ORIGINAL ARTICLE

MORAL DISTRESS AMONG NURSES IN A HOSPITAL SETTING DURING THE COVID-19 PANDEMIC

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Highlights: (1) Identifies factors that cause moral distress among nurses during the COVID-19 pandemic. (2) Contributes to strategies aimed at reducing the impacts on the professionals' health. (3) Highlights the need for improved working conditions and emotional support.

PRE-PROOF

(as accepted)

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ABSTRACT

Objective: To analyze moral distress among nurses working during the COVID-19 pandemic in a hospital setting. **Methods:** This qualitative, exploratory-descriptive study was conducted with 18 nursing professionals from a hospital located in the extreme south of Brazil. Data were collected between December 2020 and March 2021 through individual semi-structured interviews conducted via videoconference on Google Meet. All participants signed an informed consent form. Data were analyzed using discursive textual analysis. **Results:** Participants reported experiencing moral distress related to fear of exposure to and contamination by the virus, illness, terminal conditions, deaths due to COVID-19, the population's disregard for protective measures, work overload, shortage or inadequacy of materials, and insufficient bed availability, among other factors. **Conclusion:** The findings contribute to a deeper understanding of the factors that cause moral distress among nurses working in hospital settings during the COVID-19 pandemic and may support the development of strategies to minimize its adverse effects on workers' health.

Keywords: Nursing Practitioners; COVID-19; Coronavirus Infections; Mental Health; Pandemics.

INTRODUCTION

Moral distress (MD) has been investigated since the early 1980s and refers to the suffering experienced when individuals face a contradiction between their ethical beliefs and actions. Although they recognize the right course of action, they feel powerless due to personal limitations, flawed judgment, or external barriers such as institutional policies[1].

Some studies describe moral distress as a form of discomfort that affects the mind, body, and interpersonal relationships within the workplace. It is often associated with challenges in the daily routine of professional practice, such as disorganization, power

dynamics, low professional self-esteem, work-related pressure, or the need to make decisions involving different phases of life[2-3].

Nursing professionals often face moral dilemmas and conflicts in their daily practice, which can lead to moral distress. Nursing practice is grounded in ethical and moral values that guide decision-making and influence team dynamics and individual professional conduct. As a result, nurses may feel unmotivated and frustrated when they cannot act according to ethical principles or advocate for patients' rights[4].

The COVID-19 pandemic, declared a Public Health Emergency of International Concern by the World Health Organization, exposed the global population to widespread uncertainty, placing significant strain on economic, social, and healthcare systems[5]. This scenario imposed complex ethical challenges on frontline professionals caring for patients with COVID-19. Although ethical dilemmas are inherent to the profession, the emergence of this new pathological agent intensified these issues, leading many professionals to experience moral distress[6].

Factors contributing to moral distress may stem from personal characteristics, such as fear, lack of knowledge, personality traits, and life circumstances, or from external conditions, including inadequate working environments, interpersonal tensions, communication failures among healthcare team members, arbitrary management practices, or an unbalanced organizational climate[7]. Among the strategies identified in the literature to strengthen nurses' moral resilience is creating interdisciplinary institutional spaces where healthcare professionals can reflect on their experiences. These spaces should be grounded in an ethical climate and supported by existing management structures[6-8].

Understanding the moral distress experienced by nursing professionals during the COVID-19 pandemic enables the development of intervention strategies to minimize its impact on their health and daily work. These strategies may also help mitigate the harmful effects on mental health and better prepare professionals for future crises. Based on this context, the following research question was proposed: How does moral distress manifest among nurses during the COVID-19 pandemic in hospital settings? Accordingly, the objective was to analyze moral distress among hospital nurses during the COVID-19 pandemic.

METHOD

This qualitative, exploratory-descriptive study aimed to deepen the understanding of the phenomenon of interest[9] and followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines.

Eighteen nurses working in the COVID-19 Emergency Room, COVID-19 impatient unit, or COVID-19 Intensive Care Unit (ICU) at a hospital in the extreme south of Brazil participated in the study.

The inclusion criteria were being a nurse and working in the COVID-19 Emergency Room, COVID-19 impatient unit, or COVID-19 ICU of the hospital selected as the study setting. Exclusion criteria included being on sick leave, maternity leave, or any other type of leave and not having Internet access to participate in the study. Nurses were selected because they play a crucial role in direct patient care and are often the primary professionals responsible for daily care and implementing therapeutic interventions. Focusing on this group offers a deeper understanding of the moral distress experienced by these professionals during the COVID-19 pandemic.

Participants were selected through non-probabilistic convenience sampling[10], which was concluded upon reaching data saturation.

Collection and analysis of data

The nurses were invited to participate in the study and recruited via email. Data were collected from December 2020 to March 2021 through individual semi-structured interviews conducted via videoconference on Google Meet, each lasting approximately 40 minutes. Participants who agreed to take part signed an informed consent form electronically.

The authors of this study developed the interview script based on the literature to align with the study's objective. Due to pandemic-related constraints, no pilot test was conducted. All those invited agreed to participate in the study; there were no refusals or withdrawals.

One of the female authors, a subject matter expert with a Master's degree, conducted the interviews. She introduced herself and explained the study's objectives, followed by questions to gather participant characteristics, including age, gender, time since graduation, work unit, and educational background.

Guiding questions were also used: How do you describe your work as a nursing

professional caring for suspected and/or confirmed COVID-19 patients? How do you perceive the ethical problems of prioritizing access to intensive care beds? How do you perceive the ethical conflicts resulting from limited resources or restricted personal protective equipment when aiming to provide safe patient care? Do you believe other healthcare team members recognize these problems as ethical issues? How do you describe the conflicts arising from health policies and institutional issues? Do you believe these conflicts can affect patient care? And how do you perceive the consequences of the ethical problems that emerged during the COVID-19 pandemic on your mental health? No follow-up interviews were conducted, and participants did not review their responses for potential corrections.

Discursive textual analysis was used to analyze the qualitative data and generate new understandings about discourses and phenomena. This analytical process unfolds in three key stages: unitarization of the texts, establishment of relationships, and the emergence of new understandings, with a focus on constructing a self-organized process[11].

In the first stage, unitarization, the researcher immersed herself in the theme to deconstruct her preconceptions. The text was initially fragmented, with each unit coded and rewritten to reflect a new, deeper, and more comprehensive meaning. A title was then assigned to each newly established unit. The second stage involved grouping similar meanings, which formed the basis for categorizing the previously identified units. In the third and final stage, new emerging information was captured, resulting in the metatext[11]. The interviews were recorded and transcribed verbatim using a smartphone.

Ethical aspects

This study complied with the ethical guidelines for research in the Human and Social Sciences established in Resolution No. 510, dated April 7, 2016, by the Brazilian National Health Council. The Institutional Review Board at the Federal University of Rio Grande approved the study under opinion No. 4,442,367, issued on December 7, 2020. Authorization was also obtained from the institution where the participants worked. All participants signed a free and informed consent form.

An alphanumeric code, consisting of the letter “N” for Nurse followed by the number corresponding to the order in which the interview was conducted, was used to ensure the confidentiality of participants' identities.

RESULTS

Eighteen nurses participated in the study, including 17 women and one man, aged between 23 and 47 years. Their professional experience ranged from six months to ten years. In terms of the settings where they provided care to patients with COVID-19, seven nurses worked in the emergency room, five in the clinical inpatient and nursing supervision unit, and six in the intensive care unit.

Two categories emerged from the discursive textual analysis: moral distress stemming from personal and social factors and moral distress stemming from organizational problems (Table 1).

Table 1 – Categories and units of meaning, 2021.

Category	Units of Meaning
Moral distress stemming from personal and social factors	Fear of exposure to and contamination by the virus Illness Terminal illness Deaths due to Covid-19 Public neglect Lack of professional competence
Moral distress stemming from organizational problems	Work overload Shortage of materials or inadequate materials Lack of beds

Source: Study data.

Moral distress stemming from personal and social factors

This category refers to nurses' personal aspects and beliefs that may contribute to moral distress when providing care to patients with COVID-19. Key factors include fear of exposure to and contamination by the virus, illness, terminal conditions, deaths due to COVID-19, public disregard for protective measures, and perceived lack of professional competence.

Given the high transmissibility of the disease, nurses expressed feelings of fear when caring for patients suspected of or infected with COVID-19 due to the risk posed to

themselves and their families. This situation generated a moral conflict between their professional duty and personal safety when choosing to care for patients with COVID-19.

> I remember treating the first COVID-19 patient in the city. I was at home, lying down, trying to rest, and my son was in his bedroom. My partner called and told me the news about the first patient with community transmission. He hadn't been brought in from elsewhere, he hadn't come from outside. They mentioned the patient's name, and of course, I recognized it immediately. So, I sent my son to his father's. At that moment, I wasn't afraid for myself; I was afraid for the people around me—my family. It shook me emotionally in so many ways, triggering panic attacks about getting the disease, anxiety, and I can't sleep at night. (N13)

> The fear of contamination during care delivery is a challenge. I try to avoid physical contact, but sometimes, the patient needs to feel that someone is by their side and their condition is already progressing rapidly. Fear and apprehension will always exist, and we learn to deal with them nonetheless. (N12)

> We are learning day by day; we had to change our routine completely. There's the fear of contracting the virus, being exposed, and transmitting it to our families, so the emotional aspect becomes more intense. We get used to certain situations and sometimes become more emotionally detached. (N1)

Feelings of fear were heightened when the nurses in the study became ill with COVID-19, as assuming the role of a patient confronted them with the possibility of severe illness and death. Another source of distress reported by the nurses was witnessing the illness and death of their colleagues on the healthcare team. However, they also noted that these experiences fostered greater empathy toward their patients.

> It was very complicated when I got infected. I was really scared, but I completed my quarantine, and everything went smoothly. Still, when you become the patient, you realize that you might feel fine one day, and then suddenly you don't. It made me feel more tense, and it also made me take better care of my patients […] like talking to

> them more, trying to calm them down, to reassure them—because we're going through the same thing. (N18)

> The professionals in the ICU are still very afraid of getting infected. We had colleagues—a doctor who was very good—who ended up dying from COVID-19, and that made us even more apprehensive. (N14)

The nurses also reported that witnessing patients with a terminal condition and deaths due to COVID-19 was a source of suffering, triggering feelings of physical and emotional exhaustion and a desire to leave the workplace. They also found it challenging to comprehend how quickly a previously stable clinical condition could deteriorate into severe illness or death, particularly among young and otherwise healthy patients. The uncertainty surrounding the prognosis further intensified the distress they experienced.

> There were times when I didn't want to get out of bed because I thought, "I'm going back there to see all that, to see another person die and not being able to do anything for that person [...] and physically, I was exhausted, I even thought about giving up, not my profession, but giving up working at that moment, because I was already exhausted, exhausted, completely exhausted. (N8)

> I take care of people, so it's really hard to spend 30, 40, 50 days caring for a patient and in the end, they don't survive COVID-19. It's exhausting to think that all the work was in vain—it's not rewarding, and it's incredibly tiring. We're at our limit, but we keep going. (N14)

Furthermore, nurses expressed sadness and frustration when witnessing the population's disregard for protective measures against the disease, making them feel their efforts were not valued. Although they continued to fulfill their roles and care for patients, they experienced moral distress upon realizing that they could not prevent the rise in cases and deaths.

> It's hard. We go out on the streets and see that the population is not taking it seriously. Cases are increasing, deaths are rising again, and they don't take what we're going through seriously. It makes me very sad. Sometimes, I feel like filming a severe COVID-19 patient's intubation process and how they're being managed and posting it on social media. Of course, that won't happen, but it's frustrating to see that the population doesn't take what's happening seriously. (N2)

Regarding the lack of competence in caring for patients with a new disease, nurses reported that the unpredictability and instability of the clinical conditions generated feelings of helplessness. As a result, they experienced moral distress when they realized that their knowledge was insufficient to anticipate and manage the clinical complications caused by the illness.

> I feel quite incapable. I assess the condition, do the clinical evaluation, and analyze the lab tests and changes. We're with the patient daily, but we still don't know what to expect. Sometimes a patient is admitted, and we think the most they'll need is a Hudson mask delivering 15 liters of oxygen—but then we can't improve it; we try non-invasive ventilation, we intubate, and even then, there's no way of knowing. (N15)

Moral distress stemming form organizational problems

This category addresses the moral distress experienced by nurses due to organizational issues that interfered with patient care in the hospital setting during the COVID-19 pandemic. The primary problems highlighted by the nurses included work overload, shortage or inadequacy of materials, insufficient bed availability, and rigid institutional rules aimed at reducing virus transmission.

Nurses reported that caring for patients with COVID-19 occurs in a highly stressful environment, marked by heavy workloads due to high patient demand—most requiring complex care—and the absence of healthcare professionals from risk groups or those suspected or confirmed to have COVID-19. In this context, nurses experience moral distress when they cannot deliver quality care, which leads to physical and mental exhaustion.

> […] It is impossible—it's humanly impossible—for two professionals to do the work of four and still maintain quality. I worry about the limitation of care because COVID-19 progresses so quickly. Sometimes, a patient isn't in an emergency at that moment, but a few hours later, they can get much worse, and then there's nothing more we can do. This lack of staff is very complicated, and the institution should anticipate it. It's obvious that professionals will get infected and fall ill—the work overload, the stress—it all leads to more absences than usual, and the institution should foresee that. (N1)

> I believe many emotional issues have come up in our lives because of the work overload, the insults from family members, and the constant demands. Sometimes, it wasn't possible to do our best—the physical and mental overload greatly affects our health. The exhaustion, fear, and lack of empathy—whether from other professionals or family members who often don't understand what we are going through—really take a toll. (N4)

These feelings were intensified when nurses faced a shortage of materials or had to work with inadequate supplies, compromising their ability to provide quality care and leading to a sense of helplessness. Similarly, the inadequate allocation of beds for highly complex care caused frustration, as priority was not always given to patients in the most severe clinical conditions.

> No matter how professional we are or how routinely we deal with death, we're never truly prepared for certain situations. The high demand—caring for 19, 20, or even 30 patients—without enough space or staff makes everything extremely difficult. Many times, patients would arrive at the emergency room, and there would be only one ventilator. Sometimes, someone was simply lucky to arrive first and get the bed. The overload comes exactly from having to assist everyone and provide care even without the minimum necessary conditions. (N4)

Rigid institutional rules to reduce virus transmission also became a source of moral distress for nurses. Although they understood the need to comply with restrictive measures,

they expressed feelings of anguish when witnessing patients suffer without the presence of family members. Continuously facing a high number of COVID-19-related deaths—and, in most cases, being the only person present during a patient's final moments—intensified the emotional burden experienced by these professionals.

> I believe the most difficult situations are with terminally ill patients admitted as suspected COVID cases when we can't allow their families to be with them. For me, that's the hardest part. We know the patient could die at any moment, and their family won't be there. I don't think anyone wants to die alone—we want someone by our side. And even though we're there, holding the patient's hand at the end, their family isn't, and that's hard to deal with. These are the situations that affect us emotionally. (N2)

> Some terminally ill patients are admitted as suspected or confirmed cases. They pass away, dying far from their families. It's not easy—the family is deeply shaken, and there's no chance to say goodbye. The suffering is great, and that affects me emotionally. (N6)

DISCUSSION

This study revealed that moral distress among nurses working during the COVID-19 pandemic was associated with personal and social factors such as fear of contamination, illness, patient deaths, and terminal conditions, besides public disregard for protective measures and a perceived lack of professional competence. Organizational factors, including work overload, shortage or inadequacy of materials, and insufficient bed availability, also contributed to their distress. The combination of these elements led to physical and emotional exhaustion, as well as feelings of frustration and helplessness, intensifying the nurses' moral distress and directly impacting their mental health and well-being.

An analysis of the literature on moral distress among nurses in a hospital setting reveals findings similar to those in this study concerning health professionals working during the COVID-19 pandemic. The pandemic introduced new challenges and restrictions to healthcare services, leading to heightened concerns and negative emotions among professionals in these environments[12].

The fear of exposure to and contamination by the virus has had a psychological impact

on professionals, both due to the responsibility of contributing to the fight against the most significant public health challenge in decades and the anxiety and distress caused by putting their own lives and those of their families at risk[13]. In addition, the high risk of infection and inadequate protection against the disease were also reported in another study as factors associated with the potential for mental illness among healthcare professionals[14].

A study seeking to analyze how 231 Israeli nurses responded to ethical dilemmas and tensions during the COVID-19 pandemic identified that despite the high emotional burden and significant personal risk faced in the work environment, nurses demonstrated dedication in caring for patients but needed to seek a supportive environment to face their concerns[15].

In this study, participants reported using coping mechanisms to manage the fear of contamination, recognizing the situation as stressful, and adopting strategies such as self-control and social support to adapt and cope. Despite fear and apprehension, healthcare workers continued to provide patient care, responding rationally to the circumstances. However, these emotions had consequences, leading professionals to become more restrained in the care they provided[16].

In the meantime, healthcare service leaders should develop intervention strategies to support professionals, such as implementing interdisciplinary institutional spaces where health workers can share their experiences, promote mental health, and foster a more supportive work environment[6]. Employee assistance programs and mental health hotlines have also been identified as valuable resources to help professionals address psychological challenges or other concerns that may arise during the COVID-19 pandemic[17].

Healthcare professionals working to fight the pandemic are daily exposed to the risk of contracting the coronavirus. Psychological stress, insufficient protective measures, disregard for them, and the nature of the care are among the main work-related risk factors for contamination[14]. The scarcity and rationing of material resources—particularly personal protective equipment (PPE)—combined with the pressure professionals face contribute to fear and despair, leading to a significant increase in absences due to emotional stress[18], ultimately resulting in moral distress.

It is important to emphasize that protecting the health of professionals is essential to preventing the transmission of the virus. This requires adopting infection control protocols and the proper provision and correct use of PPE[14]. Given the virus's high virulence, the use of PPE by professionals providing direct care to patients with COVID-19 is crucial.

Another situation that caused moral distress among the study participants was the experience of terminal conditions and deaths due to COVID-19, which led to feelings of helplessness and unpreparedness. These emotions can be intensified, particularly when colleagues become ill or die as a result of the infection[19]. Nurses may feel guilt in the face of patient deaths, along with the pain and suffering associated with loss. Death is often perceived as a failure of the healthcare team, which can trigger negative consequences for professionals' health, including stress, anxiety, burnout syndrome, and moral distress.

Regarding feelings of devaluation that caused moral distress among participants—mainly due to the population's disregard for protective measures—the findings of this study align with a national survey conducted by Fiocruz, which revealed that approximately 21% of professionals felt devalued by their own management, 30.4% reported frequent experiences of violence and discrimination, and the vast majority did not feel recognized by the population[21]. These findings highlight the emotional strain and physical exhaustion experienced by healthcare professionals in response to the growing number of COVID-19 patients and their ongoing efforts to compensate for high rates of absenteeism[14].

Regarding technical competence in caring for patients with COVID-19, participants reported feelings of inadequacy, acknowledging that their knowledge was insufficient given the severity and complexity of the cases[18]. One study found that some healthcare units implemented on-site training to update professionals on topics related to COVID-19 and to identify potential errors that could place their health at risk[22].

The *Sistema Universidade Aberta do SUS* (UNA-SUS), coordinated by the Ministry of Health, has offered free courses on protective measures for managing COVID-19 in primary healthcare settings[23]. Additionally, the Federal Nursing Council (Cofen), in partnership with the Federal University of Santa Catarina (UFSC), has provided courses for nursing professionals focused on biosafety and the care of critically ill patients in the context of COVID-19[24]. Implementing these training programs aims to address the continuing education needs of professionals working on the front lines of the pandemic.

In addition to the situations already described, participants also reported moral distress stemming from organizational factors such as work overload, shortage or inadequacy of materials, insufficient bed availability, and policies aimed at reducing disease transmission—findings consistent with the literature[6,14].

The Brazilian healthcare system has faced precarious working conditions for many

years, and moral distress among nursing professionals working in this context has become increasingly evident. This precariousness worsened with the arrival of the COVID-19 pandemic, as professionals had to cope with work overload due to the absence of colleagues who had been infected. Nursing professionals are particularly vulnerable to COVID-19 because of their direct contact with patients, and studies indicate that it is not uncommon for them to neglect preventive measures while providing care—especially after long shifts—due to stress and exhaustion[25].

Furthermore, there is evidence of an increase in the number of healthcare professionals experiencing burnout syndrome, depression, anxiety, panic disorder, and other conditions that impact their mental health. The inadequate working conditions during the pandemic have not been conducive to delivering safe, high-quality patient care[20].

In addition to work overload, nursing professionals must contend with resource shortages, inadequate materials, and a lack of beds, all of which hinder their ability to provide quality care and lead to feelings of helplessness, demotivation, discouragement, and emotional fatigue[1]. In crisis or emergencies, health systems are often required to make decisions without including nurses, as such scenarios demand changes in organizational care standards that prioritize collective needs over individual ones[17].

In this scenario, healthcare professionals are burdened by the need to allocate scarce resources, mainly when ICU beds and ventilators are unavailable for all patients, requiring decisions to achieve the best possible outcomes and benefits[26]. Therefore, health systems are responsible for minimizing the burden associated with such decision-making and ensuring adherence to ethical principles, such as justice and equity care[17].

Finally, professionals experienced moral distress in situations involving rigid institutional policies that restricted family presence or visitation for patients with COVID-19. They reported feelings of anguish when witnessing patients suffer from the absence of their loved ones. During the COVID-19 pandemic, nurses have been motivated to adopt a care practice centered on community thinking, in which social justice emphasizes equity, the protection of rights, and the fight against structural forms of oppression[17].

Therefore, nurses have sought to renew their care practices through creative solutions, such as using tablets or mobile phones to facilitate contact between patients and their loved ones, particularly those in terminal conditions. These practices promote humanized care, even in challenging circumstances, demonstrating respect and empathy for the patient[17].

A limitation of this study is that it was conducted in a single hospital facility located in a municipality in the extreme south of Brazil. Nevertheless, the findings may encourage further research on moral distress among healthcare professionals in the context of the COVID-19 pandemic. Understanding the factors that trigger moral distress is essential for developing strategies to minimize its adverse effects on workers' health in future crises.

FINAL CONSIDERATIONS

The analysis of moral distress among nurses working during the COVID-19 pandemic in the hospital setting revealed that participants experienced moral distress stemming from personal and social factors as well as organizational problems. It is important to note that moral distress is not limited to nursing professionals but reflects a broader reality experienced by all healthcare team members who faced ethical and emotional dilemmas during the crisis.

This study's relevance lies in highlighting the importance of recognizing and addressing moral distress as a collective issue that affects not only the quality of patient care but also the mental health and well-being of healthcare professionals. Understanding these contributing factors makes it possible to develop psychological and organizational support strategies that minimize negative impacts and foster a healthier, more resilient work environment for the entire healthcare team.

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