

Healthcare professional's moral distress during the COVID-19 pandemic: an integrative review

Distresse moral em profissionais da saúde durante a pandemia de COVID-19: uma revisão integrativa

Sufrimiento moral en profesionales de la salud durante la pandemia de COVID-19: una revisión integradora

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Abstract

Background: the COVID-19 pandemic brought several moral conflicts in the healthcare context. The impossibility to act in a way that the professionals consider ethically correct, due to external or internal barriers, can trigger moral distress. This phenomenon is prejudicial to the professional's morals and can impact the quality of care provided. **Objective:** to analyze which circumstances, during the COVID-19 pandemic, cause moral distress in healthcare professionals. **Methods:** this integrative review of the literature was made in the SCIELO and PubMed databases, based on the descriptors "moral distress" and "COVID-19". Articles published between 2019-2021, in Portuguese, Spanish and English were included. PRISMA criteria were followed. **Results:** from an initial search of 171 documents, 102 were completely reviewed and 29 were included in this review. The causes of moral distress in healthcare professionals can be distributed in the following categories: personal; patients and caregivers; team; organization. Lack of resources, intermittent treatments, fear of contracting the virus, visit restrictions, and absence of explicit guidelines were some events mentioned by the articles. **Conclusion:** the pandemic caused by COVID-19 has been causing moral distress among professionals. This phenomenon can bring serious consequences for the health of professionals and the care provided by them. Education and support programs, in addition to further studies, should be encouraged to minimize the impact in the next stages of the pandemic and on future occasions related to ethical dilemmas.

Keywords: Moral distress; Healthcare providers; COVID-19; Moral.

Resumo

Introdução: a pandemia de COVID-19 trouxe vários conflitos morais para o contexto da atuação em saúde. A impossibilidade de agir da maneira que o profissional julga ser eticamente correta, devido a barreiras externas ou internas, pode causar o distresse moral. Esse fenômeno é prejudicial à moral do profissional e pode impactar na

qualidade do cuidado prestado. Objetivo: analisar quais circunstâncias, durante a pandemia de COVID-19, causaram distresse moral nos profissionais da saúde. Método: essa revisão integrativa da literatura foi realizada com as bases de dados SCIELO e PubMed, utilizando os descritores “moral distress” e “COVID-19”. Artigos publicados entre 2019-2021, em português, espanhol ou inglês foram incluídos. Os critérios PRISMA foram seguidos. Resultados: A partir de uma busca inicial de 171 documentos, 102 foram completamente revistos e 29 foram incluídos nessa revisão. As situações que causaram distresse moral nos profissionais da saúde foram distribuídas nas seguintes categorias: pessoal; pacientes e familiares; equipe; e organização. Falta de recursos, tratamentos intermitentes, medo de contrair o vírus, restrições de visitas e ausência de diretrizes explícitas foram alguns dos eventos mencionados nos artigos. Conclusões: a pandemia de COVID-19 tem causado distresse moral nos profissionais. O fenômeno pode trazer sérias consequências para a saúde dos trabalhadores e o cuidado prestado por eles. Programas de educação e suporte, além de novos estudos, devem ser encorajados para minimizar o impacto dos próximos estágios da pandemia e em futuras ocasiões relacionadas a dilemas éticos.

Palavras-chave: Distresse moral; Profissionais da saúde; COVID-19; Moral.

Resumen

Introducción: la pandemia de la COVID-19 trajo varios conflictos morales al contexto de la atención a la salud. La imposibilidad de actuar de la forma que el profesional considere éticamente correcta, debido a barreras externas o internas, puede causar sufrimiento moral. Este fenómeno es perjudicial para la moral profesional y puede afectar la calidad de la atención. Objetivo: analizar qué circunstancias, durante la pandemia de COVID-19, provocaron sufrimiento moral en los profesionales de la salud. Método: esta revisión integrativa de la literatura se realizó con las bases de datos SCIELO y PubMed, utilizando los descriptores “moral distress” y “COVID-19”. Se incluyeron artículos publicados entre 2019-2021, en portugués, español o inglés. Se siguieron los criterios PRISMA. Resultados: De una búsqueda inicial de 171 documentos, 102 fueron revisados completamente y 29 fueron incluidos en esta revisión. Las situaciones que provocaron sufrimiento moral en los profesionales de la salud fueron distribuidas en las siguientes categorías: personales; pacientes y familiares; equipo; y organización. La falta de recursos, los tratamientos intermitentes, el miedo a contraer el virus, las restricciones de visitas y la ausencia de lineamientos explícitos fueron algunos de los hechos mencionados en los artículos. Conclusiones: la pandemia de COVID-19 ha provocado sufrimiento moral en los profesionales. El fenómeno puede tener graves consecuencias para la salud de los trabajadores y la atención que estos brindan. Se deben fomentar programas de educación y apoyo, además de estudios adicionales, para minimizar el impacto de las próximas etapas de la pandemia y en futuras ocasiones relacionadas con dilemas éticos.

Palabras clave: Sufrimiento moral; Profesionales de la salud; COVID-19; Moral.

1. Introduction

The current COVID-19 pandemic has changed the world, shifting countless situations in the health context. The high transmissibility of the disease and the fact that it is airborne have led to drastic measures from the world's governments and its population, focused mainly on hygiene protocols, social isolation, and quarantine (Aquino et al., 2020).

Healthcare organizations are dealing with logistical needs, such as hospital capacity, limited resources, treatment proficiency, and maintaining the safety of patients and hospital staff. On the other hand, caregivers have to focus on the micro-issue, since they are caring for infected patients, putting themselves at risk, and also handling ethical conflicts about it (Gopichandran, 2020; Kimhi et al., 2020).

There are several moral challenges involving treating patients with COVID-19, such as restricted visitations, the nonexistence of efficient treatments and the use of unproven therapies for the disease, the responsibility to the individual patient versus to the public health, the rationing, and allocation of resources and the risk to personal safety. Many of these situations involve moral conflicts, in which the professional is faced with many alternatives of action. These ethical dilemmas can lead to a psychological phenomenon called moral distress (Mazza et al., 2020; Morley et al., 2020).

Moral distress was first defined by Jameton in 1984 (Jameton, 1984), as a negative phenomenon experienced by nurses. The condition refers to the anguish or suffering in situations in which healthcare workers are unable to perform an action that they consider ethically correct, due to external or internal barriers. Moral distress causes the violation of the

professional's moral integrity, leading to emotional and behavioral problems, such as anxiety, depression, Post Traumatic Stress Disorder (PTSD), and intention to leave the job (Epstein et al., 2019; Mook & De Carvalho Mello, 2020).

Faced with an ethical dilemma, healthcare professionals either stagnate in uncertainty or proceed with moral deliberation, consisting of a systematic and contextualized methodical analysis of the ethical values and duties of those involved to find a reasonable course of action.

The experience of moral distress by healthcare workers can also reflect negatively on a patient's well-being, resulting in low-quality care and poor social relationships, especially interactions with patients (Epstein et al., 2019). Therefore, this study aims to analyze which circumstances during the COVID-19 pandemic cause moral distress in healthcare professionals, by conducting an integrative review.

2. Methodology

The approach to this integrative review consisted of the following steps: definition of the guiding question, inclusion and exclusion criteria; survey of articles; analysis and extraction of data; categorization of circumstances that cause moral distress; interpretation of results; and presentation of the review (Souza et al., 2010). PRISMA guidelines were used to evaluate references for inclusion in the review (Page et al., 2021).

The guiding question of this study was elaborated from the PVO strategy (an acronym for Patient, Variables, Outcome), considering: (P) health professionals; (V) situations of performance during the COVID-19 pandemic; (O) identifies the moral distress. Thus, the following guiding question was elaborated: "Which circumstances during the COVID-19 pandemic cause moral distress in health professionals?".

Search Methods:

A literature search was performed in the PubMed and Scielo online databases. The last search was carried out on August 19, 2021.

In the Scielo database, the following descriptors were used: "estresse psicológico" and "infecções por coronavírus". While in the PubMed database were used: ("morale"[MeSH Terms] OR "morale"[All Fields] OR "morales"[All Fields] OR "moralism"[All Fields] OR "moralities"[All Fields] OR "moralization"[All Fields] OR "moralize"[All Fields] OR "moralized"[All Fields] OR "moralizing"[All Fields] OR "morally"[All Fields] OR "morals"[MeSH Terms] OR "morals"[All Fields] OR "moral"[All Fields] OR "morality"[All Fields]) AND ("distress"[All Fields] OR "distressed"[All Fields] OR "distresses"[All Fields] OR "distressful"[All Fields] OR "distressing"[All Fields]) AND ("covid 19"[All Fields] OR "covid 19"[MeSH Terms] OR "covid 19 vaccines"[All Fields] OR "covid 19 vaccines"[MeSH Terms] OR "covid 19 serotherapy"[All Fields] OR "covid 19 serotherapy"[Supplementary Concept] OR "covid 19 nucleic acid testing"[All Fields] OR "covid 19 nucleic acid testing"[MeSH Terms] OR "covid 19 serological testing"[All Fields] OR "covid 19 serological testing"[MeSH Terms] OR "covid 19 testing"[All Fields] OR "covid 19 testing"[MeSH Terms] OR "sars cov 2"[All Fields] OR "sars cov 2"[MeSH Terms] OR "severe acute respiratory syndrome coronavirus 2"[All Fields] OR "ncov"[All Fields] OR "2019 ncov"[All Fields] OR ("coronavirus"[MeSH Terms] OR "coronavirus"[All Fields] OR "cov"[All Fields]).

Eligibility Criteria:

The search included articles published from November 2019 to December 2021, in English, Portuguese and Spanish, with the keywords in the title or abstract. Studies in editorial format, systematic reviews, and opinion articles were excluded, as well as, research that did not answer the guiding question did not indicate possible causes for moral distress, or did not

approach healthcare professionals. No limitations were applied as to the methodology of the studies – qualitative or quantitative.

Procedures:

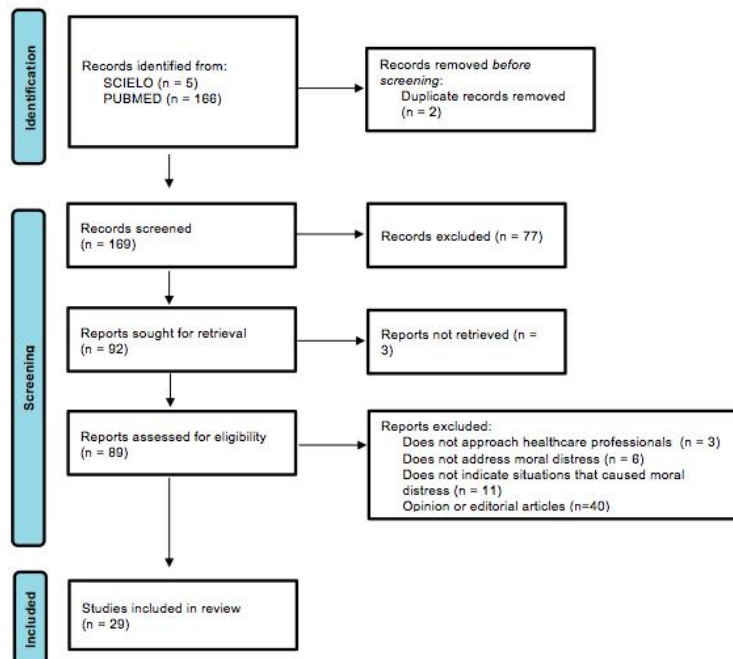
All researchers selected the articles jointly and any doubts were decided by consensus. After selecting the studies, an analysis table was prepared for collecting information from the articles. Then, the thematic content analysis proposed by Minayo (2014) was used, which has three stages: pre-analysis, material exploration, and interpretation of results. For the analysis of the evidence level of the articles, the proposal of Souza, Silva, and Carvalho (Souza et al., 2010) was used.

Situations related to moral distress were analyzed according to the division into categories already proposed in the literature (Corradi-Perini et al., 2020; Maffoni et al., 2018).

3. Results

From the initial search, 171 articles were found. In the end, 29 articles met all criteria and were included in this study. The process of analysis is shown in Figure 1.

Figure 1 - PRISMA flow diagram.



Source: Authors.

The characterization of the studies selected, including citation, purpose, method, sample, major themes that caused moral distress, and level of evidence is shown in Table 1. Studies were classified with the level of evidence 4, as they are descriptive studies (non-experimental) or with a qualitative approach or level 5 for evidence from case reports or experience.

Table 1 - Characterization of the studies included in the integrative review.

Citation	Purpose	Method	Area	Sample	Themes	Level of Evidence
(Hines, Chin, Levine, & Wickwire, 2020)	To report initial measurements of self-reported distress and moral injury among HCWs at the onset of the COVID-19 and evaluate their relationships with demographic, occupational and resilience-related risk factors.	Quantitative	Medicine	219	Excessive inpatient care duties	4
(Mazza et al., 2020)	To evaluate moral decision-making, level of perceived stress, ability of mentalizing and empathy in university students and Italian workers, AND between the health workers categories.	Quantitative	Multidisciplinary	1300	Risk of infection; Shortages of protective equipment; Dealing with patient's negative emotions and separation from families	4
(Miljeteig et al., 2021)	Describe priority-setting dilemmas, moral distress and support experienced by nurses and physicians across medical specialties in the early phase of the COVID-19 pandemic in Western Norway.	Quantitative	Multidisciplinary	1606	Relocation of sectors; Interruption of care; Resource limitation	4
(Butler, Wong, Wightman, & O'Hare, 2020)	To describe the perspectives and experiences of clinicians involved in institutional planning for resource limitation and/or patient care during the pandemic.	Qualitative	Multidisciplinary	61	Resource limitation; Interruption of care; Absence of explicit guidelines; Uncertainty treatments	4
(Evans, Jonas, & Lantos, 2020)	-	Case Study	Multidisciplinary	2	Access to care due to restrictions on the hospital; Resource limitation	5
(Maaskant et al., 2020)	To investigate how family involvement had taken place, and to explore the experiences of nurses with family involvement during the COVID-19 outbreak. In addition, we aimed to formulate recommendations for the involvement of family.	Qualitative	Nursing	9	Restriction of visitors; Rapid protocol changes; Strict rules	4
(Nathiya, Suman, Singh, Raj, & Tomar, 2021)	To investigate the psychological impact of COVID-19 among frontline workers battling against COVID-19 and to explore the association of quality of life, resilience and mental health outcomes.	Quantitative	Multidisciplinary	418	Fear of contracting the virus; Absence of explicit guidelines	4
(Rose et al., 2021)	To understand how communication between families, patients and the ICU team was enabled during the pandemic. Secondary objectives were to understand strategies used to facilitate virtual visiting and associated benefits and barriers.	Quantitative + Qualitative	Multidisciplinary	117	Restriction of visitors	4
(Sulkowski, 2020)	-	Case Study	Multidisciplinary	1	Postponing procedures	5
(Kok et al., 2021)	To assess the prevalence and incidence of burnout symptoms and moral distress in ICU professionals before and during the coronavirus disease 2019 crisis.	Quantitative	Multidisciplinary	332	Limited resources, staff and time; Working with colleagues who are not sufficiently qualified; Working with colleagues who don't use security equipment properly	4
(Estes, Varghese, Jacques, & Naidu, 2021)	To conduct a national evaluation of nurse and technologist perspectives, measuring the direct and indirect impact of the pandemic on their work and personal environment and experience.	Quantitative	Nursing	450	Inadequate support from leadership and administration; Fear of contracting the virus; Limited resources; Absence of guidelines	4

(Doherty, Colleran, Durcan, Irvine, & Barrett, 2021)	To assess the effect of the ongoing Covid-19 pandemic on Irish doctors by investigating the incidence of burnout and long COVID among senior medical staff in Ireland.	Quantitative + Qualitative	Medicine	114	Delay to usual care; Inadequate resources and infrastructure; Relocation sectors	4
(Guan et al., 2021)	To examine the prevalence of moral distress and its domains of influence, and to identify demographic and work-related characteristics associated with moral distress among OSWs.	Quantitative	Social Worker	745	Family's insistence to continue aggressive treatment; Witness health care providers giving "false hope" to patients or family	4
(Meese, Colón-López, Singh, Burkholder, & Rogers, 2021)	To address a current gap in the literature by identifying unique stressors and correlates of distress, including resilience, for various team members within a health system during the COVID-19 pandemic using the same validated instruments.	Quantitative	Multidisciplinary	1130	Increased job demands and responsibilities; Fear of contracting the virus	4
Tong; et al. (2021)	To understand the experiences of remote volunteer palliative care consultants during the initial COVID-19 surge.	Qualitative	Medicine	15	Resource limitation; Uncertainty treatments	4
(Sukhera, Kulkarni, & Taylor, 2021)	To explore how residents perceive moral distress as it relates to the care of structurally stigmatized patients during the COVID-19 pandemic.	Quantitative + Qualitative	Medicine	23	Restriction of visitors; Limited access to culturally and linguistically appropriate services	4
(Hesselink et al., 2021)	To assess changes in well-being and perceived stress symptoms of ED staff in the course of the first COVID-19 wave in the Netherlands; and, to assess and explore the stressors experienced by ED staff since the COVID-19 outbreak.	Quantitative	Multidisciplinary	191	Fear of contracting the virus; Need to use self-evident safety precautions	4
(Rao et al., 2021)	To describe the drivers of distress and motivations faced by interdisciplinary clinicians who were on the frontline caring for patients with COVID-19.	Qualitative	Multidisciplinary	50	Resource limitation; Fear of contracting the virus; Restriction of visitors	4
(Gray, Dorney, Hoffman, & Crawford, 2021)	To document nurses' immediate reactions, major stressors, effective measures to reduce stress, coping strategies, and motivators as they provided care during COVID-19.	Quantitative + Qualitative	Nursing	110	Uncertainty about when the pandemic will be under control; Fear of contracting the virus; Limited resources, staff and time; Conflict between duty and safety; Worry about families emotional reactions	4
(Petrella et al., 2021)	To assess HCW psychological welfare at one of London's biggest university hospitals during the acute phase of the COVID-19 pandemic, as well as their use of available supportive services.	Quantitative	Multidisciplinary	1127	Poor team communication; Working with colleagues who are not sufficiently qualified; Lack of administrative support; Unclear goals of care; Resource limitation; Fear of contracting the virus; Concerns about personal qualification and abilities	4
(O'Neal, Heisler, Mishori, & Haar, 2021)	Investigates clinical health workers' risk perceptions and concerns about the ethics of their clinical decision-making, the actions of their institutions to address resource scarcity concerns during the COVID-19 pandemic, and their ability to voice safety concerns, as well as their own views on how scarce resources should be allocated.	Quantitative	Multidisciplinary	839	Resource limitation	4

(Kreh et al., 2021)	To investigate the nature of resilience and stress experience of health care workers during the COVID-19 pandemic.	Quantitative + Qualitative	Multidisciplinary	13	Increased job demands and responsibilities; Need to use self-evident safety precautions	4
(Ducharlet et al., 2021)	To explore potential sources of moral distress for clinicians providing nephrology care in the context of the COVID-19 pandemic and consider potential responses for individuals and services seeking to reduce such distress.	Case Study	Medicine	4	Resource limitation; Fear of contracting the virus; Rapid protocol changes	5
(Lake et al., 2021)	To explore factors associated with nurses' moral distress during the first COVID-19 surge and their longer-term mental health.	Quantitative	Nursing	200	Shortages of protective equipment; Fear of contracting the virus; Restriction of visitors	4
(Donkers et al., 2021)	To assess levels of moral distress and quality of ethical climate experienced by intensive care professionals in the Netherlands during the COVID-19 pandemic and to determine factors that cause moral distress in these health care professionals.	Quantitative + Qualitative	Multidisciplinary	504	Dealing with patient's or family members negative emotions; Working with colleagues who are not sufficiently qualified; Unable to allow patients to have a dignified farewell	4
(Ness, Saylor, DiFusco, & Evans, 2021)	To understand the impact of professional stressors on nurses' and other health care providers' professional quality of life and moral distress as they cared for patients during the COVID-19 pandemic.	Quantitative + Qualitative	Multidisciplinary	171	Shortages of protective equipment; Rapid protocol changes; Inadequate support from leadership and administration	4
(Norman et al., 2021)	To characterize the prevalence of moral distress among FHCWs; identify common dimensions of COVID-19 moral distress; and examine the relationship between moral distress, and severity and positive screen for COVID- 19-related PTSD, burnout, and work and interpersonal difficulties.	Quantitative	Multidisciplinary	2579	Fear of contracting the virus; Restriction of visitors; Not being able to do enough for COVID-19 patients	4
(Silverman, Kheirbek, Moscou-Jackson, & Day, 2021)	To explore causes of moral distress in nurses caring for Covid-19 patients and identify strategies to enhance their moral resiliency.	Qualitative	Nursing	31	Uncertainty treatments; Fear of contracting the virus; Miscommunications; Resource limitation; Restriction of visitors; Need to use self-evident safety precautions	4
(Ditwiler, Swisher, & Hardwick, 2021)	To explore the experiences of physical therapists regarding the professional and ethical issues they encountered during the COVID-19 pandemic.	Qualitative	Physical Therapists	10	Loss of patient autonomy in discharge decisions; Need to use self-evident safety precautions	4

Source: Authors.

From the data, it can be seen that the studies investigating multidisciplinary health workers represented the majority of the sample (n=18), followed by studies analyzing only physicians (n=5), only nurses (n=5), and physical therapists (n=1).

The analysis of the methodology used by the articles revealed that the quantitative approach (n=13) was used in the majority of articles, representing 44,8% of them, followed by a quantitative-qualitative approach (n=8; 27,6%), qualitative approach (n=5; 17,3%) and case studies (n=3; 10,3%).

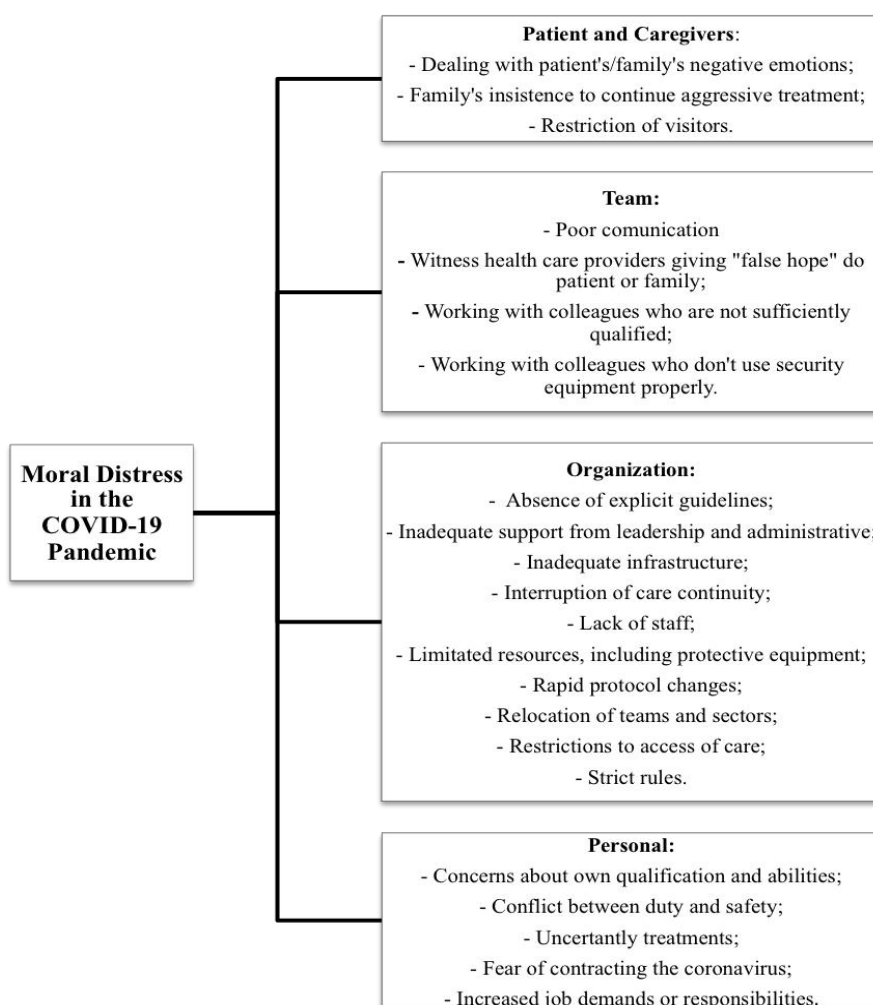
Regarding the geographical area of analyzed articles, the distribution was: 51,7% from United States of America (n=15), 14,0% from Netherlands (n=4), 10,3% international (n=3), 7,0% from United Kingdom (n=2), 3,4% from India (n=1), 3,4% from Ireland (n=1), 3,4% from Italy, (n=1), 3,4% from Norway (n=1) and 3,4% from Canada (n=1).

The analyses revealed that the totality of the articles (n=29) was written in English. The temporal distribution of the studies resulted in 6 articles published in 2020, representing 20,7% of the selected studies, and the other 23 articles published in 2021, representing 79,3%.

Moral Distress in the COVID-19 Pandemic

Figure 2 shows the situations that cause moral distress related to the coronavirus pandemic, as indicated in the articles included in this review. Situations were distributed according to the division into categories already proposed in the literature.

Figure 2 - Moral distress in the COVID-19 pandemic.



Source: Authors.

It is possible to note that more factors were identified in the organization category, followed by personal aspects. Also, safety, in terms of contamination with the COVID-19 virus, was an aspect mentioned in more than one category.

4. Discussion

The outcomes of the pandemic on mental health are not limited to the grief for the lives that were lost. Besides the constant fear of contracting the disease, the COVID-19 situation also affected human interactions, causing insecurity across

personal and social aspects. In this scenario, healthcare professionals are facing ethical dilemmas in their practice, which can make the occurrence of moral distress even more common (Faro et al., 2020).

One of the situations related to moral distress mentioned in the articles of this review is hospital visits, a known way to provide patients access to their familiar support system, as it can optimize the patient's well-being. However, due to COVID-19 disease, and its elevated level of transmission, hospital visits have been limited, therefore infected patients are going through a rough treatment alone, isolated from their support system (Maaskant et al., 2020; Rose et al., 2021).

Some healthcare workers try to minimize these losses of emotional support by being the link between the infected person and the outside world. They use technology to contact their families, but still, the restriction of presence and physical touch is remarkable (Morley et al., 2020; Silverman et al., 2021).

Additionally to the patients and their families emotional stress, caused by isolation during treatment, when patients die, healthcare professionals are unable to provide a dignified farewell, which can be a morale distressing factor to the worker. Families don't get the chance to say goodbye, due to the possibility of contamination with the virus (Gopichandran, 2020). The impossibility of participating in the farewell ritual is also a risk factor for the development of complicated mourning (Dantas et al., 2020).

Another relevant aspect that has been contributing to the development of moral distress in healthcare workers is the limitation of resources. The scarcity of basic items, such as hospital beds, ventilation, and medication, requires healthcare workers to make clinical decisions on their distribution. This decision selects some patients over others, and the necessity to choose between two undesirable options can cause moral distress since the professionals feel that they are unable to do enough for their COVID-19 patients (Gopichandran, 2020).

The front-line workers are highly exposed to the virus and, nevertheless, have been receiving minimal personal protective equipment (PPE), due to their unavailability. Therefore, they are left with the duty of protecting others, while not being safe, which includes the risk of infecting their loved ones when returning home after a day of work (Gray et al., 2021; Hesselink et al., 2021; Kreh et al., 2021; Lake et al., 2021; Mazza et al., 2020). The hospital organization has the responsibility to ensure the safety and health of the providers, by providing adequate PPE, time for rest and recuperation, and comfortable spaces. Nonetheless, the professionals are being let down in this matter, causing substantial moral distress (Berg, 2020; Gopichandran, 2020).

Due to the high volume of COVID-19 patients in hospitals, caregivers experienced reallocation to different areas of the hospital. Some healthcare workers were transferred to COVID-19 care and had to work outside their usual scope of practice without being adequately trained for the job. This situation is linked to an increase in fear of unemployment and the risk of burnout, moral distress, and moral injury (Ducharlet et al., 2021; Estes et al., 2021).

The high influx of COVID-19 patients has a logistical and financial impact on the organization. The hospital's administrative staff is equally affected by the situation, which may cause inadequate support to healthcare professionals (Estes et al., 2021). During this pandemic, supportive leadership is essential for the development of staff's resilience and well-structured support mechanisms can protect against moral distress (Miljeteig et al., 2021).

Moreover, healthcare services considered "non-essential" were left aside during this pandemic. Many non-emergency cases were denied treatment due to isolation restrictions and efforts to contain the dissemination of the virus. With this measure, childcare services, mental health clinics, and chronic diseases care were suspended, leaving these patients with minimal care and attention. The delimitation of what is considered an essential service and the limits between providing excellent treatment and respecting social distancing protocols triggers moral distress in professionals (Gopichandran, 2020).

The great demand for patients and care forced some hospitals to call in professionals from other areas to help, creating

problems within complex intra- and inter-professional relationships. The constant work with new teams results in challenges that could compromise patient care. For example, a conflict could happen when there are different perspectives on care plans and appropriate end-of-life treatments (Miljeteig et al., 2021; Silverman et al., 2021).

Another complication is inadequate communication between staff. Miscommunication problems can happen when a professional feels intimidated by the chain of hierarchy and does not feel comfortable discussing treatment plans with another colleague. This problem not only affects internally the relationship of the team, but also the safety and best interest of the patient (Silverman et al., 2021).

Studies (Donkers et al., 2021; Kok et al., 2021; Petrella et al., 2021) have shown that having to work with colleagues who are believed to act unsafely or who are not primarily qualified to deliver ICU care is morally distressing and increases symptoms of burnout in the team. Since the new personnel has not been properly trained for the pandemic circumstance, some professionals may end up overwhelmed with work. Also, qualified healthcare professionals could be responsible for several sick patients at a time, creating a situation of moral distress once the workers need to choose which ill person they should help first (Silverman et al., 2021).

Regarding the personal category, moral distress seems to be related to the management of emotions (Maffoni et al., 2018). The analyzed articles (Ducharlet et al., 2021; Estes et al., 2021; Lake et al., 2021; Mazza et al., 2020; Nathiya et al., 2021; Norman et al., 2021; Silverman et al., 2021) demonstrated, in particular, the professional's fear of contracting the new coronavirus. In addition to insecurities with their health, healthcare professionals are concerned with the risk of being asymptomatic carriers of the virus and causing harm to their families, to the point of feeling like "plague spreaders", a term associated with both fear and shame (Kreh et al., 2021).

Professionals are having to care for patients during the pandemic, while the scientific community still learns more about the virus. Due to many uncertainties, caregivers are required to weigh personal risks while dealing with their job responsibilities. Therefore, moral distress is caused by the conflict between personal obligations and fears (Morley et al., 2020).

The emotional tension also becomes greater when healthcare workers are required to conserve their PPE. In this situation, moral distress is related to the belief that maintaining their safety may have an impact on the care provided to patients, even though they are not obligated to act in circumstances where their safety is not guaranteed. An example is taking some extra seconds to put on personal safety items while a patient is in cardiac arrest (Morley et al., 2020).

Another cause of moral distress is the feeling of not being able to provide the level of care used to and the sense of responsibility for poor outcomes, regardless of whether they were adhering to institutional recommendations or requirements (Butler et al., 2020; Silverman et al., 2021).

The overwhelming number of patients in need of immediate and critical care in a short period, combined with uncertainties and the lack of appropriate treatments for patients with COVID-19 leads to concerns among the professionals regarding their ability and qualifications. Also, in this sense, the limits between accurate care and treatments considered futile - little chance of success and great possibility of being harmful to the patient - are blurred and elusive (Neville et al., 2015; Petrella et al., 2021; Silverman et al., 2021).

Considering that moral distress affects not just the mind, but also the body and the relationships, studies reveal that it has the potential to impact professional and personal domains. Therefore, consequences were found in different areas, such as errors in patient care, distancing from patients and their families, depression, and changing careers, among others (Mccarthy & Dedy, 2008).

Recommendations

Knowledge of moral distress can strengthen moral courage and the capacity to cope and seek support when needed. Furthermore, being able to recognize it can help to prevent potential moral conflicts, especially during crises. This is particularly important in health workers at the beginning of their careers, such as trainees and fellows (Ducharlet et al., 2021).

Although situations that create moral distress and moral injury cannot be entirely avoided, some measures can help reduce its impacts. Some of them aim to empower professionals to deal with the moral dilemmas that may occur during their activities such as ethical education, debriefs, and reflective practice with peers and family and conversation circles (Altaker, Howie-Esquivel, & Cataldo, 2018; Browning & Cruz, 2018; de Boer, van Rosmalen, Bakker, & van Dijk, 2015).

Other measures that can help mitigate moral distress are aimed at the organizational sphere of work and include priority-setting guidelines and the designation of a clinical team to support clinicians in the making of decisions on withdrawing life-sustaining treatments. As important as adequate training skills for the workers who are assigned new responsibilities, to reduce experiences of a perceived failure to fulfill moral duties (Ducharlet et al., 2021).

Further environmental factors that can help during the present and future pandemic crises are creative approaches to technology to enhance communication during social isolation, to ease emotional burden not only for patients but also for health professionals, providing a better work environment (Ducharlet et al., 2021).

Limitations

This study has several limitations. Initially, the search criteria may not have been adequate to find all articles on the topic, since “moral distress” is not yet considered an official health descriptor/keyword. In addition, the heterogeneity of the studies, regarding the methodology and investigated sample, may have reduced the possibility of generalizing the results found in this review. Some of the articles reviewed included subjective perceptions and emotions, both of which can make generalizing even more difficult.

5. Final Considerations

The circumstances that may cause moral distress are multiple and involve different barriers related to the professional, the team, the patient, the caregivers, and the institution. This study showed that, especially during the COVID-19 pandemic, situations related to lack of resources, discontinuation of treatments, and visitor restrictions cause ethical dilemmas for professionals.

Even though the world has already gone through several health crises, healthcare systems are still learning how to manage these emergencies. The lack of preparation for such a catastrophic event contributed to the occurrence of morally distressing situations.

Considering that moral distress can cause serious health conditions and impact the quality of care provided, further studies on the phenomenon are necessary to prepare for the next phases of the pandemic and future emergencies. Support and educational programs should be investigated as effective proposals for preventing and reducing this phenomenon.

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