Conclusion

The findings indicate on the attenuation of professional care, need to developing evidence-based clinical guidelines with regard to the resulted insights. In addition, devising appropriate interventions is recommended to psycho-emotional support of frontline healthcare workers, especially the nurses.

Introduction

Emerging COVID-19 pandemic affected all aspects of human life throughout the world by posing numerous ethical, social and economic challenges(1). In a statement on January 30, 2020, the World Health Organization (WHO) announced the new coronavirus outbreak as the sixth leading cause of emergency situation and threatening factor to public health over the world(2). The knowledge about COVID-19 care and management is also restricted due to some especial features of the virus including super-spreading characteristic and recombination and frequent mutations(3).

In crisis like COVID-19 pandemic, health systems face difficulties due to decisions in prioritizing scarce resources in terms of how, when, and where to allocate them(4). In addition, public health systems face significant ethical issues related to protecting patients' rights and the public benefits. People crowd in health centers, overcrowding of hospital beds, extreme fatigue of staff, shortness of manpower, psychological reactions, and other concerns due to lack of equipment are some factors cause

challenges(5). In this situation most challenges are related to the ethical issues focused on protecting patients' rights and access to healthcare services(6).

Healthcare workers often are faced moral dilemmas and involved in critical situations during crisis. Difficulty in dealing with ethical issues, and conscious decision-making cause frustration of medical team, especially nurses(7). Inability to make ethical decisions and communicate patients, shortness of manpower, and inappropriate care cause moral distress(8), and job burnout(9). In this circumstances, quality of care would be affected(10).

Similar to other countries, COVID-19 pandemic and preventive measures to combat it, such as isolating affected people, quarantine and social distancing in Iran, imposed various alterations in health system in terms of current plans and activities which leads to rise ethical challenges. In early phase of the pandemic, some essential services such as screening, risk assessment and case finding were suspended, as well as, following-up and care of patients with non-communicable diseases (NCDs) turned into the distance modality by telephone(11). Contrary to expectations, the second wave of the pandemic started in the summer 2020 in the country and the third and fourth waves occurred in autumn and winter(12).

In a study on medical ethics related to Ebola, ethical challenges in managing the disease included the duty to care for and fear of transmitting the virus to family members, quarantine and respect for individual autonomy, benefits and harms of intubation and mechanical ventilation, and the use of unauthorized and experimental therapies without a clinical trial protocol(13). In a review study, the most important ethical challenges in managing and responding to COVID-19 were movement restrictions, refusal for preventive and curative interventions, rights and duties of health care workers, allocation of scarce resources, and off-label therapeutic measures(1). Most of studies on the ethical challenges during the early phase of pandemic experienced by nurses, have reported the threat to professional values, lack of holistic care, difficulty in decision-making and prioritizing due to scarcity of resources(14–16).

It is worth note, healthcare professionals should be trained based on the principles of professional ethics to manage crises like COVID-19 pandemic. They should also be sufficiently sensitive to ethical issues, and be able to make ethical and informed decisions(17). A broad study of the lived-experiences of healthcare professionals can provide a deeper insight into the ethical challenges during the pandemic and the adoption of strategies to provide an appropriate response, especially in the early phases of an epidemic or pandemic. This study aimed to explain the lived-experiences of healthcare professionals of ethical challenges during primary waves of COVID-19 pandemic.

Methods

Design

The qualitative study with content analysis approach was conducted to explain the lived-experiences of healthcare professionals of ethical challenges, from July to October 2020.

Participants

Key participants were 18 healthcare professionals working in educational medical centers and hospitals of the public or private sectors, in Tehran, capital of Iran. Sampling was conducted by purposive and snowball methods. The participants were purposefully selected among expert and experienced professionals involved in the management and care of COVID-19 patients. First, 12 experienced people was selected and interviewed. Then, interviews were continued with 6 people who introduced by them. Totally, 18 participants entered into the study whom their characteristics represented in Table 1. To observe maximum variation in sampling, participants with diversity in terms of age (28–55 years), gender, expertise and work experience recruited into the study, and some of them simultaneously were working in private sector.

Data collection

Data were collected through semi-structured in-depth interviews from July to October 2020. 22 interviews were done with 18 participants which lasted 30 to 70 minutes and stopped after theoretical saturation. Interviews were done with participants who met inclusion criteria and started with the open question: "What ethical challenges did you experience during COVID-19 pandemic?" In order to deepen the interviews, some probing questions such as "what did you experience while taking care of the patients?", "what did you feel?", and etc. were asked.

The interviews were conducted in the preferred time and place of the participants both in-person and by telephone by the first and last researcher. 18 interviews were conducted by voice call via cell-phone or WhatsApp application and 4 interviews were conducted in-person due to the desire of some participants, in compliance with health protocols. The interviews were recorded with the permission of participants.

Data analysis

Data were analyzed by Graneheim and Lundman approach(18). Immediately after each interview, the recorded interviews were listened by the researchers and transcribed verbatim. After reading the text several times, semantic units and open codes were extracted. The open codes were then compared and categorized into more abstract subcategories and categories based on their similarities and differences. MAXQDA 10 software was used to facilitate data analysis process.

Table1: Demographic characteristics of the participants

Participant Number	Specialty	Degree	Gender	Work place	work experience (Year)
P1	Nursing	MSc	female	Educational hospital	7
P2	Nursing	BSc	male	Educational hospital	17
P3	Nursing	BSc	female	Educational hospital	10
P4	Nursing	PhD	female	Educational hospital	13
P5	Nursing	BSc	female	Educational hospital	15
P6	Nursing	BSc	female	Educational hospital	10
P7	Nursing	BSc	female	Educational hospital	5
P8	Physician	Resident	female	Educational hospital	1
P9	Physician	Sub-specialist	female	Educational hospital	14
P10	Physician	Resident	female	Educational hospital	1
P11	Nursing	BSc	female	Educational hospital	17
P12	Nursing	BSc	female	Educational hospital	16
P13	Nursing	BSc	male	Educational hospital	13
P14	Medical ethics	MD, PhD	Male	Private hospital	17
P15	Medical ethics	MD, PhD	male	Educational hospital	13
P16	Nursing	BSc	male	Educational hospital	4
P17	Nursing	BSc	female	Educational hospital	19

P18	Medical ethics	MD, PhD	male	Private hospital	25

Rigor

long-term engagement and peer check were used to increase credibility of data. The leader researcher also resided in a coronavirus medical center for one week and observed the management and care processes. Regarding member check strategy, two participants were asked to confirm the labels and codes. To develop dependability, moreover peer checking, the experiences of some participants were directly quoted. Bracketing, peer check and member check were observed to make sure about reliability. variation of expertise and increasing auditability by reporting step by step were ways to incline possible transferability of the findings.

Ethical considerations

This research was licensed by the Ethics Committee [IR.SBMU.RETECH.REC.1399.359] from the Vice Chancellor for Technology and Research of Shahid Beheshti University of Medical Sciences. After explaining the research objectives and emphasizing on the confidentiality and anonymity of information, the verbal consent was obtained from the participants.

Findings

The ethical challenges were categorized into 4 categories and 11 sub-categories (Table 2).

Table 2- Categories and sub-categories

	Category	Sub-category
Main Challenges	Poor professional care	Disrupted communication;
		Ambiguity of nurses' role;
		Uncompassionate care
	Preference of public interests over individual care	Ignorance of family-centered care;
		Lack of mourning care
	Difficult decision-making	Ambiguity in standards of care;
		Forced to choose
	Moral distress	High workload and negative attitudes;
		Concerns about Coronavirus transmission to family members;
		Uncertain ethical climate;
		Emotional fatigue

Category I: Poor professional care

Most participants acknowledged that wearing personal protective equipment (PPE) and fear of COVID-19 infection interfered in communicating with patients. This category is made up of 3 sub-categories.

Disrupted communication

Most participants experienced communication problems with patients:

“The doctor covers himself so much and distances from the patient, so that he did not hear what the patient is saying and did not communicate with the patient.”(P7)

Ambiguity of nurses’ role

Most nurses experienced ambiguity in their role and over-demand by physicians:

“I called the physician to report him the emergency situation of the patient. Instead of coming to visit the patient, he wanted me to give him history. When family member of the patient wanted to talk with physician, they designated this task to the nurses.”(P6)

Uncompassionate care

Most participants perceived that sometimes the care provided by healthcare professionals was uncompassionate:

“Disappointment in patients raised increasingly, I think these patients should be given more psychological care than just treatment, because they have the view that there is no cure and they will die. Sometimes, for example, the patient asks the physician and he says, 'I don't know! - sometimes clerics came and talked with patients and calm them down”. She continued: “Some physicians or even nurses do not take care of patients with COVID-19 who are affected by other underlying diseases like cancer, it does not matter the patients are young or aged. This is annoying.”(P7)

Category II: Preference of public interests over individual care

Most of the participants stated while there was need to psycho-spiritual support and presence of the patient family, the presence of a companion with the patient was prohibited and it was not possible for the family to say goodbye to the deceased patient. This category contains 2 sub-categories.

Ignorance of family-centered care

For most participants, the Family Absence Act was a challenge:

“Today I had an elderly Turkish-speaking patient with whom I could not communicate in any way. But his companion talks to him and provides their needs and psychological support.”(P4)

Lack of mourning care

Most participants experienced the emotional needs of patients' families to say goodbye to their patient during mourning or after the sudden death:

“Patients were in good health, suddenly they needed to resuscitation but families really could not believe that their patients had died or connected to the ventilator; they could not accept and say, 'Oh, it is impossible!' They became angry and fight with staff.”(P16)

“We had trouble regarding to visiting end-stage patients by their family members. The families were begging us to let them see their patients for the last time; we were in situation whether the family could see him or not.”(P5)

Category III: Difficult decision-making

Most participants experienced difficulty in decision-making situations due to complexity of the coronavirus, as well as a lack of resources. This category consists of two sub-categories.

Ambiguous standards of care

The experiences of most participants indicated the difficulty and ambiguity in diagnosis and treatment of the patients with COVID-19:

“In the early phases, the guidelines were written without considering diabetic patients, prioritization of patients to receive services, and how the mourning process; One challenge was to impose the burden of decision-making for intubation on professionals due to a lack of a clear protocol and insufficient skills and tools.”(P15)

“Nurse Manager, and anesthesia assistant asked us what should we do now? Whether there is indication for resuscitation of this patient or not?”(P1)

Forced to choose

Most participants experienced the challenge of being forced to choose between patients:

“Another challenge that bothered me a lot was choosing between bad and worse; which patient had to be chosen to connect to ventilator?”(P4)

"Most of the time, we had to make decision about which patient has to stay alive or not.”(P8)

Category : Moral distress

Most participants experienced heavy workload that caused them fatigue and distressed. This category consists of 4 sub-categories:

High workload and negative attitudes

Most participants experienced high workload and negative emotions:

“My relatives and friends became less in touch with me, when they find out I work in where patients with COVID-19 were hospitalized.”(P2)

“I witnessed many nurses were working by heart, they ignored their rest time. But someone says that nurses receive money, it is their duty, hearing these, upset us more.”(P7)

Concerns about Coronavirus transmission to the family members

Most participants experienced stress due to fear and anxiety about transmission the infection to their family members:

“We were more worried about our family members. I was really worried about affecting my father with COVID-19 because he has an underlying illness.” (P8)

“Staff constantly considered the patient as a threat. I am more worried because my wife is pregnant and I have a double stress."(P13)

Uncertain ethical climate

Most participants believed that COVID-19 pandemic as an unexpected circumstance, undermined the ethical climate:

“I tell the emergency unit, I'm busy now, I'm intubating the patient, don't send a patient towards us, they did not listen me at all.”(P4)

“Some doctors look at the patient as a mean, they come quickly for visits and write hasty orders."(P7)

"Because of crowding of the patients in emergency unit and leaving the doors open for proper air circulation and ventilation, their privacy was not fully observed." (P14)

“Some physicians in ICU wards desire to give an alternative drug and evaluate its effect. They prescribed the drugs without patient's consent because the patient was unconscious, there was no companion with patients, and there was no supervision by ethics committee.”(P15)

Emotional fatigue

Most participants experienced emotional exhaustion because of that their colleagues or patients were affecting or dying of COVID-19, unexpectedly:

“One of the worst things we experienced was that we witnessed many deaths during a work day. We got depressed, the patient was dying, we were crying with their family - I really felt a burnout in some

situation, and I wanted to resign of work."(P1)

"It was very hard to see the death of 10 patients together one day, and it was harder when all of them died at the same time. I still have a nightmare. We became like people coming back from the war. We really need psychiatric counseling."(P8)

Discussion

In this study, ethical challenges were emerged in 4 categories: poor professional care, preference of public interests over individual care, difficult decision-making, and moral distress. Threat to professional values, lack of holistic and family-centered care and difficulty in decision-making were also the most ethical challenges reported by similar studies(14–16).

In our study poor professional care was the first category that was emerged. According to the participants, the unknown and contagious nature of COVID-19 disease disrupted the communication of frontline healthcare workers with patients due to fear of infection and use of PPE, and caused failure to play their professional role and to provide compassionate care. Studies showed that the elements of nonverbal communication and reassuring touch were inhibited by using PPE, while these patients need compassionate care and more psychological support(19). Compassion with patients and families as a key moral virtue and feature of compassionate care helps to build a trustful relationship and to alleviate their sufferings(20).

The second category was the preference of public interests over individual care. The COVID-19 pandemic raises important ethical questions about how to balance the public interests with individual, respectful and holistic care(19). The experience of the lack of a holistic approach and family-centered care during the pandemic was also reported by some scholars, thus they suggested the development of protocols to enhance professional care(21).

Difficulty in decision-making was the third category. The participants stated that they were not trained for making ethical decisions in such situations and need to learn emotion and anger controlling and coping skills. Other scholars also reported these experiences in their studies in the early phases of pandemic(16, 22). Researchers found that in the absence of ethical guidelines, healthcare workers are strongly influenced by the emotional atmosphere of the crisis and the guidance of their opinions(23). These findings notify the need to new ethical considerations for day-to-day care decisions.

The last category was moral distress. High workload and negative attitudes, stress of transmitting the infection to family members, and emotional fatigue were experienced by the participants, especially the nurses. Most participants believed that COVID-19 pandemic as a complicated circumstance, undermined the ethical climate. In similar studies, most nurses also found themselves afraid, confused and nervous, and at the same time committed to their professional role(24). They experienced lack of knowledge and professional skills, role ambiguity, and lack of emotional support(22). Thus, it is necessary to provide

them comprehensive training to cope with such critical situations, ethical decision making and develop a safe and ethical climate, as well as, devising psychosocial and supportive interventions.

Overcoming repeated waves of COVID-19 requires rearrangement of organizational and clinical capacities(19). Although in the early phases of pandemic, the analysis was focused on resource allocation among people with COVID-19(25), in the rearrangement phase, how to generate more benefits and how to promote the public interests requires careful ethical considerations(19).

One of the limitations of our study was difficulty in conducting face-to-face interviews due to the contagious nature of COVID-19. However, some participants were interviewed in-person due to their willingness.

Conclusion

The participants experienced numerous ethical challenges and moral dilemmas that all could undermine professional care. Given the preference of public interests over individual preferences in responding to the pandemic of infectious diseases, and the attenuation of professional care, developing evidence-based clinical guidelines with regard to the resulted insights, play an important role in access to comprehensive quality care services. In addition, devising appropriate interventions is recommended to psycho-emotional support of frontline healthcare workers, especially the nurses.

Declarations

Authors declare no conflict of interests

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