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College of Psychology and Community Services

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William C. Washington

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Walden University
2023

Abstract

A Qualitative Study of Moral Distress in Physicians During The COVID-19 Pandemic

by

William C. Washington

MA, John Carrol University, 2015

BS, Xavier University, 2011

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Psychology

Walden University

Winter 2023

Abstract

The spread of Coronavirus (COVID-19) created a pandemic and had a world-shattering effect on healthcare organizations. As a result, many healthcare professionals were exposed to health situations that stretched them beyond their professional ethics, mental health, and emotional capacity. Throughout the last 30 years, moral distress has been understood as the type of stress that medical professionals experience. Research has substantially grown regarding COVID-19 and moral distress, exposing gaps in the ability of experts to care as they should. Moral distress was a term created to define the emotional disruption that occurs when a professional cannot work within their ethical duty due to organizational or policy constrictions but know the needed moral action. The purpose of this generic qualitative study was to understand eight physicians' perceptions of moral distress during the pandemic. Jameton's concept of moral distress was the framework for understanding physicians' perceptions. The generic qualitative approach explored physicians' treatment during the pandemic for this study. Interviews were conducted using semi-structured interview questions via videoconferencing (Google Meet). Braun and Clark's thematic six-step analysis was used to analyze and code the data. The results of the eight semi-structured interviews demonstrated that moral distress was a cyclic effect. Four themes that emerged as a result of understanding the perception of moral distress during the pandemic included that the system was reactive, causing maladaptive behaviors. The research explored physicians' perceptions while promoting positive social change by improving self-awareness to educate pandemic-related barriers or constraints professionally faced daily.

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Dedication

This paper is dedicated to my ancestors, the marginalized, and the evolution of modern healthcare. I cannot stress enough how being in the position I am was due to the bloodshed, tears, perseverance, creative chaos, and dismantling of my people. I dedicate this paper to the moral distress Blacks have inherited due to the systems in place. I dedicate this paper to future generations in the hope that they see themselves never being a product of what was oppressed, but what has grown through the cemented cracks of racism and systemic oppression. I dedicate this paper to the multitude of people that never gave me a chance to show how brilliant I am and ignored me when I knew what was healthy and just. The people that made me feel like I had to jump to be seen as an equal, knowing I should have just left. I refuse to ever live in someone else's promise. The people that never respected my time and took my inevitable positivity for granted. You no longer have that space, and I hope you find your center.

I dedicate this paper to the believers, faithful, and cycle stoppers. Those that take social justice to heart and refuse to shadow themselves because it feels "uncomfortable." This paper is dedicated to Black men. I see and feel how conditional your worth may feel at times, but this is a sign that it gets better when you find your tribe and can simply breathe. This paper is dedicated to Black women: this world does not deserve what you have sacrificed to be here. I am sorry for not always being everything I could have been too. I have a new journey to heal my path now. I dedicate this paper in the name of healing.

God/Spirit/Source/Yah/Guider/Deliverer/Higher Power/Self/Space provides.

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Chapter 1: Introduction to the Study

Introduction

The COVID-19 pandemic was not just a health issue; instead, it became an issue of personal wellness for many professionals in the health industry (Sheather & Fidler, 2021). The way the world shut down for two years created adversity in overall wellness for people (Spilg et al., 2022). The virus had spread across the globe, created barriers to care, and exposed the lack of resources many healthcare organizations faced (Sheather & Fidler, 2021). The COVID-19 virus caused comorbidities to exacerbate upon severe levels, and medical professionals attempted to manage moral distress under these conditions (Spilg et al., 2022). The work required to understand and prevent this pandemic had considerable costs due to its impact worldwide (Sheather & Fidler, 2021).

Due to the pandemic, medical professionals were becoming at-risk treatment providers, and healthcare organizations were struggling to create protective support (Sheather & Fidler, 2021). Physicians were experiencing a level of support that no longer had the exact boundaries they were once comfortable with (Sheather & Fidler, 2021). Interventions that were once used to help bring relief to physicians were no longer effective due to the strict policy adjustments to the pandemic (Spilg et al., 2022). As the pandemic continued, medical professionals witnessed death at an alarming rate and felt hopeless from the lack of support.

Andrea Garcia from the American Medical Association (AMA) (2022) reported that COVID-19 cases now exceed 78 million. Furthermore, Garcia (2022) reported the daily cases were just over 100,000, hospitalizations were approximately 67,000 per day,

and there was an increase in 14 states with 2,000 deaths per day nationwide as of February 2022. Medical professionals were witnessing pandemic-related deaths at an alarming rate, and their role in this had yet to be fully understood (Sheather & Fidler, 2021). Physicians were struggling to process the impact of their treatment and ability to provide appropriate treatment (Sheather & Fidler, 2021).

Not being able to provide treatment and cause effective change due to institutional constraints had created moral distress on a grander scale (Berg, 2020). Medical organizations, especially hospitals, could not service through the supportive barriers in place and were being exposed to weaknesses they once could overlook, such as protective equipment or respirators. Physicians were overworked and unable to do their duty in a supportive environment. After years of a strict level of care and adjustments, physicians were questioning their professional position during treatment and were unable to process the feeling of helplessness (Spilg et al., 2022).

The central concept of this study examined moral distress and physicians' perceptions regarding it during the pandemic. The evolution of this term began as a nursing-specific issue, but more medical professionals were experiencing it during the pandemic (Jameton, 2017). COVID-19 made it universally difficult for physicians to adjust and regulate proper treatment, causing them to experience a level of moral distress that had yet been recorded (Spilg et al., 2022). The pandemic created stress that health professionals are exposed to at dangerous rates. The potential social implications of this study could provide a comprehensive understanding of moral distress as it evolved

through the years. This study could have a social impact by integrating a new perspective of moral distress in a global crisis.

After this introduction will be 12 sections that navigate from the background of the study to the summary. The purpose, research question, conceptual framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance will be presented to provide adequate detail regarding the study. The last section summarizes the chapter.

Background

Jameton (1984) defined moral distress as knowing the right thing to do, but treatment cannot be executed because of institutional constraints. Since the 1980s, Jameton (1984) examined how nurses would be put in professionally compromising positions and were left unable to care for their patients. After almost 30 years of research, the term's evolution began integrating into other medical professions (Jameton, 2017). Jameton (2017) recognized that the symptoms of moral distress infiltrated healthcare at an astounding rate, causing medical professionals to be put in emotionally dysphoric states. Medical professionals were beginning to make adjustments to be considered adequate; however, they were approaching their ethical limit. Researchers found that other medical professionals noticed unethical treatment that aligned with moral distress (Kalvemark et al., 2004). Research was explored regarding onset symptoms resulting from moral distress (Vittone & Sotomayor, 2021). Medical professionals were placed in risk-causing treatment and were unable to appropriately treat patients due to their medical organization's lack of resources and support. In 2019, moral distress became a topic of

conversation again due to the COVID-19 pandemic (Huremović, 2019). Huremović (2019) began noticing the psychiatric effect of pandemics throughout history. Professionals noticed emotional affect because of the pandemic-related issues and support regarding their adversity, ultimately noting emotional causation. Moral distress became a trigger for other harmful emotions, causing secondary traumas because preventative measures against COVID-19 were ineffective (Huremović, 2019).

Researchers began studying the disease and how to treat it because many people were dying, which left hospitals struggling to create preventative measures due to the lack of resources (Golinelli et al., 2020). Dubé et al. (2020) examined how hospitals were unprepared, and research was not providing an alternative care solution. Physicians were suffering from a lack of support and an inability to navigate pandemic-related barriers, such as treatment protocol, effectively. Researchers Dewey et al. (2020) initiated learning supportive interventions because physicians had to abide by policies that were often oppositional to their standard treatment care. Researchers concluded that physicians had secondary trauma due to watching their patients suffer as a result of bare resources (Dean & Simon Talbot, 2019).

Research has shown moral distress occurs broadly within hospitals, and researchers Epstein et al. (2019) found instruments to identify the level of symptomatic expressions occurring in professionals, such as burnout and compassion fatigue. Researcher Fourie (2017) found that the symptoms of moral distress were showing in other medical professionals, and hospitals were unable to provide interventions to address the rise of moral distress. Researchers Morgantini et al. (2020) found that physicians

were left unable to provide adequate treatment and forced to live a personal life without relief for the safety of their own family and loved ones.

The pandemic created higher states of moral distress. Researchers Rushton et al. (2020) studied alternative solutions for moral distress so physicians could prevent burnout, compassion fatigue, or moral injury. Recently, researchers have been more forthrightly addressing healthcare gaps (Sheather & Fidler 2021). Unfortunately, the research into physicians' state of mind during this pandemic has not been published yet. An open-ended questionnaire or quantitative measure has been the closest attempt to precisely understand how moral distress coexists within physicians during a pandemic (Sizoo et al., 2020). This study explored the perception of moral distress with physicians during a pandemic, which has yet to be investigated.

Problem Statement

The COVID-19 pandemic caused physicians to experience a level of emotional distress that had a detrimental effect on their ability to maintain a healthy standard of care (Frezza, 2019). As a result, physicians were dealing with lethal experiences of moral distress and had yet to find a way to be more preventative from the onset, which leads to secondary traumas such as compassion fatigue, burnout, and even moral injury if the emotional distress is prolonged (Frezza, 2019). Moral distress within physicians was beginning to turn into secondary traumas more sporadically (Frezza, 2019).

The moral distress experienced has manifested a level of emotional illness that exposed the adversity clinicians were perceiving. According to Shanafelt et al. (2019), the aftermath of moral distress resulted in symptomatic expression such as burnout,

which has caused approximately a 50% increase in suicidal ideation in physicians. Suicidality was among some of the adversity faced and has been increasing for physicians within the past decade due to hostile work environment and inability to treat due to pandemic-related barriers (Frezza, 2019). Since the 1980s, around 400 doctors have committed suicide every year due to ethical obligations and institutional constraints, indicating that moral distress was a formative aspect of a physician's experience (Frezza, 2019). COVID-19 was creating new challenges that today's doctors have yet to be supported in (Vittone & Sotomayor, 2021).

The COVID-19 pandemic had made the level of care environments more hostile, causing an unrest and sense of hopelessness for healthcare professionals (Frezza, 2019). Clinicians were becoming overworked, unsupported, and emotionally neglected during the fight to save patients. Even worse, they were struggling to save themselves (Frezza, 2019). Physicians were experiencing pandemic-related moral distress, which caused a double threat to clinical care (Vittone & Sotomayor, 2021). During the pandemic, institutional constraints and safety policies were causing moral injury due to the length of moral distress that goes unaddressed (Frezza, 2019). The preparation, resources needed, and preventative measures challenged medical professionals' effectiveness within healthcare organizations (Epstein et al., 2019). Fulfilling new treatment policies and creating interventions to support physicians led to more understanding regarding how rampant COVID-19 had become in hospitals (Rodney, 2017).

Researchers wanted to discover how to create a buffer that prevented moral distress in physicians, thus impacting the quality of life for both clinicians and patients

(Sizoo et al., 2020). Limited resources and interventions regarding moral distress inhibited physicians' ability to effectively cope with their symptoms of moral distress during the pandemic (Rimmer, 2021). Physicians actively experienced signs of moral distress and were unable to find reprieve through traumatic repression (Rushton et al., 2020). Being unable to acknowledge and assess the level of symptomatic expression of moral distress hindered the emotional intelligence to address it.

Substantial evidence regarding physicians' experience of moral distress during the pandemic was currently limited due to COVID-19 being identified in 2019 (Nott, 2020). Recent studies have addressed the gaps in hospital resources, policies, and secondary trauma (Shanafelt et al., 2019). However, studies that align with physicians' perception of moral distress before burnout, compassion fatigue, or moral injury had yet to be determined (Sheather & Fidler, 2021). There remains a gap in the literature on the perception of moral distress during the pandemic. The research problem under investigation was the perception of moral distress within physicians because of the pandemic.

Purpose of the Study

The purpose of this generic qualitative approach was to study physicians' perceptions of moral distress during the COVID-19 pandemic. The COVID-19 pandemic presents a crisis that challenged medical professionals' quality of life (Vittone & Sotomayor, 2021). Exploring physicians' perception of moral distress could lead to opportunities to support them emotionally (Rushton et al., 2020). The opportunity to

understand their perception during a critical moment worldwide may have a revitalizing response for supporting healthcare workers.

Research Question

What are physicians' perceptions of moral distress during the COVID-19 pandemic?

Conceptual Framework

Jameton's (2017) term *moral distress*, which was developed in 1984, was the conceptual framework used to ground the study. Jameton (1984) defines moral distress as an individual knowing what the right thing to do is but not being able to perform their ethical duty due to organizational or institutional constraints. His definition of moral distress addresses ethical dilemmas and moral uncertainty evolving throughout time (Jameton, 2017).

Understanding the development of moral distress and its evolution within medical professionals and organizations could help determine how medical professionals are an at-risk population (Jameton, 2017). The research question aligns with this conceptual framework because it prepares moral distress to be examined from a qualitative lens. By examining each participant's perception, their definition of the coined term could be looked at through themes, patterns, or conclusive ideation. The semi-structured interview questions were formed to explore the awareness of moral distress currently occurring among physicians.

Nature of the Study

This study used a generic qualitative approach to explore physicians' perceptions of moral distress during the pandemic. The generic qualitative approach provided a clear perspective of moral distress during the pandemic. Generic qualitative research has a level of flexibility to maintain the integrity of the participant's perception (Percy et al., 2015). In this method, participants' perceptions, awareness, and symptomology are all considered worthy of investigation and are part of thematic analysis (Percy et al., 2015). Exploring their perception of moral distress allowed no boundaries or limitations to be established and for thematic analysis to be the resulting factor in their perception of moral distress.

Moral distress during the pandemic was an ongoing crisis, meaning that generic qualitative research enables the perception of physicians' moral distress to be studied without the concern of philosophical assumptions. This topic focused on physicians (medical doctors) from the U.S. treating patients with COVID-19. Research was undefined regarding effective strategies to alleviate moral distress symptoms for physicians. Therefore, a generic qualitative approach regarding their perception or awareness provided a foundation for the scholarly community to approach physicians' symptomatic expressions regarding moral distress during pandemic-related crises. Data were collected via interviews with seven semi-structured open-ended questions and recorded via videoconferencing (Google Meet), and transcription was performed before analyzing for any significant thematic results (Braun & Clarke, 2006). Thematic analysis includes six steps (familiarizing data, survey patterns, organizing codes, thematic data,

definition creation, analyzing data collection for report) to identify codes, categories, and presenting themes to help create conclusive results regarding perceptions (Braun & Clarke, 2006). The steps in thematic analysis were a qualitative analytic method designed to extract data from participants to help explain perception based on their response to the experiment (Braun & Clarke, 2006).

Definitions

COVID-19: An illness caused by the coronavirus originating from severe acute respiratory syndrome coronavirus 2(SARS-CoV-2) that causes respiratory illness.

Outbreak: An outbreak is when a disease has grown suddenly (Turner, 2020). Outbreaks are typically known as occurring with food or gastrointestinal symptoms (Morens et al., 2009).

Epidemic: An epidemic is more severe than an outbreak (Turner, 2020). It is an outbreak with a contagious disease and is not considered a localized event (Morens et al., 2009). Typically, it can spread across the country due to its contagious nature (Turner, 2020).

Pandemic: A pandemic is considered worldwide or globally contagious. This supersedes an outbreak or epidemic (Turner, 2020).

Secondary trauma: Secondary trauma is when one becomes a witness to someone else’s traumatic experience (Frezza, 2019). There are reactions resulting from being a witness, such as fatigue, somatic reactions, stomach aches, nervous reactions, or other irrational emotional cognitions such as burnout or compassion fatigue (Morgantini et al., 2020).

Moral injury: Moral injury is the emotional detachment that causes a person to disrupt or disregard their identity, beliefs, or understanding about their life (Frezza, 2019). Veterans were known for this due to the consistent dissociation resulting from continually being exposed to traumatic expressions (Nott, 2020).

Moral distress: The realization and feeling of knowing the proper procedure or action but not being able to perform to the best of your ability due to institutional or policy constraints.

Assumptions

The assumptions for this study were as follows. Each participant would understand how to answer all questions regarding their perception during the pandemic. The participant would understand moral distress and apply past and present awareness accurately. Participants would have been unable to use coping skills to alleviate moral distress symptoms. The study participants would be emotionally articulate regarding moral distress and their experiences during the pandemic. Participants would be medical doctors with experience of treatment during the pandemic.

Scope and Delimitations

The study's participants included physicians who provided treatment in the U.S. during the pandemic. In this study, I focused on their perceptions of moral distress resulting from pandemic-related experiences. What I excluded in the study were any medical professionals who were not medical doctors (MD). I ensured that all medical professionals were not a conflict of interest and had no preconceived biases. The research

context was explained in the consent form to each participant as a method to address potential transferability.

Limitations

Limiting factors included the diversity of physicians to examine moral distress and the ability to recruit them due to COVID-19 (Parker et al., 2019). Parker et al. (2019) stated that representation of participants can be limited due to participants choosing from their pool. This could also cause selection bias if not properly screened against. Ensuring interview questions were not misinterpreted was a concern (Braun & Clarke, 2021). Braun and Clarke (2006) reported that interview questions limit the phenomena due to how the experience is recorded. Thematic analysis could have become limited if there was redundancy within the interview (Braun & Clarke, 2021). Hospitals were also a barrier due to confidentiality and information gathering; therefore, the hope was that physicians would send the study information directly to other physicians rather than going to hospitals (Parker et al., 2019). The flyer posted to recruit participants ensured the qualifications and requirements were presented for extra measure. Upon contact, the participant would state how their qualifications were aligned with the study. The limitations mentioned were addressed by screening when participants responded to the initial recruitment inquiry.

Significance of the Study

This research could fill a gap in understanding regarding physicians' perceptions of moral distress during the pandemic. Healthy clinicians were imperative when all medical professionals and first responders were unable to keep up with crisis care. This

research was unique because it addressed an under-researched area of physicians' perceptions of moral distress throughout this pandemic. Furthermore, moral distress had yet to gain adequate research since the onset of COVID-19. The pandemic was life-altering for physicians, rendering them uncapable of self-preventative interventions to maintain professional and ethical duty, which in turn affected health organizations (Rushton et al., 2020). This study could contribute to understanding ways possibly support physicians with healthy options they did not have during this pandemic (Vittone & Sotomayer, 2021). Although health advisories were put in place during the pandemic, moral distress continued to impact physicians' ability to create an effective treatment (Sizoo et al., 2020). As a result, the lives of physicians were emotionally at-risk and susceptible to higher suicidality rates (Frezza 2019).

This study addressed moral distress from the experience of how it was developed within physicians' psyches during the pandemic (Rushton et al., 2020). Moral distress symptoms could not be treated with policy-driven impacts within a pandemic (Zhang et al., 2020). However, learning what was emotionally needed for a physician to feel supported could improve their professional quality of life (Zhang et al., 2020).

Learning how organizational constraints, interventions, and preventative measures work concerning physicians' moral distress could lead to developing the therapeutic responses necessary for the pandemic and incidences like it (Rimmer et al., 2021). The information presented in this study supports positive social change by developing practices that could help emotionally prepare physicians to care for patients under pandemic-related barriers or constraints. Understanding how physicians could be

supported during emotional distress could reconstruct the approach to modern healthcare solutions and integrative practices (Sizoo et al., 2020).

Summary

In this study, I explored physicians' perceptions of moral distress providing treatment in the U.S. through interviews using Google Meet. All data collection methods regarding thematic analysis were utilized to ensure consistent interviews were recorded and collected. It was imperative to ensure that the perception, attitude, emotions, and emotional distress data were gathered to bring awareness of moral distress experienced during the pandemic. Research had yet to be substantial and was more inclusive towards the harsh environment of treating under pandemic-related barriers. In their work, Nott (2020) mentioned that doctors had become stressed to the point of being considered frontline surgeons due to the relentless treatment that was needed.

Rimmer (2021) reported that eight out of 10 doctors had experienced moral distress during the pandemic, and they had been considered to be suffering from moral injury due to not addressing it. Rimmer explained that doctors could no longer offer the same level of care they were once trained to provide. Many factors have caused emotional hostility, such as limited resources, policy adaptations, and imbalanced work-life options (Sheather & Fidler, 2021). Physicians have always had an at-risk profession, but the pandemic exposed a new level of emotional turmoil (Frezza, 2019). This study offered an educated exploration of their perception.

In Chapter 1, a background of the study, problem statement, purpose of the study, research question, conceptual framework, nature of the study, definition of terms,

assumptions, scope and delimitations, limitations, significance of the study, and a summary were provided. Chapter 2 presents information on the history of pandemics, how COVID-19 infiltrated the healthcare industry in multiple ways, how physicians perceive different levels of trauma due to moral distress, and efforts to restore professional quality of life.

Chapter 2: Literature Review

Introduction

The COVID-19 pandemic caused physicians to experience a level of emotional distress that had a detrimental effect on their ability to maintain a healthy standard of care (Frezza, 2019). The purpose of this generic qualitative study was to explore physicians' perceptions of moral distress during the pandemic. Substantial growing evidence suggested that moral distress was evolving in other medical professions due to the prevalence of institutional gaps in care; however, there was a lack of research on the perception of moral distress within physician care due to the term's origin and how it relates to the current pandemic. Literature has yet to define physicians' perceptions during the COVID-19 pandemic and provide modern solutions to support them during this crisis.

Literature Search Strategy

I condensed my research into the past five years when conducting the literature research unless there were defining terms relevant to the study (moral distress). Due to the topic being recent because of the pandemic, I attended a conference on moral distress with Jameton in 2022 and interviewed him regarding the evolution of his coined term. I followed researchers actively working on moral distress techniques and interventions currently occurring because of the pandemic. I selected the following research databases: PsychBOOKs, PsychINFO, PsychARTICLES, Google Scholar, ProQuest, PubMed, SagePub. The next key terms were used to select relevant research articles related to my topic: *compassion fatigue, burnout, moral distress, moral reasoning, stress, quality of*

life, stress management, empathy distress, secondary trauma, COVID-19, pandemic, epidemic, outbreak, moral injury, PTSD, hospital gaps, personal protective equipment, perception of moral distress, bioethics, moral residue, ethical dissonance, physician suicide, organizational ethics.

The terms listed above were utilized in the research databases mentioned. EBSCO and Google Scholar were primarily used for their search strategy options when reviewing. Google Scholar had more recent articles published due to the pandemic currently happening; however, Google Scholar did not present sustaining literature on physicians' perceptions during the pandemic. The need for understanding medical professional perceptions regarding moral distress in both databases was recognized. The gap was based on the recent exposure of COVID-19 and the lack of preparation for physicians. Due to how new this topic was, I continued to search for relevant information and exhausted the literature until this study was complete.

Conceptual Framework

The conceptual framework used for this study was Jameton's (2017) moral distress (M.D.). Jameton developed the origin of M.D. in 1984. His definition of moral distress was related to an ethical dilemma and moral uncertainty concerning medical professionals. Because of organizational ethics, he saw M.D. as knowing the right thing to do but being constricted in the follow-through process. Much of the research acknowledged the constraints and experience of nurses, but the level of distress was not yet determined. Jameton (2017) found that moral distress incurred symptoms medical professionals could align with. Wilkinson (1987/88) also studied the concept by

considering the experiences of nurses with moral distress by creating psychometric properties. Wilkinson recognized M.D. as the uncertainty and adverse feelings caused by healthcare infrastructural constraints (1987/88). He also conceptualized the psychological effects by describing moral reasoning, coping interventions, and the stress experienced in ethical dilemmas. Wilkinson used ethical terms and dilemmas to help organize the formation of moral distress and created psychological application (1987/88). Furthermore, Wilkinson (1987/88) acknowledged that moral reasoning was a factor in M.D., along with ethical decision-making. The challenges medical professionals faced were becoming a work-life imbalance. He studied stress by examining prolonged life, unneeded procedures or tests, and the yearning for transparency (1987/88). Subsequently, the data collected made M.D. broader known and better understood beyond the origin.

M.D.'s narrative focused on initial and reactive distress, acknowledging how healthcare professionals often worked beyond their emotional capacity (Jameton, 1993). Jameton used the term *initial distress* to describe the psychological experience faced when institutional parameters became obstacles, and he used *reactive distress* as the distinction when people do not address their initial distress. Kälvemark et al. (2004) used Jameton's definition in 1993 as a foundation for the experience of ethical dilemmas within the health care system, concluding that this concept was not dedicated to one specialty of the health care profession. They also expanded Jameton's understanding of ethical dilemmas, noting that healthcare organizations' limitation within resources and support regarding the causation of moral distress was due to poor education in ethics. For over 30 years, M.D. expanded into other health professions (Fourie, 2017).

Jameton (2017) revisited the concept of M.D. in 2017 and recognized that there was more to be considered. Jameton (2017) acknowledged that the perception of stress-reduction required further research and institutional investigation. In the essay, Jameton (2017) noted that naming and acknowledging moral distress led to more insight into organizational ethical policies, such as restricting the medical doctors from delivering best practices to patient care and having to conform to managed care, which led to physicians feeling morally distressed. Healthier organizational ethical approaches were the aftermath of research for healthcare professionals after learning more about stress-reduction (Jameton, 2017).

Furthermore, Jameton (2017) concluded that ethics and moral distress should be considered both globally and socially due to the universality of healthcare. He also acknowledged that moral distress could affect the institution and could be seen relationally, which causes a downhill effect on wellness and safety within healthcare organizations (Jameton, 2017). If an ethical dilemma or moral injury was occurring with other demographics, Jameton believed that the concept of moral distress would need to be understood in a specific category due to its dynamic mental instability (2017).

The conceptual framework informed the interview questions to acknowledge the ethical dilemma and address initial and reactive distress (Jameton, 2017). Jameton's review of the evolution of M.D. established a forum for physicians to discuss their perceptions during the pandemic, which has yet to be fully explored (2017). Jameton (2017) acknowledged the global scale of M.D. and how it would develop in the future. In

2020, the COVID-19 pandemic would align with his future concern for medical professionals.

Literature Review Related to Key Variables and/or Concepts

History of Pandemics for Healthcare

The Coronavirus 19 (COVID-19) was connected to of a lineage of pandemics and other infectious diseases (Piret & Boivin, 2020). There have been more than nineteen recorded pandemics throughout history (Turner, 2020). Piret and Boivin (2020) identified the most noted pandemics were the following: plague of Justinian, black death, first cholera, second cholera, third cholera, fourth cholera, fifth cholera, third plague, Russian flu, sixth cholera, Spanish flu, Asian flu, seventh cholera, Hong Kong flu, severe acute respiratory syndrome-related coronavirus (SARS), swine flu, middle east respiratory syndrome (MERS is ongoing), and COVID-19. Researchers investigated what creates a pandemic and how it is a product of societal development (Piret & Boivin, 2020).

Understanding Outbreaks, Epidemics, and Pandemics

Piret and Boivin (2020) defined outbreak, epidemic, and pandemic as the manifestations of a health condition in contrast to its established growth rate. Researchers also considered the spread of the health condition geographically (Piret & Boivin, 2020). An endemic was described as an outbreak within a specific region at a predicted rate. Piret and Boivin (2020) defined an outbreak as a health condition with erratic occurrences in a new area. To follow, an epidemic was described as a health condition that reaches more significant geographic areas (Piret & Boivin, 2020). Lastly, a pandemic has the same criteria as an epidemic, yet spreads globally (Piret & Boivin, 2020).

Researchers reported that these pathogens that become global pandemics stem from a cross-species transmission and evolve to the point that human-to-human transmission is the method of sustainability (Piret & Boivin, 2020).

Impact of Outbreaks, Epidemics, and Pandemics in Society

It was imperative to understand how cyclic pandemic history was due to its effect on humankind (Huremović, 2019). As a result of human transmission, researchers reported that a level of monitoring needed to be implemented to create preventative measures (Piret & Boivin, 2020). Populations that are effected in large geographical areas could spread deadly health conditions to other lands and the infections could travel easier due to climate change. For example, researchers reported that mosquitos increased the predicated rate due to their access to humans and natural disasters (Piret & Boivin, 2020). Piret and Boivin (2020) found that fleas, rodents, and contaminated water were consistently reported as pandemic-related factors from 541-2019. Communication, transportation, trades, and environmental expansion affected health organization's ability to improve preventive barriers needed to maintain the health of the human population. Piret and Boivin (2020) considered transmissions almost inevitable due to the multiple outbreaks and endemics.

Healthcare Organization Response to Outbreaks, Epidemics, and Pandemics

Piret and Boivin (2020) saw the plague of Justinian, the Black Death, and the bacteria Y. pestis as the most notable disease spreads and acknowledged by the World Health Organization as re-budding infectious diseases. These plagues would re-emerge in alternative variants, prompting health organizations create protocols and taskforces to

lower population exposure. Piret and Boivin (2020) found that pandemics have patterns through studying recurrent pandemics (species origin or habitat modification), and healthcare organizations would continue to find preventative measures indefinitely. They realized that future pandemics were inevitable due to the globalization of supply and demand (Piret & Boivin, 2020).

Organizational Gaps in Healthcare as a Result of the Pandemic

Understanding the COVID-19 pandemic and how health organizations responded was based upon past research of their preventative measures taken (Huremović, 2019). The last few years were an eye-opening reality regarding state of current health care that ultimately exposed the disparities organizations face (Chakraborty & Prasenjit, 2020). Chakraborty and Prasenjit (2020) exposed healthcare gaps (medical supplies and funding) that had not been addressed, noting that with further research, there may be room to mitigate these offsets. Organizations were unprepared to handle the level of attention needed to be preventative. According to Piret and Boivin (2020), the protocols, medical resources, and adjustments needed to support treatment providers were barriers to the COVID-19 pandemic. Preventive measures were missed because healthcare professionals and physicians were significantly affected more than usual (Chakraborty & Prasenjit, 2020).

COVID-19 within the last three years

The COVID-19 pandemic became a global calamity within the last several years and is considered the greatest unexpected medical challenge in comparison to other pandemics (Chakraborty & Prasenjit, 2020). Since 2020, researchers found that the

World Health Organization (WHO) reported that COVID-19 impacted over 21,644,111 people and killed more than 2 million people in over 200 countries worldwide. The virus was disruptive due to the migration of global sustainability and was the fifth pandemic within the century. The WHOs acknowledgment brought awareness to the economic, environmental, and psychological adversity resulting from interrupting the flow of healthcare management. Chakraborty and Prasenjit (2020) identified that the medical response to this virus exposed the challenges in solidarity medical professionals already faced.

Professionals Unprepared for a Global Crisis

The lack of solidarity needed to address this global crisis caused an emotional impact that many medical professionals were unprepared for (Frezza, 2019). Frezza identified that a doctor's competence in new treatment protocols needed for COVID-19 had not been fully established. As a result, Frezza (2019) described the adjustment as moral distress. However, medical policy, resource, intervention, and patient care failed their mark for the past three years in promoting wellness. More noticeably, Frezza (2019) reported the level of consistency needed for personal care for professionals was yet to be acknowledged. Frezza (2019) identified that the emotional distress experienced within healthcare organizations could not be addressed without understanding moral distress for medical professionals that weren't nurses.

Moral distress in physicians was explored by Frezza (2019) as a result of the increased COVID-19 cases. He acknowledged physicians' limitations became aggravating on top of the ethical issues they were facing (patient care and policy

adherence). The conflict between efficient working environments and physician care protocols were difficult to address. He reported that physician suicide rates had increased the most out of all other medical professional groups. Frezza (2019) also identified that moral distress in physicians recognized internal dilemmas and the scarcity of solutions within the healthcare system to lower suicidality amongst physicians. Daubman et al. (2020) found through their research that resilience was a tool for managing moral distress, and unresolved emotions regarding a clinicians' ability to care for patients would create endless moral residue. The stress that professionals encountered affected healthcare systems, and COVID-19 exposed the frailty of internal systemic prevention (Kayee et al., 2020).

Healthcare Organization Preparation for Physicians During the Pandemic

Kayee et al. (2020) reported that the lack of resources, extensive work hours, mandated isolation, ethical boundaries, and moral dilemmas impacted professional satisfaction for physicians. Researchers (Kayee et al., 2020) noted that COVID-19 required new planning and regulations to mitigate the deficiencies that hindered the process of preventative care. Berg (2020) reported that healthcare inequities subjected communities to poor healthcare system relationships. Lower socioeconomic communities were unable to sustain themselves as well, and hospitals could not withstand the wave of illnesses (Berg, 2020).

Healthcare systems had endured a bottlenecking of resources, with reduced funding to the point of causing psychological stress upon physicians (Sheather, 2021). It was reported that doctors simply working harder was no longer an effective tool

(Sheather, 2021). Moral distress had become emotional cancer for physicians within the healthcare system (Sheather, 2021).

Personal Protective Equipment (PPE) and Healthcare Efficiency

Kayee et al. (2020) reported that healthcare facilities worldwide had lost PPE, sanitization, toilet paper, and water supplies. The problem with this deficit was that COVID-19 exposed hospital healthcare proficiency to a critical need level. There were significant healthcare losses due to the unsupportive policies implemented in preparation. Cancellation of outpatient visits, procedures, surgeries, and other facility treatments strained organizational financial stability. Kayee et al. (2020) found medical centers were also in critical states, due to attempting to expand their facilities to accommodate the regulations and policies for safety while lacking proper protective equipment. Medical research institutes also struggled, which impacted research that would help with disease management (Kayee et al., 2020). Physicians were left with the notion that they should continue treatment even though the lack of PPE put them in harm’s way as they did their job (Berg, 2020). This disposition led to many moral and ethical issues that triggered moral distress (Berg, 2020)

The authors reported that the restrictions to protect all those involved require new investments that were not expected (Kayee et al., 2020). For instance, telehealth became a worldwide need that was essential to healthcare (Kayee et al., 2020). Medical equipment such as ventilators and proper masks to cover the face were delivered rapidly to ensure technology could override any barriers (Kayee et al., 2020). These changes

occurred extremely fast due to the fatality rate, especially in nursing homes. Kayee et al. (2020) found that 40% of the fatalities of the pandemic were in residential facilities.

Psychosocial Effects and Organizational Response

Kayee et al. (2020) acknowledged that marginalized populations and psychosocial effects had been correlated due to the impact of the pandemic on the world. Anxiety, depression, suicidal ideation, substance abuse, stigmatization, and racism have been factors exposed at higher rates due to COVID-19 (Kayee et al., 2020). A 3.3. trillion-dollar deficient occurred as a result of pandemic relief. Berg (2020) reported that socioeconomic factors were significantly impacted because of their already lack of funding.

The pandemic created more disparities and relied on upper socioeconomic communities to allocate the limited resources they already had (Berg, 2020). Unfortunately, many doctors had to accept that they did not have the resources to save lives (Berg, 2020). Moral distress became more significant than the sustainability of a community (Berg, 2020). Andrea Garcia (2021) reported that mandating vaccinations has helped organizations seem more responsible, yet the disparities were rampant throughout the U.S.

Physicians Issues with Fulfillment Satisfaction and Service Quality

The lack of fulfillment in physicians was studied due to moral distress becoming empirically monitored (Epstein et al., 2019). Researchers found that moral distress affected professionals on multiple levels, such as occupational environment, burnout, compassion fatigue, and ethical liability (Epstein et al., 2019). Rimmer (2021) found that

80% of doctors aligned with moral distress to understand their internal complications that affected the overall fulfillment quality. A study was done to determine the difference between moral distress and moral injury to ensure that physicians understood the difference (Rimmer, 2021). After 1864 respondents, 56.2% reported that they experienced moral distress, and 51.6% said they were familiar with moral injury (Rimmer, 2021). It could be understood that physicians identified the definition, and there was an experience that made treatment providing unfulfilled (Rimmer, 2021). Doctors with minority backgrounds were more likely to report moral distress than white doctors. The psychological impact doctors were experiencing was becoming more prevalent, and the pandemic has only intensified these definitions (Rimmer, 2021). There has yet to be a conventional method regarding self-care and attending to their aid for healthier approaches (Rimmer, 2021).

After learning that the root causes of moral distress stemmed from various factors, the lack of response from organizations affected patients, medical professionals, and their teams (Epstein et al., 2019). The ability to have a satisfying life within the past three years was paused due to managing the health policies needed due to COVID-19. Epstein et al. (2019) found that organizations with ineffective team communication, staff shortages, and less administrative support contributed to the severity of moral distress. (Epstein et al., 2019). Epstein et al.'s (2019) findings indicated that using their evaluation tool helped target the proper intervention for support. Unfortunately, the phenomenon of moral distress directly impacted patent care quality (Epstein et al., 2019).

Physicians have become part of the 33-year-long nuance through qualitative and quantitative studies describing the residual of moral distress (Rodney, 2017). Rodney (2017) noted that clinicians were conceding themselves to the point that moral distress would become inevitable. Other researchers found moral distress being prolonged due to policy adjustments to maintain safety for the patient, without regard to the physician's quality and fulfillment of care (Sizoo et al., 2020). Receiving support for clinicians required organizational support; otherwise, it exacerbated the symptoms of moral distress. Rodney (2017) understood that moral distress addresses the understanding of other constituents such as moral injury, moral dilemmas, and moral uncertainty affecting the quality of treatment service.

Moral Injury and its Significance with Moral Distress

Moral injury becomes an aftermath of secondary trauma and unmanaged self-care (Freeza, 2019). Being unable to process moral distress for an elongated period causes chronic mental health complications (Frezza. 2019). Moral distress and its link to moral injury had increased within the past three years (Shanafelt et al., 2019).

Secondary Trauma and Moral Distress

COVID-19's high mortality rate was traumatic in hospitals, and professionals experienced secondary trauma. Secondary trauma is defined as a witness or onlooker of another patient or person's traumatic experience (Frezza, 2019). Physicians facing moral distress were also victims of secondary trauma (Frezza, 2019). Frezza (2019) described secondary trauma responses as physical, mental, emotional, and behavioral conditions considered irrational. Some of these secondary traumatic symptoms Frezza (2019)

described were the following: fatigue, muscle ache, heart palpitation, gastral irritation, unfocused, confusion, indecisiveness, shock, anxiety, depressive symptomology, worry, dread, shame, insecurity, abusive patterns, poor habits, or defensive adherence to patient care. If moral distress was unaddressed from that moment, the result is moral injury (Shanafelt et al., 2019). It was considered the aftermath of secondary traumatic (compassion fatigue, burnout, etc.) responses to an already established at-risk profession (Frezza, 2019).

Origin of Moral Injury

Moral injury was described by Dean and Simon Talbot (2019) for combat veterans suffering from the aftermath of war. Moral injury was defined as making sense of contravened moralities and beliefs skewed due to involvement in the war (Frezza, 2019). Veterans could not recognize the self-destructive habits in their daily functioning. Soldiers would often lose their sense of character, identity, and emotional ability to process their relationship with society. Physicians were facing caveats to moral distress, and their ability to respond rationally was no longer within their power (Frezza, 2019). Frezza (2019) concluded that moral injury and moral distress correlate due to the emotional detachment and compassion needed due to internal conflict with societal standards.

Moral Distress and Burnout

Moral distress was considered an onset of burnout, causing approximately a 50% increase in suicidal ideation (Shanafelt et al., 2019). Having symptoms of burnout often causes hostile work environments (Shanafelt et al., 2019). Shanafelt et al. (2019)

surveyed U.S. physicians regarding their satisfaction with work-life balance and noted that burnout had become an increased risk for physicians within the last ten years. Researchers reported that altered practice structure led to more internally distressful feelings for physicians due to practice models not conducive to their needs (Shanafelt et al., 2019).

Recently, it was found that COVID-19 caused a level of burnout that was more detrimental to the health professions (Hlubocky et al., 2021). Hlubocky et al. (2021) found that practice health was a major concern for the quality of continued care. Burnout exposed oncologists to greater susceptibility due to the high levels of stress experienced specifically with patient care (Hlubocky et al., 2021). It was also noted that organizational roles could contribute to the pace at which burnout was experienced (Hlubocky et al., 2021).

Moral Distress, Moral Injury, and Compassion Fatigue

Dzeng and Wachter (2020) found that moral distress being the onset of other maladaptive behaviors and experiences caused needed attention to the execution of care for clinicians. Dzeng and Wachter (2020) identified compassion fatigue in moral distress as a byproduct of burnout and other secondary traumas. As secondary traumas were prolonged without supportive involvement, moral injury became the chronic effect of moral distress (Frezza, 2019). Moral distress was being analyzed with more consideration and development regarding the onsets (Daubman et al., 2020).

Daubman et al. (2020) identified moral distress as a staged approach using indignation, resignation, and acclimation as the formation during the pandemic. Through

indignation, Daubman et al. (2020) believed that physician's secondary trauma was based upon the lack of resources, witnessing improper care, and fear of safety. The authors presented the next stage as resignation due to the duration of moral distress experienced (Daubman et al., 2020). Health providers were then put into a state of moral injury due to prolonged symptoms of moral distress, feeling helpless or unable to make the change they ethically devote themselves to (Daubman et al., 2020). Resignation was the only choice to counter their emotional distress (Daubman et al., 2020). Daubman et al. (2020), however, found the stage of acclimation among moral distress as a sign of nuance due to finding meaning out of their adversity. The ability to find empowerment within their commitment allowed the poor outlook on moral distress to be still formattable. Daubman et al. (2020) found that using the three stages translated the processing of moral distress into other forms of secondary trauma, such as compassion fatigue, burnout, and moral injury.

The stigma physicians experience as a result of moral distress

Frezza (2019) reported that the stigma physicians face created blockage towards getting the help needed for moral distress. The researcher noted that if a physician self-reports, their license could be withheld (Frezza, 2019). It can be concerning due to physicians' overall need to feel the responsibility to present themselves as healthy and competent. Morley et al. (2019) found their competency and ethical obligation to conflict. Ethical challenges in healthcare caused an uprising of moral distress among physicians (Morley et al., 2019). Physicians were forced to consider their ethical constraints unavoidable, feeling helpless and contributing to the stigma they faced (Morley et al.,

2019). The stigma and ethical awareness caused repressive behaviors to express moral distress (Frezza, 2019).

Physicians are facing moral distress globally

It was reported that moral distress during the pandemic was more than a United States issue (Morley et al., 2019). Morley et al. (2019) found that physicians needed to reflect the same adversities in other countries, ultimately putting restrictions on organizing care effectively. The researchers (Morley et al., 2019) noted that the quality of life and ethical considerations presented were challenged and multifaceted, making their care cross boundaries. For instance, Morley et al. (2019) found resource restriction as an underline result for moral distress. To understand moral distress globally, Morley et al. (2019) created a criterion to help distinguish the experience physicians faced because of moral distress. The following were moral events: moral conflict, moral dilemma, moral uncertainty, or moral constraint (Morley et al., 2019). The second criterion consisted of psychological distress to acknowledge the diverse emotional classifications of negative symptoms correlating to stress (Morley et al., 2019). The third criterion represented the relationship between the first two by explaining how moral distress transcended across countries and brought physician disparity awareness within healthcare organizations (Morley et al., 2019).

Resources Needed for Physician Care

Although clinicians (doctors and nurses) had limited resources and interventions during the pandemic, researchers believed further investigation regarding the ability to alleviate emotional distress was needed to enhance clinicians' dialog and engagement

among health professionals (Rushton et al., 2020). Being unable to normalize the medical conversation and organizational transparency due to COVID-19 protocols put cohesive workflow in unusual dispositions regarding patient care and professional quality of life (Rushton et al., 2020).

Physicians were not reassured about returning to their families (Berg, 2020). With the demands of healthcare systems and the intensity of exposure, many physicians became risks to their families, causing ostracizing moments and dampening the ability for self-care (Berg, 2020). Berg (2020) noted there was no contingency or resource for physicians to know they would not compromise their families. Dealing with the inability to separate themselves from work elongated moral distress due to the lack of boundary physicians experienced (Berg, 2020). Morley et al. (2019) reported the lack of employees created tension amongst healthcare professionals and harsh work conditions. Healthcare organizations could not supply healthy staffing concentrations to ensure quality patient care (Morley et al., 2019).

Barriers and Ethical Concerns

Morley et al. (2019) reported that the medical decision constraints are no longer within clinicians' control due to the pandemic. Moral distress becomes a premier challenge in their ability to find a functional work ethic (Rushton et al., 2020). Contractual obligation had become ambivalent and out of physicians' control (Sheather, 2021). Sheather (2021) found that virtuous employees could no longer practice under such strenuous ethical conditions due to the shortening of care and peer support needed.

The intolerable moments had caused policy and procedure to concede due to rationing resources (Sheather, 2021).

Fourie (2017) discussed that moral distress became broadened due to the universal liability of the patient care, self-care of professionals, and the relationships they experience professionally. The researchers (Rushton et al., 2020) noted that the longevity of this adversity eventually led to post-traumatic stress or under-reported illness that had physical, emotional, or mental concerns. Enhanced dialog among clinicians and providing a foundation to speak openly regarding the lack of care allowed moral distress to be an acceptable approach to emotional processing (Rushton et al., 2020). Unfortunately, there were cuts regarding the number of funds allocated to the wellness of doctors to stay consistent at their best level of practice. As a result, interventions had become creative to manage moral distress (Sheather, 2021).

The resources needed for physician care have focused on proper patient care intervention (Fourie, 2017). Moral distress becoming moral injury has become a pipeline due to the lack of proactive barriers needed during organizational shifts (Rushton et al., 2020). Physicians cannot maintain the Hippocratic oath and ethical duty they were taught to abide by (Rushton et al., 2020). Liability became inevitable when physicians could not meet an organization's requirements (Rushton et al., 2020).

Bioethics during a Life-altering Pandemic

Bioethics was described as an educated, skilled response during moments of adversity for clinical ethics (Vittone & Sotomayor, 2021). Vittone and Sotomayor (2021) reported the goal was to create a level of resilience or intervention to prevent harmful

reactions in the line of duty, such as moral distress. Collective protection can be unstable due to the loss of moral value in policy-driven measures (Vittone & Sotomayor, 2021). Moral distress compromised the integrity clinicians faced to preserve their professional obligation (Vittone & Sotomayor, 2021). The goal of bioethics was to maintain professional resilience while managing care (Vittone & Sotomayor, 2021).

Restoring Professional Integrity during the Pandemic

Moral distress symptoms could not be treated with policy-driven impacts within a pandemic (Zhang et al., 2020). The pandemic was life-altering for physicians, and not being capable of self-preventative interventions to maintain professional and ethical duty affects health organizations (Rushton et al., 2020). The mental anguish that occurred due to providing safety measures and patient-provider accountability exposed the organization's bioethics (Zhang et al., 2020). Ultimately, these organizational decisions created symptoms of moral distress (Zhang et al., 2020). Berg (2020) reported that the relationship between patient and doctor was skewed, so no healthcare system was prepared for. The human connection was part of the healing process (Berg, 2020). The inability to be present in their time of need degraded the moral responsibility that validated the level of care expected (Berg, 2020). Moral distress had become psychologically and ethically damaging to the point that policy and procedure did not fully identify the exertion doctors were putting through (Sheather 2021). The time needed for reflection and self-care was not considered within organizational development during the pandemic (Sheather, 2021).

The authors (Zhang et al., 2020) found that crisis management no longer became a solution-focused intervention, and unstable procedures were inevitable. The COVID-19 pandemic had challenged ethics to the point of clarity not being a form of understanding (Zhang et al., 2020). As a result, the authors found constraints and professional obligations affect practices beyond their legal consideration. Professional judgment and healthcare system authority was unbalanced (Sheather, 2021).

The Future of Moral Distress

Hu and Dill (2021) reported the COVID-19 pandemic had reduced the ability of physicians to ultimately make earnings. This decline in earnings was occurring within the past two years (Hu & Dill, 2021). Furthermore, the restriction and forced flexibility had decreased physician work hours. Hu and Dill (2021) noticed the lack of physicians working caused an obligation that exacerbated moral distress. Physicians were denied their full-time work status because of organizational care funding and regulatory changes. The authors reported their work and activities decreased from 83.9% to 78% (Hu & Dill, 2021). Female physicians' work decreased from 17.98% to 14.10% (Hu & Dill, 2021).

Jameton (1984 & 2017) concluded that moral distress caused more healthcare dilemmas in the following decades. The pandemic was a mere forecast of the amount of havoc our healthcare system was internally in (Jameton, 2017). Moral injury is the result of unattended moral distress (Frezza, 2019). The layers that went into developing emotional trauma had reached clinicians to the point of helplessness. This once nurse-defined definition had evolved into something that transmutes into other communities and no longer had a barrier to resilience (Jameton, 1984, 2017).

Garcia (2021) reported that the future of the COVID-19 would not go away any time soon due to the variants and lack of preventable measures that are not taken. Since October 2021, 65% of the population in the U.S. have received one dose of the COVID-19 vaccine, and of those, 56% of that population had been fully vaccinated. They reported that COVID-19 transfers through communities that do not have the proper support, and the last wave of the virus was unsure due to the winter months (Andrea Garcia, 2021).

Jameton (2017) recognized that what would transpire in the future will only be deterred if policy and organizational support step in advocacy rather than policy. The years of research had only led to other inevitable trauma and moral distress becoming the onset of these secondary traumas (Frezza, 2019). Jameton (2017) believed that the only chance to change the protection outcome for these clinicians was to put them in the front line of the policy change and resources.

Summary and Conclusion

The pandemic had become a life-changing experience for physicians. From learning the evolution of moral distress, physicians were no longer protected in ways organizations can commit. The COVID-19 pandemic created a level of severe exposure that physicians were not trained for. Research found the result of moral distress as moral injury, becoming more prevalent than expected (Dean & Simon-Talbot, 2019). Research also found moral distress to be the foundation within secondary traumatic responses (including moral injury) and overall physician’s wellbeing (Daubman et al., 2020). There was no current answer in the literature for a modern solution because the pandemic

currently affects physicians and healthcare organizations daily (Garcia, 2021). Literature regarding the emotional perception of physicians and their interventions to such drastic changes within healthcare was insubstantial at this time.

Moral distress had become a link to many pandemic-related barriers for first responders and medical professionals (Jameton, 2017). Jameton (2017) understood that the prevalence of moral distress created more barriers to self-awareness and emotional restoration. This study was needed to understand moral distress's reoccurrences and find mapping within the reaction towards it (Hu & Dill, 2021).

This study became the gap in addressing how moral distress can be understood internally and may provide more research opportunities to find alternative healing solutions. Research must begin to consider the perception of physicians and allow their processing to be documented (Morley et al., 2019). Chapter 3 I explained the overview of the generic qualitative research design and approach

Chapter 3: Research Method

Introduction

The purpose of the research study was to study physicians' perception of moral distress during the pandemic. Because moral distress was evolving and present in other medical professions, it was imperative to understand a physician's perception of it before secondary trauma was expressed (Hu & Dill, 2021). Unfortunately, the medical and mental health community did not know how to thoroughly alleviate the symptoms of moral distress and administer preventative interventions to cease the suffering (Daubman et al., 2020). The research question focused on physicians' perception of moral distress due to pandemic-related adversity. This chapter includes a review of this study's research methods, design, and evidence-based justification. Walden's University's Institutional Review Board (IRB) was utilized for ethical guidance and overview of candidate selection.

Research Question

What are physicians' perceptions of moral distress during the COVID-19 pandemic?

Research Design and Rationale

Generic Qualitative Research Design Rationale

A generic qualitative approach utilities inclusive methods to capture the participants' view of the phenomena (Kostere & Kostere, 2021). By capturing people's subjective opinions, beliefs, and awareness, a generic qualitative approach focuses on broad notions to develop themes. This methodology allowed physicians to describe moral

distress in a manner that captured the perception of emotional severity during the pandemic (Kostere & Kostere, 2021).

Role of the Researcher

As the primary instrument, my role as the qualitative researcher is to gather the study participants' rich and in-depth perceptions regarding moral distress during the pandemic. In this process, I maintain active and utilize ongoing reflexivity or self-reflection to maintain awareness regarding my biases about research settings, how I selected participants, and how my personal experiences affected my research or relationships with the participants. I also used self-reflection practices regarding the data generated and my interpretation of the data analysis. I frequently assessed my positionality and subjectivities on how this could influence my study. As the researcher, I was transparent by maintaining a journal or diary to document my biases, thoughts, and self-reflection.

Methodology

Population and Sampling Procedures

The population was physicians that provided treatment for COVID-19 patients during the pandemic. Using snowball sampling, a derivative of purpose sampling, I utilized networking of criteria-based characteristics as a means of recruitment for the doctors (Parker et al., 2019). Snowball sampling was chosen due to the subgroup of physicians. Their specific work focus during the pandemic created an inclusive network. The number of participants required for this study was eight to 10, as supported by Kostere and Kostere (2021). Because the requirements of the participants were specific to

the pandemic, the saturation of the data collected would be consistent, due to the specificity of treatment needed to align with the study. To ensure saturation was met, I asked the participants to share the recruitment flyer with other possible participants based on the same criteria-based characteristics, and I ensured the right sample size of eight to 10 participants was achieved (Parker et al., 2019).

Inclusion and Exclusion Criteria

The population was specific. I recruited physicians (medical doctors) that treated patients with COVID-19 since 2019 to ensure they had completed school before coming to the knowledge of the virus. Their practice locations were actively attended within the United States and was affected by the pandemic. Participants were sent an email asking if they had pandemic-related stressors, and if they knew the definition of moral distress. Once participants met the qualifications, they were offered timeslots that could be added to their calendar from Calendly with videoconferencing information connected to the slot.

Instrumentation

Semi-structured interview questions were deemed by Kallio et al. (2016) as more natural as a data-collecting method for qualitative studies. For this study, I created a semi-structured interview with seven open-ended questions. The seven semi-structured interview questions ensured physicians' perceptions were recorded accurately. The seven interview questions were developed from the peer reviewed literature and the moral distress conceptual framework. Interview question one was inspired by Vittone and Sotomayer's (2021) research discussing the difficulty physicians experience with treatment options. As a result, physicians were forced to witness patients suffer from

moral distress due to treatment options not being guided by the best standard of practice (Vittone & Sotomayer, 2021). Interview question two helped me understand the efforts of healthcare organizations supporting physicians (Sheather & Fidler, 2021). The researchers found that organizations contributed to moral distress due to their inability to support their physicians with resources (Sheather & Fidler, 2021). Interview question three was designed based on Spilg et al. (2022) because the adjustments that occurred before and during the pandemic made it stressful for physicians. The positions physicians were once in control of no longer had the same effect, and many of their obligations changed without appropriate preparation (Spilg et al., 2022). Interview question four was inspired by Jameton's (1984) first definition of moral distress. Interview question five was designed in alignment with Frezza (2019) regarding the severity of moral distress increasing the risk of suicide for physicians. Frezza (2019) noticed that moral distress became more prevalent during the pandemic, and secondary traumas resulted from prolonged exposure. Question six was constructed based on Berg's (2020) understanding of how moral distress symptoms have increased in intensity. Interview question seven was designed from the most recent conversation I had with Jameton regarding the future of moral distress. The data collected presents more alignment due to the semi-structured questions, creating perceptions of moral distress to be more detailed.

The interview was an open-ended dialogue with interview questions (Appendix A) asking about moral distress and their perspective of moral distress during the pandemic (since COVID-19 was officially acknowledged). My committee qualitative

methods expert reviewed the instrument for consistency with the research question and content validity.

Procedures for Pre-test

The semi-structured interviews for the research are opened-ended dialogues using semi-structured interview questions that focus on moral distress and physicians' perceptions during the pandemic. The questions were reviewed and given feedback to ensure no obscurities resulted from interview guidance. For the pre-test, I interviewed a family member that is a medical professional, which ensured that the collection tools and instrument used were clear, focused, and aligned with the participants. The purpose of the pre-test was to ensure that the pandemic-related perceptions of moral distress were actively aligned with the procedures and that the effect on emotional health was present. This ensured that the collective instruments were being accurately used.

Procedures for Recruitment, Participation, and Data Collection

I posted a flyer on social media (Facebook groups), group pages (physician networking groups), and my company (Washington Wellness Institute) LinkedIn page. When a participant contacted, I reached physicians through their primary form of contact, social media, group page, or direct message. I asked them if they would share my flyer with their colleagues. My backup plan was to directly contact physicians at private practices with the needed criteria of the study. If they were interested, they scheduled for the most convenient time with a consent form to read and reply that they consent. The consent form provided confidentiality and guidelines per IRB purpose at Walden University to ensure that identity was protected and their ability to stop the study was

within their rights (Appendix B). Each participant was read the consent form to participate in the study.

I used a 60-minute videoconferencing platform (Google Meet) for interviewing the participant. The videoconferencing software recorded the responses with a closed captioning setup. I collected the data through videoconferencing, and a transcript of the recording will be documented as well. If recruitment resulted in too few participants, the follow-up plan was to find an alternative method of contacting participants who were once interested by asking if they were interested in participating in the study.

For debriefing, participants were thanked and given a debriefing sheet (Appendix D) regarding options for further help if they felt emotionally distressed based upon their sharing of awareness. The debriefing paragraph was read to the participant, asking if there was any other information that should be considered prior to ending the study. I will let them know that their transcript will be emailed to them and reviewed for accuracy, and allowed them the opportunity to add, remove, or edit any information. There were no follow-up requirements after their acceptance due to the information regarding further care will be listed during the debriefing.

Data Analysis Plan

Each interview was transcribed through the videoconferencing software (Google Meet). The videoconference was translated into an audio file, and alphanumeric identifiers such as ‘P1’ was used to ensure participants’ confidentiality. I read through the transcripts multiple times to ensure the data transcribing was accurate. The organizing of the data was done via Microsoft Word data analysis table. Braun and Clarke’s (2006) six

thematic analysis steps were used to identify codes, categories, and presenting themes. The thematic phases Braun and Clarke (2006) proceeded as,

I familiarized myself with the data, giving self-assurance that the content was well-versed to engage the data actively. I immersed myself in the data by reading the transcripts multiple times to identify meanings and emerging patterns. I noted ideas or highlight potential interests of the recording. The focus was on gathering information and not deducing information at this time.

I surveyed patterns or noted recognizable data to initiate coding, creating meaningful phenomena. Coding features collected ensured data was imperative to each code. I began making labels or tags on another document to make sure the relevant data was gathered. The research question was at the focus of this moment because the coding is based on alignment. Some codes were semantic because they mirrored the participants' language. The latent codes were considered after the recording to ensure an appropriate list of codes were aligned with the research question.

I explored themes by organizing codes and finding similarities formed into other themes. The focus was to generate themes by building from the codes gathered. I clustered other codes that aligned to create the theme. Thematic maps/tables were used to help align potential relationships. This was an interpretive process that focuses on having shared meaning when clustering the data.

I ensured that the themes were conclusive and data-driven to be supported. I started testing the themes and check the frequency of the themes. I determined if the theme had enough quality and focus on reflection on the coded data. This step cannot be

finished until I feel there are qualities and boundaries that reflected the coding and were consistent with all themes presented amongst other participants' data.

I generated definitions and themes, naming them based on supported data. I made the central concept of the theme an abstract-descriptive label. A definition of a few hundred words gave the framework of how the theme was presented. The number of themes chosen were enough to bridge the themes together and present the report without fragmenting the data. To avoid fragmentation, no more than three theme levels were used (overarching themes, themes, sub-themes).

I analyzed the data collected to create a report. I selected the order in which to present the themes. Each theme was built into each other and provided compelling data to reflect the research question and literature. Analytic conclusions across the themes were presented to ensure the themes were illustrated appropriately.

Interviews were organized through an Excel spreadsheet, while manual hand-coding was also integrated to analyze and provide the trustworthiness of the study. Chapter 4 described themes and subthemes to further the data analysis process.

Issues of Trustworthiness

The following sections were organized: trustworthiness, credibility, transferability, dependability, confirmability, and member checking.

Trustworthiness

Generic qualitative research created room for biases due to experiences related to the participant's first responder lifestyle. Therefore, reflexivity allowed my ability to establish credibility to be found. Each participant was emailed their

transcription to be approved and checked for accuracy to ensure credibility. The method of reaching out with flyers to participants was only followed up if there was a response rather than reaching out a second time. After the specific timeframe had waited, saturation was exhausted to ensure validity. Regarding member checking, participants were given their interview transcripts to ensure no errors or inaccuracies. Phone and email were permitted if any adjustments or corrections were needed from the interview.

Credibility

Qualitative research studies establish credibility through member checking and exhausting all resources (Braun & Clarke, 2021). I received physicians' perceptions of their experiences through member checking before the interview. Afterward, transcripts were reviewed, and feedback was discussed.

Transferability

Transferability ensured that the research study applied to other research (Gutierrez, 2021). Transferability was confirmed using the snowball sampling method because purposive sampling directly affected outreach (Parker et al., 2019). Processing information to offer generalizations as a result of data collection provided future implications for the research (Gutierrez, 2021).

Dependability

Dependability was essential for qualitative research because it verified how relevant research would be (Creswell & Poth, 2016). Through various methods such as triangulation and peer examination, data collection can produce new findings (Creswell

& Poth, 2016). Using videoconferencing, Audio replays, and manual/auto transcriptions allowed documentation to be align to the qualitative study.

Confirmability

Confirmability was needed during the research process to ensure objectivity was validating data. An auditing process occurs to confirm the findings were objective and the process was accurate (Creswell & Poth, 2016).

Member Checking

Member checking provides accurate information that was disseminated as a result of the research study transcriptions (Creswell & Poth 2016). The participants were emailed to ensure whatever changes were needed and verified for alignment.

Ethical Procedures

This study followed Walden University's IRB and HIPPA compliant regulations in the United States to ensure confidentiality. All outreach occurs after Walden's IRB approval and interview questions aligned with Walden University's IRB guidelines.

Confidentiality was essential for this topic due to the environment and current pandemic. Hospitals were currently in transition, adjusting to the rigorous safety measures, and their policies are strict when divulging information. Participants' confidentiality was supported by consent, created by Walden University's IRB.

Treatment of Human Participants

All participant demographic information was removed to secure confidentiality. Therefore, name, address, phone number, and hospital were released. The dissertation chair, committee members, and I were the only people privy to participant information.

Treatment of Data

A consent form was created to maintain confidentiality and hold the researcher accountable for privacy. The research data was kept in Google Drive secured for future research. The data was kept for seven years per the ethical guidelines of the American Psychological Association (APA, 2020)

Threats to Validity

The chair and committee members review the interview instrument and give feedback. The participant also had autonomy, choosing to step down from the interview if they felt like they did not want to continue. A thank you card was given for their participation, and I refer them to a local therapeutic provider if they felt as if mental health was affected. The National Suicide Prevention Lifeline at 1-800-273-8255 was also sent to ensure care.

Summary

Chapter 3 explained the generic qualitative research process and design approach. I selected generic qualitative approach to gather the perceptions of moral distress in physicians due to the pandemic. I explained the researcher's role and methods and reviews to ensure the research study met compliancy. The semi-structured interviews were manually transcribed, followed by hand-coding and thematic conclusions.

The research design, rationale, role, methodology, population and sampling procedures, inclusion and exclusion criteria, instrumentation, procedures for instrument pilot test, strategies for recruitment, participation, qualitative data analysis pan, data collection, issues of trustworthiness, credibility, transferability, dependability,

confirmability, member checking, trustworthiness, ethical procedures, treatment to human participants, treatment of data, and threats to validity were all addressed for Walden University's IRB guidelines. Chapter 4 discussed the setting, demographics, data analysis, results, and summary. Chapter 5 had the conclusive findings, limitations, recommendations, further implications of research, and conclusion of the study.

Chapter 4: Results

Introduction

Jameton (1984) was the first researcher to acknowledge that there is a level of emotional distress that occurs when the feeling or perception of inability and occupational engagement is constricted. Physicians during the pandemic became an at-risk demographic of medical professionals that were products of a broken healthcare system (Brydges et. al, 2020). It was essential to understand the perception of physicians regarding moral distress due to their contribution to the healthcare field. The purpose of this generic qualitative approach was to study physicians' perception of moral distress during the COVID-19 pandemic. One research question guided the study. Jameton's definition of moral distress was presented as my conceptual framework. My study's research question was as follows: What are physicians' perceptions of moral distress during the COVID-19 pandemic?

In this chapter, I present the results aligned with this generic qualitative study. The chapter will begin with the research setting, followed by the participants' demographics. The data analysis process will be explained in alignment with chapter 3 and how it was used during the data collection step.

Pilot Study

The purpose of the pilot study was to gain an understanding of how the interview would be done and ensure that the questions were aligned to the study. I asked a fellow relative that is a physician if they could treat the pilot as an interview and critique the questions for clarity. I tested the interview over Google Meet and learned how the open-

ended questions were perceived. I was reassured regarding the questions and gained techniques on how to ensure note taking was accurate, as well as how to probe for more explanation. The pilot study was not completed until I received Walden IRB approval.

Research Setting

For this research, the ability to provide a confidential setting was not difficult due to the consent form prepping the requirements for a safe environment. Videoconferencing (Google Meet) software ensured that the participant was in a safe space prior to conducting the interview. I completed interviews with a total of eight participants. Each participant was instructed to remain in a confidential setting for the interview's duration. Organizational conditions were not a factor or had any influence on the participants or results.

Demographics

The eight research participants were all doctors that served patients throughout the pandemic. There were four female and four male participants in the interview process. One participant owned their own medical facility, whereas the other seven participants worked for hospitals. Each participant had different numbers of years practicing and different specializations. Overall, their involvement in COVID-19 heavily impacted their ability to provide treatment of care as attending physicians.

Data Collection

The research study instrument was a questionnaire with seven open-ended semi-structured questions asking in an interview form for up to 60 minutes to gather the perception of moral distress on physicians during the COVID-19 pandemic. After

receiving approval number (08-25-22-0670932) from Walden's IRB on August 25, 2022, I initiated the collection process. I posted the flyer on Facebook and other physician networks, asking them to send the recruitment document to their social media groups. I asked those that did consent to the study if they were also willing to share the recruitment flyer with other eligible medical professionals.

The interview questions were used to obtain participants' perception of moral distress during the pandemic. There were a total of eight participants, and all interviews were conducted on Google Meet, as well as its third-party application to transcribe each interview. After each interview was transcribed, it was automatically saved. Each interview took no longer than 60 mins. The data were stored securely on Google Drive, and only the researcher and committee chair had access to the documents. Each interview was checked for accuracy, then sent to the participant for member checking. Member checking was done by email, through which I asked the participant for feedback or changes needed. There were no major changes or situations encountered in the data collection process.

Data Analysis

For my data analysis, Braun & Clark's (2006) six-step thematic analysis was used to refine the data codes, categories, and themes. The participants were identified alphanumerically as P1-P8 for confidentiality. After transcribing the interviews and having them member checked for accuracy, I became familiar with the data. I read the interviews multiple times and became more comfortable with the interview responses as the first step. The second step was creating initial codes by identifying similarities within

the transcription. The coding was done by hand; there was no other qualitative data analysis software used to interpret the data. I took phrases or patterns and piled them together to find categories and eventually emergent themes once the categories kept repeating.

For the first attempt in cycle coding, 100 codes were analyzed. After much processing, the second cycling coding presented 64 codes analyzed. The codes were reduced based upon the relevancy of the categories formed. Some codes did not have the same relevance once categories were created. Some codes came from isolated events and did not have alignment with other interviews. I also found that some categories were aligned with others, which allowed me to combine some of them. The grouping helped me find boundaries within the codes found and placement for them within the categories. The 64 codes were grouped into eight groups and 13 categories. The data cycled to the point of pattern occurrences, and emergent themes became clearer. The fifth step of Braun and Clark’s (2006) six-step thematic analysis was to define and list the four themes and four subthemes that did occur. The final step presented the final codes, categories, and themes to a codebook spreadsheet made by using Microsoft Word. There were no conflicting cases found in the analysis of this analysis.

Evidence of Trustworthiness

Credibility

Credibility was established through the member checking done post interview. All the participants reported that the transcription required no changes, and it accurately reflected their sentiments and perception of moral distress. The information provided

during each interview question was given and responded to with equal participation. In addition, any remaining or last words that the participant wanted to add were offered at the end of the interview to ensure that the participant felt it was complete. Participants were told the purpose of the research study during the interview for alignment, as well as my contact information if there were any other needs regarding their interview.

Transferability

Transferability was completed by providing requirements to participate in the study, ultimately creating a specific demographic of the medical profession. Narrowing the requirements for participation to physicians and their treatment of patients during the pandemic provided enough transferability for future research. The requirements were general enough to be used by other researchers.

Dependability

I ensured that the study was referenced-checked, transcriptions were accurate, and diary notes were aligned throughout the interviews. I used probing statements to ensure each participant was able to thoroughly answer each question. A pilot study was completed to ensure the quality of interview questions, and videoconferencing was used to ensure the interview recording process was not distracting.

Confirmability

During the data collection process, I would engage with the participants, ensuring their response was complete. I would ask open-ended probing statements to understand what they meant by an answer. I ensured that confidentiality was respected, and personal perception or beliefs were not shared to safeguard that my influence was not reflected

upon the research study topic. I used active listening skills such as acknowledging the information provided by the participant to support their response.

Results

Four themes emerged from the data analysis based on the central research question (see Table 1). The eight participants were given seven semi-structured interview questions that examined their perception of moral distress during the pandemic. The themes emerged from the perception of moral distress resulted in a cycling effect.

Table 1

Emergent Themes

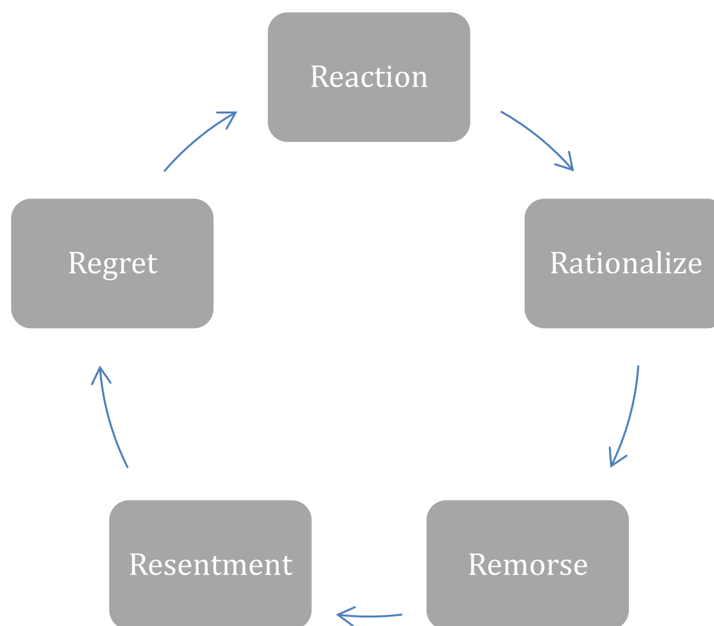
Themes	Subthemes
Theme 1 The system was reactive, causing maladaptive behaviors.	Subtheme 1A Physicians were put into conditions that lacked resource, updated knowledge, and provider support.
Theme 2 Physicians rationalized their performance and devotion, unaware of internalized burdens and conditioned self-concept.	Subtheme 2A Lack of treatment options and decisions without break caused moral dilemma and radical acceptance on their patient attending ability (remorse).
Theme 3 Physicians became resentful towards the healthcare system and feel as if they cannot return to normal conditions of treatment.	Subtheme 3A Emotionally callused due to not being heard and having to perform beyond their ethical training
Theme 4 Physicians regret how they have no power in the wellbeing of their patients and disregard their own self-awareness.	Subtheme 4A Being reminded of their own Self-care as a "lip service" from the healthcare organization.

Note. The subthemes are substantial and aligned to the related emergent themes.

After the emergent themes and subthemes were established, a cycle was noticed (see Figure 1). This reflects the themes and subtheme pattern actively occurring but in stages.

Figure 1

Moral Distress Cycle – Emotional Callusing



Theme 1: ***The System was Reactive, Causing Maladaptive Behaviors.***

Each participant had been a part of the healthcare system and had represented an organization during their career. Through the pandemic, it was evident that they all found a level of inevitable changes in the system as it adjusted through the pandemic. This theme emerged from the participants' response to their feelings of uncertainty over the reactive measures the healthcare system went through. Although participants were in different specialties within the healthcare system, they all experienced being forced to comply with a system that did not hold accountability for how change would be navigated through their treatment options. P1 shared the following.

> There's all sorts of just regulations and paperwork and test lists that the public has no idea that doctors have to do. And from our standpoint, it's a complete waste of time. All we care about is treating the patient, giving us all the paperwork and all the billing and all that stuff. That's just kind of annoying to us, but I can honestly say that for me, all that stuff with the organization mostly went out the window because I just didn't care, because I personally was just like, what are you going to do to me? All the rules for me just went out the window.

The participants noticed that the system was protecting itself and removed themselves from being a boundary from medical system shortcomings. P2 shared,

> I think if I saw my organization focus on kind of prioritizing with their physicians, I would see a difference in moral distress. Put more energy kind of processing it, and knowing that it was taken more seriously. It does have a longer-term impact than what it is seen as. I think we had kind of a lot of appreciation in the sense of like, oh, thanks for going into work, health care heroes and kind of just acknowledgement for kind of what we did. But as time went on, that kind of waned and went away, even though what we did was consistent and still there. And I think the kind of approach where we want to take care of our health care workers and kind of avoid them from being so jaded would kind of changed my perception of it. Kind of more of an organizational focus. Like a true. Like true intervention on how things could be better or how things can be improved for us in the long run.

Subtheme 1A: Physicians Were Put Into Conditions That Lacked Resource, Updated Knowledge, and Provider Support.

Many of the participants explained that their ability to live within limitation and expected care was an affront to their dedication. One participant talked about knowing that the lives of their patients could not be mourned over as they would normally do, simply because they knew from the beginning there were no other treatment options that could be considered. While participants reported that they did everything possible to provide the best treatment, they created irrational reactions rather than healthy responses to care. Participants reported that the efforts to learn updates to care, debunk false information, and accept the hospital's inability created a level of stress unfamiliar to their typical experiences. Participants had to believe in something greater than the healthcare organization they devoted themselves to. P3 shared,

> The concerns were primal. Are we going to make it or our loved one's going to make it? I had family patients who died. You know, my concerns were more basic survival stuff. Now it's back to the norms of treating patients and the constraints of medical insurances and the typical things that I was dealing with before the pandemic. When it was the pandemic, I was praying for my patients, hoping all of them will survive. You know, that's the difference. It was just more of a survival mentality during the pandemic.

Most of the participants felt as if they already sentenced patients and had to emotionally accept that they had dead patients walking in. P1 felt as if they had to take their own risks to ensure that the process of death was respectful because the hospital did not have

an answer for their patients' families. P7 acknowledged that more of their work included calling families and giving updates frequently of their loved one's death updates. P2 shared,

> As I mentioned, it hit so close to home and there wasn't time to process in it because any talking we'd reflect with coworkers about it, but that would now hit closer to home or a more tragic story behind it. Like one example is that I saw a patient, a mother, that I was treating for COVID. She had told me that very day when the ambulance went to go pick her up, she had woke up to her son, finding her son dead from COVID. And she was still processing that as she was in the hospital herself being hospitalized for COVID.

P6 shared,

> The burden of getting people to actually do their actual job while we're here, it became a little bit stressful. And then the paperwork, especially, this happened more at the height of when it first started. There wasn't a clear protocol for how to handle patients. So basically, you go to one center and in one center you were doing this procedure, no problem. And the next center, they're saying, well, we don't do that procedure just because the person, the patient, is to be tested for a cold first and needs to be proven to be negative. And sometimes it's stresses me out because, you know, in the grand scheme of things that this patient probably needs this procedure. And then another thing that was happening was patients were being categorized with something random as to what procedures were okay to do, and what procedures were not emergent.

Theme 2: ***Physicians Rationalized Their Performance and Devotion, Unaware of Internalized Burdens and Conditioned Self-concept***

Participants noted that being under a fractured system put them into positions they normally would never be in control of. This created a new rationalization of performance and devotion that participants recognized through the interview process. The theme emerged from the level of awareness of their own internalized burdens due to rationalizing multiple events that were covered under performance and devotion. Some participants mentioned how they never took the time to recognize their symptomology or internalized burdens because they "signed up for this life," unaware of the emotional distress that has impacted them. P7 shared,

> I think maybe not everybody felt this way. I definitely felt like this was just a part of my job as a doctor, and I really didn't. I...I feel super upset. I kind of was like, I never got COVID throughout the time, which is like amazing. A lot of my colleagues did. Somehow, I did not, but I really didn't think twice about it. I was kind of just like, this is part of my job as a doctor. This is what I signed up for. I mean, I didn't think I'd be training through a pandemic, but for me, I kind of was like, this is just, you know, we chose this job and we're supposed to treat sick patients. So I think for me, I, I felt like this was just what I was supposed to be doing.

Participants believed many of their cases required more than case-to-case mindsets, and some felt they had to remove themselves from expectations they once believed in. P7

reported that they felt as if they couldn't feel bad for their patients, knowing that they could of done more and felt emotional dissociation. P1 Shared,

> I have this really sick patient here, they are on oxygen, they're intubated on a ventilator and the oxygen is still 70%. I'm maxing out everything I can do. They're dying in front of me, and I can't get them what they need. For whatever reason, there's no ambulances left. They're all out. There's no ICU beds, there's no nurses. You know, whatever reason, I cannot get them out of my E.R. and I'm not going to be as good as an ICU doctor and taking care of that. So they really need to get there. And you're just, like, helpless. And it sucks. But yeah, there's literally nothing you can do. And so that sucks and it doesn't feel good. And I guess I'll get to how I handle that internally later.

Participants began understanding their own perception of moral distress when revisiting what they endured and recognized other mental health symptoms within them. P2 shared,

> I think a lot of my colleagues even joke that we probably don't even know it, but a lot of us have just PTSD from what we've seen the last two years. And what we've experienced ourselves treating patients that have gone through and what has happened with us within the last few years, I think, does have a lasting impact on how we do treat patients in the future.

Many participants acknowledged that their rationalizing of traumatic moments caused an emotional callus with how healthcare systems have moved on from the pandemic level of attention. Participants were shocked by how the system "moved on"

from what the participants had done to save patients' lives, and now they have rationalized medical abandonment.

Subtheme 2A: Lack of Treatment Options and Decisions Without Break Caused Moral Dilemma and Radical Acceptance on Their Patient Attending Ability (Remorse).

All participants perceived their treatment options as inevitable because breaks were not given while patients suffered. The mentality that was created during this pandemic focused upon what the participants could only output, creating demands that participants would typically be unwilling to perform. P5 shared,

> For instance, a few months ago, deciding what patients get it [medication]. And then patients were sometimes upset. You're not offering it to me because "X" and it was a really hard drug to prescribe. And so trying to make sure, number one, I'm giving it to the right people and then I'm not withholding it from other people sometimes make me feel like, are we all kind of playing God? Because there wasn't any really good data.

All participants felt a level of relentless power and no ability to have a cooldown in treatment options and decisions. Many of the participants became more willing accept treatment on their own terms because the healthcare organization would not deliver options fast enough. P1 stated that they challenged medical policies because they knew they could not fire then because of the need for staff. P7 also found themselves without rest and being put into many expectations that were limiting. P1 shared,

> I don't think it's like affected me in terms of like my daily life and moving around and doing all that. Maybe it has and I just don't know it. I'm not a super, super emotional guy, so I'm pretty good at being like that, but that really sucks. And like, I have sympathy and empathy and you got to do the best you can. Like, I'm not God, I'm one person. I may be a doctor, but like, I can only do what I can do and I just. I just move on. Hopefully that makes sense.

P1 shared,

> I can't take a break and I have to walk in there. And you [patient] might be like, I've been waiting for 3 hours. So what do I say to that? I'm sorry. Well, there's a dead baby right next to it [patient room]. I can't say that. When I just got out of a room of a crying mom whose kid just died. So part of the nature of self-selecting is you've got to be able to. It may sound bad but you have to move on to the next one. What are you going to do? Go outside and take a one hour break? What are all those air patients going to do? Someone else with a heart attack going to come in and die? You can't take a break. So, on one hand, it's like, how do you handle it? Well, you swallow it up and move on.

Theme 3: Physicians Become Resentful Towards The Healthcare System and Feel As If They Cannot Return to Normal Conditions of Treatment

Every participant did not have positive emotions regarding the stabilization of the pandemic. Many participants identified that the feeling of "acting as if nothing happened" was insulting to their level of devotion. P8 acknowledged that the system never valued them, and they could only perform requirements over genuine care. While many

participants stayed in their respective healthcare organizations, some refused to return to normal conditions of treatment because they had been exposed to a level of harm that could "turn on" again. The theme that emerged came from the number of dissociative actions that took place and actualizations due to the healthcare system not acknowledging what physicians went through. All participants reported having feelings of resentment and losing empathy for patients that did not get vaccinated. P8 stated, "I feel sometimes like I'm a cog in the wheel until you talk about these systems that are in place." Other participants found themselves unable to be the change that they could be because the system did not provide the space for assistance, or they had to perform against their own belief. P6 shared,

> So as an institution the big hurdle is kind of having to maneuver a big ship with a lot of individuals, personalities and situations and still trying to steer it the right way. And, you know, you're going to get some collateral damage just because you cannot conform to everybody's specific needs, because the mission of the ship is to get patient care taken care of.

Many participants acknowledged that how they were being treated was as if the pandemic was over and never existed. The residual effect of this experienced gave participants a level of resentment towards the healthcare system and how they normalize their daily function. There was also the P1 shared this sentiment,

> And I'm curious to see what the history books are going to say in 20 years. I don't know if you have kids but our kids are going to be like, what was it like? They're

> going to say that we're going to be like, I don't know, you just stayed home all day. Like, I don't know how to explain it. We just stayed home all day long.

P8 shared,

> Like, am I just like a conduit for like the drug companies to a patient? Like, am I really actually like implementing change? And yeah. So I think sometimes that can get a little overwhelming and you get a little bit of the compassion fatigue, but. I don't know. I just I even think yeah, I think that the patients that I do work with, they seem to give me feedback and they let me know. I'm asking for the feedback, and they kind of give that feedback like, hey, you [P8] are making an impact. And that seems to help when it seems like a lot of the things are way above our heads and a lot of our attempts to change or fix things are like futile, I guess.

All participants found their return to normalized treatment standards had been an unhealthy adjustment. While some had to change departments because of the shortage of care, some had to accept that they could not move on and had to become what the system demanded. P4 shared,

> What I was witnessing on a health system basis, also what I was witnessing within my own community, identifying as a black woman and being postpartum, it really forced me to like make or reinforce connections with people who had shared identifiers as me because there was no way I was going to return that to the health system. And I knew early that I was not going to be able to return with sanity, with renewed compassion for this work without it.

Subtheme 3A: Emotionally Callused Due to Not Being Heard and Having to Perform Beyond Their Ethical Training.

All participants found alternative coping mechanisms to help maintain their consistency in care. While many participants repressed their emotions, some used dark humor, fascination, or their colleagues to find foundation to their unexplained emotional distress. P7 shared,

> I'll be honest, sometimes we used a lot of dark humor to get through things. I hate to say that, but I think. I think a lot of it helped being with fellow residents that were in the same boat. You know, sometimes I would come home and talk to my husband. But, you know, I think talking to somebody that was in the same boat as me and knowing that they're struggling, too, and that this is very mentally taxing, was something that was helpful. And I know that, you know, our hospital has like a somebody specific for physicians that I could have spoken to during this time. I didn't utilize that. I just chose not to. But it's yeah, I mean, it can be tough. But again, it was just one of those things that like. Not that I was punishing myself saying you signed up for this, but it was just I truly felt like I am a doctor. This is what I'm doing. I'm here to help people. So, I kind of took solace in that, that like I'm doing what I can for my patients. But I think I think a lot of it was just having to see these things and talk with the patient's family and seeing patients that were totally healthy beforehand. And then they come in with five chest tubes and then they die.

P4 Shared,

> I’m working for a much larger institution that is much more financially stable, but they still have margins that we have to reach. And it’s not necessarily how I like to deliver care, but I also choose to work in this environment. I guess it’s distressing in the sense that some days you want to give more, you feel like there is more to give. And some days you just feel like I’m doing the best that I can and it’s still never going to be enough. And so that’s I guess that’s the distressing piece for me is constantly fighting the battle of getting institutions to see where there are needs, where there are gaps, but I’m really getting exhausted from doing the fight.

P1, P4, and P8 were detailed regarding them accepting a healthcare system that was not built for them. As a response, it was their job to dissociate from the level of devotion they were naturally conditioned by. When completing the research study, it was acknowledged how each participant believed in their patient’s wellness and how much they were willing to endure what they were limited by. They made treatments possible for their patient, even if it meant challenging the foundation they represented.

Theme 4: Physicians Regret How They Had No Power in The Wellbeing of Their Patients and Disregarded Their Own Self-awareness

The participants reported being stopped and having treatment options taken from them created a level of regret because they knew what should of happened. Many participants also felt the sense of hope slowly fading with each lost case that walked in. The participants emphasized how their personal beliefs and their ability to care no longer were aligned and the reactions were highly noticeable. At that point, moral distress

became more aware, and their emotional distress in perceiving helplessness became a reality for their well-being. This theme emerged when participants began having notable reasoning why they could hold on to the feeling of hopelessness. P3 shared,

> And, you know, in some ways I failed the patient. You [patient] didn't get me better. That's what the doctor is supposed to do. But I have to be able to deal with myself. My questions are, did I do what I could do. I'm not God, you know, I can't fix everything. So I very much live in that reality that yeah, there's only so much I can do. But did I do what is within my power? And if I did, I go to sleep, you know, that's just kind of how it is. That's the calculus I make in my head that, Hey, did you write the letter? I know it takes extra time. Did you do the prior authorizations to get the medicine? Did you look for coupons for patients to be able to afford their medication? If I did all that, that's within my power, right? The fact that they have an insurance that doesn't cover that, that's not within my power. So I have to be able to function and go on and say, hey, you know, you can't help everybody, unfortunately.

P4 shared,

> So true backing by institutions and medical departments and medical societies or clinicians or providers who are doing community engaged work and not just putting a kind of lip service to it. Actually supporting in time and effort supporting the financial kind of legwork that comes with that backing and funding community-driven research. That at least for me, that's the most distressing part of our work.

The ability to reconnect with self-awareness and provide a sense of clarity within the hopeless was presented by P1, P4, and P8. All participants wanted more from themselves because the feeling of regret and remorse not being able to do more for themselves was not supported by institutions. P4 shared,

> That's how I figured out how to deal with the distress. I don't know if that's the complete answer, but it really forced me to do some internal work and I think the support around me now looks 100% different than what it was like pre-pandemic. And I probably did this years ago or even at the start of my training. I just didn't know how badly I needed it. And so, like, I text regularly with certain people and groups to just maintain sanity and to hone in on my direction as a clinician to kind of recenter my work on the community, which is really what gives me joy. It's the reason why I got into medicine. Not all the hoops and challenges that the institution kind of puts on us. And so that reconnecting to purpose, both personally and professionally, have helped to reconcile the distress of the pandemic.

P8 shared,

> I went to teacher training for yoga during the pandemic. I mean, just how I listen to my body is different. And I was really kind of like go, go, go and do, do, do. And I don't think I really internalize a lot of those experiences. And so I feel like now I'm a little more sensitive to those things. So, I feel like I sometimes experience it more because I'm more in tune with those feelings. And so I'd say, yeah, I'd say that it's more like I think I've opened up things or information or

kind of feelings that I didn't acknowledge. And so now when I do feel them, I kind of stop and listen, and it hurts more, but it's also made me more in touch, which I guess is as good as well.

P5 shared,

I feel like the amount of administrative stuff that I spend doing versus medical is way insane, and I think that's what it's going to take. It has to be a top down approach where they show us that they care about what's actually going on with us and say hey, we're going to take steps to make changes so that you feel good about the care that you're providing and feel good about being from this organization. Right now, medicine is too much of a business for that to happen. But you know, I'm holding out hope that that's maybe slowly changing as we're realizing that medicine shouldn't be a business because it doesn't make sense on any. If you talk to any businessperson, it actually just doesn't make sense at all as a business. And so, I'm hoping that's the thing that will happen because so many doctors are leaving in droves right now. And I'm hoping that they take that as a signal that something's wrong in medicine, that all of us trained so long and we're willing to just leave it behind.

Subtheme 4A: Being Reminded of Their Own Self-care as a "Lip Service" From The Healthcare Organization.

Not every participant was detailed in how they made their own self-care because many believed they were still going through the pandemic. Participants noted how healthcare organizations were moving on and still having constraints being an issue left

them pessimistic. This subtheme emerged due to the lack of support and barriers that remained after the pandemic's height. P5 shared,

> I think if the institutions did more than pay lip service to some of these things because they know that this is happening, they know that we are all working hard to try to provide care that we know we should be, and that there are barriers in the way. And instead of them giving us more of these modules to do about self care and all this, like figure out what can you do to actually support me? Can you hire a scribe? Can you? So that I'm not working on my notes all the time and I can actually provide patient care.

P2 shared,

> Interventions on how things could be better or how things can be improved for us in the long run. Because I think it was kind of touched upon when things got real bad. But despite it getting better, it's not in the spotlight anymore. It's not focused on anymore, even though I think it's still there, a kind of moral injury from COVID.

P3 shared,

> If you work at an institution that has rules, you know, you have to follow. That's the environment you're in. You have constraints. You have to make a living.

However, the participants mentioned that their ability to want self-care and taking ownership of their wellness did improve with understanding how the healthcare system was willing to put them through. P6 shared,

> And that was kind of a theme to learn. This whole setting that the people still showed up for work and we're there to do their job despite the readiness. So yeah, it was a learning experience for everybody. Everybody got something out of it. The whole medical field has changed because of it.

Summary

Regarding the participant's perception of moral distress during the pandemic, the findings revealed that the participants emotionally cycled through a patterned stage of emotions. The first was reactions, causing all participants to create maladaptive behaviors against their conditioned and trained response to any medical adversity. In the second stage, all participants' perceptions were rationalizing experiences and perceiving them as minimal due to their oath and obligation of performance. The third stage was the development of remorse, sensing the perception of hopelessness because of different limitations and subjection. There was an immense perception of guilt and overbearing ownership of their patient's care. The fourth stage was resentment, making all participants feel hopeless about the system they had devoted themselves to and attempting to connect with something more meaningful. The fourth stage was regret, which made all participants repentant regarding who they had to become as a result of the system and for their patients. This patterned stage of emotions would cycle back to the first stage and become more internalized and motive-driven as awareness increased. In doing so, the longer the interview lasted, the more physicians had to state regarding the perception of how moral distress works on them and in the grander scheme of wellness.

Findings indicated that all eight participants believed that the perception of moral distress was an organizational and institutional dilemma with no intention of changing, thus creating internalized burdens. All participants had accepted the unwillingness of genuine support, and being called “Hero” insulted their devotion and sacrifice. Four participants mentioned that the healthcare system ran as a business with no direction toward provider support. Knowing that a company was at the forefront of taking care of those unable to afford medical care created a sense of hopelessness and dissociation towards their obligation to work.

Findings also indicated how the participants perceived their level of moral distress as a societal issue. P3, P4, P8 discussed how institutionalized racism, the George Floyd murder, and how poor communities are also why moral distress was able to be so powerful and destructive in the healthcare system. It affected participants’ identity and ability to navigate self-care and find solace within healthcare institutions. All participants mentioned how they could not trust the institution due to the lack of societal awareness. Two participants stated that their identifiers had to hold more ground than their occupation because they could treat themselves seriously and control what it meant. It was mentioned by P1, P3, P4, and P5 that understanding the work done in their control led to a healthier approach to working in an environment that did not advocate for their wellbeing to provide treatment.

Lastly, all participants agreed that a health institution unwilling to prioritize and understand the moral distress physicians face as they connect to their community was a sign that the healthcare system has never healed. This meant physicians could not find a

solution or healing for that system either. Chapter 4 comprises an overview of the demographics, research setting, data analysis, data collection, evidence of trustworthiness, results, and summary. Chapter 5 consists of the interpretation of findings, limitations of the study, recommendations, implications, and a conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this generic qualitative research study was to understand physicians' perception of moral distress during the pandemic. There had not been any research regarding the perception of moral distress on physicians during the pandemic due to how recently the event occurred. I focused on the perception of moral distress by eight physicians that treated patients during the COVID-19 pandemic. I collected data through in-depth semi-structured interviews via videoconferencing software. The generic qualitative approach was utilized to record, analyze, and understand the perception of moral distress as physicians.

The results of the eight semi-structured interviews demonstrated that moral distress was a cyclic effect and brought awareness to a more significant issue facing the healthcare system. The remainder of Chapter 5 discusses the study's findings to support the information provided in Chapter 2, as well as the limitations, recommendations for future research, implications for social change, and the conclusion of the study. The themes that emerged as a result of understanding the perception of moral distress during the pandemic included the following:

Theme 1: The system was reactive, causing maladaptive behaviors.

Subtheme 1A: Physicians were put into conditions that lacked resources, updated knowledge, and provider support.

Theme 2: Physicians rationalized their performance and devotion, unaware of internalized burdens and conditioned self-concept.

Subtheme 2A: Lack of treatment options and decisions without a break caused moral dilemma and radical acceptance on their patient attending ability (remorse).

Theme 3: Physicians become resentful towards the healthcare system and feel as if they cannot return to normal conditions of treatment.

Subtheme 3A: Emotionally callused due to not being heard and having to perform beyond their ethical training.

Theme 4: Physicians regret how they had no power in the wellbeing of their patients and disregarded their own self-awareness.

Subtheme 4A: Being reminded of their own self-care as a “lip service” from the healthcare organization.

Interpretation of the Findings

Chapter 2 detailed information about the history of diseases, illness, COVID-19, the history of pandemics (Chakraborty & Maity, 2020), and the distress medical professionals experience (Chan et al., 2020). The study’s findings confirmed that physicians’ perception of moral distress was active and affected their perception of care for themselves or their patients. The four themes and subthemes presented the findings from the semi-structured interviews.

Theme 1: The system was reactive, causing maladaptive behaviors

The first finding was that participants acknowledged their behaviors during the pandemic were not normal to what they were conditioned to regarding treatment and operations. The system’s inability to provide a healthy response to an unforgiving virus caused the system to overlook the well-being of its medical professionals. As a result, all

participants reported that their worth felt forfeited for the sake of system integrity, not provider support. The barriers created hindered self-care and resulted in participants reacting with new behaviors that went against standard policy. P1 detailed how they had to undermine policy at times because it never aligned with what was occurring in the ICU, making them create their own form of care. P1 mentioned how they did not care about getting in trouble and had to do what was needed for the patient because there was no time to wait for a new procedure to be implemented.

Past research regarding the pandemic as the greatest unexpected medical challenge was confirmed (Chakraborty & Prasenjit, 2020). Research focusing on the lack of preparation caused professionals to adjust to unscalable amounts of work had increased and not become better (Frezza, 2019). This theme confirmed the past research \ exposing the frailty of the healthcare system and subjecting physicians to levels of stress beyond their training (Kayee et al., 2020).

Subtheme 1A: Physicians were put into conditions that lacked resources, updated knowledge, and provider support.

The first subtheme was that physicians were put into environments that lacked resources and support that would extend their ability to care. P6 mentioned that the barriers faced were systematic and unsupportive of the patient, and the feeling of being considered in a hopeless position of care became demoralizing. P2 stated that the lack of PPE and simple resources to protect their colleagues became traumatic to the point of PTSD, due to the level of exposure. One participant noted that the amount of

misinformation passed to other physicians and having to educate clients became frustrating due to not being able to work in alignment with the system.

The first finding addressed the more significant issue of a system that was never meant to heal. P1 stated that there were noticeable gaps in the ability to protect other physicians trying to do their job, and the healthcare system was not interested in their wellbeing. P4 reported that their identifiers (Mother, Black, wife) were the only way to keep themselves safe from the system so they could do their job and remember the purpose of their vocation. P8 and P3 acknowledged that the system was a reminder of institutionalized racism and being part of a system that was never meant for communities in true need. P4 also mentioned that the system was not meant for poor people who could not afford wellness. The internalized anger caused maladaptive behaviors and apathy toward those unwilling to follow government protocol (vaccines, masks, social distancing).

The past research (Huremović, 2019) on pandemic history and how it affects society was confirmed. This study furthers the understanding of disparities and offsets that have been researched in the past organizationally (medical facilities) (Chakraborty & Prasenjit, 2020). The subtheme extends the past data, recognizing the inequities participants faced within the poor communities served (Berg, 2020). From my findings, I was able to confirm the perception of moral distress Frezza (2019) described. The addition of this research confirmed physicians were overwhelmingly concerned about the liability being unbearable. Within the new research, physicians were no longer afraid of the results of self-treatment and began to reinvest in independent thinking. Further,

Hlubocky et. al (2021) concluded that professional organizations impacted professional burnout during the pandemic. This study confirmed how the lack of flexibility within the healthcare organization caused maladaptive behavior to occur from the lack of supportive resources. This study also confirmed and further supported Kälvemark et al. (2004), who noted how the lack of supportive resources and not discussing ethically troubling situations caused moral distress.

Theme 2: Physicians rationalized their performance and devotion, unaware of internalized burdens and conditioned self-concept.

The second finding is that the study participants indicated rationalizing how bad they were dealing in the pandemic because they "signed up for this." Four of the eight participants mentioned that their ability to continue to work through the pandemic was due to accepting that this is what they signed up for. Many participants rationalized traumatic moments with dark humor or simply "swallowing" the deaths before having to move on to the next patient. One participant mentioned that their moment of reprieve did not exist, and PTSD had been discussed heavily for the past two years. The participants explained how they did not have the time to address how ineffective treatment, care, or support was because the death rates were too high to process. One participant mentioned that most of their job was giving accounts of their family member's death process until completion because of how policy was.

The more participants discussed how unavailable they were to adhere to the processing of what happened throughout the last two years, their awareness of internalized burdens and emotions regarding the impact they made became more evident.

P3 mentioned their frustrations and how they felt about themselves came from what they could control and no longer hope for. Another participant had the same sentiment, describing that they began praying because they were no longer in control of their level of care. All participants found their performance, devotion, and ability to make an impact broken by a system they had to rely upon and became a reflection of that.

Physicians from the study described their secondary trauma responses (burnout, compassion fatigue) from a realization during the interview. This finding confirms Morgantini's et al. (2020) research regarding the factors that contributed to pandemic professional burnout. It was stated by Morgantini et al. (2020) that factors such as limited access to PPE, making life-or-death choices, and shortages of medical supply were common in their reports of burnout stress levels. My study aligned with how physicians first noted that their emotional stress came from the awareness of the healthcare system not being resourceful, not attentive to the adversity being managed by providers.

Once interviews were completed, all participants gained a broader perspective on their internalized burdens. In 2019, Morley et al. had research confirmed as a result of the current study discussing the moral responsibility of healthcare institutions and their ability to engage in health inequities. The current research provided additional information recording the sentiments of physicians discussing how dissociating it was to understand the work they devote themselves to was seen as a business with no intention of supporting the community. The majority of participants in the current study reported how their level of devotion and the support they received were insulting to their ability to be effective in treatment.

Subtheme 2A: Lack of treatment options and decisions without break caused moral dilemma and radical acceptance on their patient attending ability (remorse).

The second subtheme went into further detail of how hindered participants felt. Three of the eight participants recognized feeling like God because they had to choose who could live or die, and there was not enough support to save everyone. All participants mentioned negative emotions when being put into that position because they took their work seriously. All participants felt upset that there were no moments of reset between patients, and many had not acknowledged their processing to ensure proper care was a priority. Three participants were taken out of their departments and put into new environments while learning how to care appropriately. P1 and P2 stated that they had to accept the death of patients that walked in without attempting to try alternative routes because they knew their departments were at capacity.

The subtheme confirmed past research in recognizing the ethical boundaries challenged, moral dilemmas faced, and extensive work that occurred (Kayee et al., 2020). Sheather (2021) confirmed the level of devotion physicians met, acknowledging the underfunding of resources causing psychological distress. Daubman et al. (2020) aligned with this subtheme by describing the moral residual because of unbridled, endless support for their patients. Kayee et al. (2020) indicated that the norm for being considered best work practice was invaded and caused compromised emotional damage to physicians. The level of devotion to maintaining best work practices had been forfeited, causing high levels of moral distress (Kayee et al., 2020). Kayee et al. (2020) aligned with what was found in this study due to the willingness of the physicians and how they accepted their

own inability to process. There were some participants that left and found other workplaces and even changed or considered changing occupations.

Theme 3: Physicians become resentful towards the healthcare system and feel as if they cannot return to normal conditions of treatment.

The study's third finding related to how the resolve and stabilization of the pandemic had not been settling for physicians. Every participant noticed that the healthcare system was attempting to act as if the level of sacrifice that had occurred for the past two years was complete. Participants mentioned that the healthcare resource barriers (PPE, medical equipment, and bed availability) prior to COVID-19 remained, and the level of treatment has not changed. The number of workers that quit and left their profession was a sign that there was still dysfunction within the hospital system. P1 mentioned that physicians are looking for other professions because they cannot handle another pandemic load of treatment. P4 said that without finding outside connections to different communities, their purpose for doing the work ceased to exist. Participants four, six, and eight all explained that their level of self-care had increased and was used to dissociate from the system's expectations, so they no longer felt used.

Some participants explained how they felt the support from the healthcare system was triggering because of the lack of attempts to make it right and how fast they were to normalize policy and protocol without the acknowledgment of physicians. P8 mentioned how they believed it made them separate the difference between self-care and maintaining the boundaries needed to still care about their patients in an environment that was not designed for them to be supported.

No past studies could confirm physicians' ability to return to working conditions due to the pandemic currently happening; however, research by Kälvemark et al. (2004) was confirmed through this study regarding how the decrease of moral distress occurred if organizations took more responsibility with daily care practices and ethically troubling conversations. Much of the past research has not recorded the perception of physicians returning from a pandemic but confirmed past data that caused moral distress. For instance, Kayee et al. (2020) reported that the level of fatigue in stressful conditions heavily increased as the level of devotion to the care occurred. This was confirmed in the study as physicians resented the fact of going back to what appeared normal. The fatigue experienced was not momentary and became a culture of exposure. The research completed in the past confirmed how one participant left their job to find another job that aligned with their values. This theme stood alone, yet brought alignment to the concept of moral distress that Jameton (2017) defines. The current research furthered Rimmer's (2021) study in how physicians are products of their working environments where moral distress creates higher exposure. The current study's findings regarding physicians' perception of moral distress suggested the same changes Rimmer (2021) acknowledged in their study. These changes included funding and resources, increased staffing, empowerment for doctors, workshare culture, and relieving healthcare bureaucracy (Rimmer, 2021). The current research also confirmed Rimmer's (2021) study on how doctors could alleviate their moral distress symptoms. These steps included discussing moral distress, creating networks, speaking out against indifference, seeking advice, and

creating a self-care plan. The findings and results were aligned with the themes presented.

Subtheme 3A: Emotionally callused due to not being heard and having to perform beyond their ethical training.

The third findings subtheme led to participants feeling emotionally callused. Some participants acknowledged that the second wave of COVID-19 was more difficult because they were expected to treat patients the same as the first time, but there was a vaccine, and people were unwilling to get the vaccination. Even with research and proper information, the choice to have empathy towards patients who did not want the vaccine, yet took ventilators from those vaccinated, created an intense perception of moral distress. P1 mentioned that they could not feel sorry for patients who chose not to protect themselves to the best of their ability because of false information. P8 mentioned that they could not perform their best because of how patients would come with false information and could not receive proper treatment. According to participants, society was more against their ability to care, and they also struggled with feeling confident as things changed by the day. Past research discussed the increase of severe mental health symptoms that physicians experienced due to the lack of a supportive environment (Frezza, 2019). This theme extended the research Rushton et al. (2020) discussed about learning how unavailable and unhealthy medical professional engagement and organizational transparency have been within the last three years.

Theme 4: Physicians regret how they had no power in the wellbeing of their patients and disregarded their own self-awareness

The study's final finding demonstrated that participants felt powerless, yet held themselves to high responsibility. Being in this double bind created blind spots in their own health and awareness of self-care. Some participants mentioned they were professionally obligated while emotionally unequipped for treatment. A participant mentioned their devotion to patient's well-being meant going against the system that hosted them. P6 mentioned struggling with being put in departments they were not trained to work in and could only follow protocol because they had no authority or familiarity with the environment.

P7 continuously acknowledged they believed in what a doctor stood for to push through, not knowing what to expect and still be helpful to any colleague. At times, it was mentioned by many participants that the patient was the only reason they could continue to believe in trying each day. Many participants mentioned that they chose their career over their family and loved ones while watching friends mourn over their families. Many participants accepted not returning the same mentally and had to process the reality at the end of the pandemic. Many participants stated in the interviews that they did not believe the pandemic was over because they had not yet addressed their experience. The more participants considered moral distress, they began recognizing behaviors that did not align with their form of self-care.

Sheather (2021) confirmed this theme by acknowledging the contractual obligation becoming out of the physician's control to care for patients. Policy and procedure issues that participants went through highlighted Sheather (2021), Vittone and Sotomayor (2021) research on the loss of moral value. To further, the research study

from the past two years confirmed the theme in acknowledging how physicians compromised integrity for the sake of professional obligation. Berg (2020) extended what participants struggled with by becoming emotionally distressed by the lack of human connection during the pandemic. The lack of self-care ethically damaged physicians (Sheather, 2021). Frezza (2019) acknowledged the importance of emotional liability physicians faced, and the current study confirmed the level of thought-processing that physicians were exposed to.

Subtheme 4A: Being reminded of their own Self-care as a "lip service" from the healthcare organization.

The subtheme detailed the support the healthcare system gave was disingenuous due to the continuation of inadequate reconnection. P5 mentioned that interventions provided in self-care by the institution were ineffective. They also mentioned the need for change in administrative care would shift how they would be seen in the healthcare system. Many participants mentioned the ability to navigate the system without barriers to treatment options and having multiple resources to delegate. According to P1 and P4, removing the physicians from their actual practice of care desensitized their willingness to connect with hospital obligations.

Past researchers (Zhang et al., 2020) confirmed and extended the subtheme, recognizing the ability to move forward was not genuine toward the changes needed. Participants recognized that institutional racism, health inequities, and being upset about healthcare priority extended the unbalanced solution-focused interventions. Participants' perception of not being reassured that they could return to their families extended the

research from the past (Berg 2020). The work conditions mentioned in past research (Morley et al., 2019) confirmed the perception of moral distress resulting from unhealthy staffing concentrations to ensure quality patient care.

Conceptual Framework

Jameton's (2017) definition of moral distress served as the conceptual framework for this research study. Jameton (1984) defined moral distress as knowing the right thing to do, but the individual cannot perform their ethical duty due to organizational or institutional constraints. The evolution of what moral distress means grew into other medical professions, and the definition of it has become more applicable to each hardship medical institutions and organizations face (Jameton, 2017).

The study's participants supported the definition of moral distress. Near the end of the interview, the definition of moral distress became clearer due to how it was applied to their emotional residual stemming from the pandemic. P1 mentioned that the definition of moral distress was more a part of their life than they thought. P3 also supported the definition of moral distress and brought awareness to it being an everyday experience. P8 also mentioned that the definition of moral distress brings awareness to an institutional flaw that physicians are victims of, especially physicians of color.

The concept of moral distress evolved in a way that Jameton (2017) foreshadowed. The five stages (reaction, rationalize, remorse, resentment, and regret) have become the emotional cancers that define how physicians were suffering from the cycle of internalized burdens. From understanding the institutional flaws and learning the

perception of moral distress, the five stages were created and brought awareness to two new terms that would not have been otherwise recognized.

This study's findings did a multitude of new awareness and psychological perspectives. The term "emotional callus" defined the moral distress cycling that occurred due to the inability to recognize the emotional disposition of their lack of perception and victimhood. Emotional callus can be defined as having an awareness of distress yet absent of the perceptual ability to process its effect. After the distressful event occurred, identifying the gravity of its impact created an internal impasse.

The physicians in this study dealt with levels of emotional callusing to the point that patterned behaviors created a character severity or professional survivalist mentality. This behavior was for the sake of their patients and the rejection of the healthcare system's inequities. In the past literature, I recognized the behaviors and experiences of war doctors and how they moved toward adversity (Nott, 2020). The pandemic doctors were not aligned with the behavior of war doctors. The mentality and behavior of these physicians as they processed moral distress became evident. One participant acknowledged that a new generation of physicians working in the healthcare system will defy social injustice and inequities for the sake of their patients and self-preservation.

Physicians are choosing a holistic integration to their medical obligation. I consider these physicians as maverick doctors or "Mav docs." Mav docs can be defined as physicians that recognize social injustice, self-preservation, and reject systemic oppression for the integrity of their oath to the patient. Mav docs do not follow orders; they follow the desire to heal, be healed, and attempt to adapt conservatively to the

requirements of their medical facility or environment. They have become aware of the moral distress cycle that emerged and have begun dismantling the mental obligation that was emotionally unequipped by using universal principles that focus on their purpose.

This study was built upon moral distress in a manner of intrapersonal learning in an adverse environment. Jameton's (2017) definition of moral distress has evolved and was presented as a new level of distress that may have a universal holistic integrative approach. The new terms and concepts of distress reflected past research in unconventional systemic distress.

Limitations of the Study

This study provided in-depth knowledge about physicians' perceptions of moral distress during the pandemic, and limitations of trustworthiness could be present because the truthfulness of their statements cannot be tested. The term moral distress was new to their knowledge, and their ability to answer accurately could have provided a limited or biased answer. As the researcher, I executed the interview assuming that all participants were truthful and accurate in delivering answers. Secondly, I obtained physicians from all over the United States, not specifically gathering other identifier information.

For future studies, it may be expounded upon to get regions, gender, sex, race, and other identifiers that provide more insight about the participants other than an occupational identifier. Also, limitations of transferability may be an issue due to the study being specifically during the pandemic and it being collected almost two years into the pandemic.

Recommendations for Future Research

The study was conducted to understand physicians' perceptions of moral distress during the pandemic. Current research on this study had not been made, and a generic qualitative study had not been done in reflection of moral distress in this manner. Further qualitative research studies could explore regional perception, international perception, and perception of moral distress based on race, gender, sex, and family structure. One important aspect from the participants' interviews was their emotional awareness once the perception of moral distress was defined. The five stages (five R's) were acknowledged, but there was a focus specifically on the detachment from organizational support to preserve self-awareness.

Future research could conduct a mixed methods study on the patterned stages to see if the cycle does exist to detach from organizational constraints. A tool would be helpful to organize this possible experience. Future research findings could be compared to this study to support the need for healthy attachments to systems that do not align with healthy self-care interventions. Bringing this study back to nurses, which moral distress originated, may be proven beneficial. Having a focus group comparing doctors and nurses would be insightful.

Implications for Social Change

Physicians existing as an at-risk medical profession due to their occupational obligations has become alarming. Exploring their perception of moral distress during this pandemic brought awareness to how unhealthy the healthcare system became and how physicians were unaware of their own internalized burdens. It is too late when physicians are aware of moral injury, compassion fatigue, and burnout. They suffer in the residual of

being unaware of the healing that is needed. The support for physicians to be seen as healers needing healing requires an environment with intentional language and acknowledgment. Unfortunately, the stereotypes of a doctor were saturated even by their own colleagues, never being able to acknowledge the breach of vulnerability. This study better understood what physicians were truly fighting with: an unhealthy healthcare system.

The pandemic created a new war doctor, a maverick doctor, who is emotionally callused. This generation of "Mav docs" are medical professionals who can go beyond their comfort and self-care for a patient's well-being. They can go against the system if it means protecting their patient or themselves. Although this may sound noble, it puts a needed profession at risk, and many have quit or felt medically abandoned within only two years of their serving. Physicians felt a limit, and the healthcare system was unable to hold accountability and feel responsible for integrating self-worth into a group of people willing to do anything for their patients, creating emotional cancer. This emotional cancer can mean going against the system put in place to serve the community. This study has brought moral distress to a new level of awareness that has become a stress currency of wellness and performance.

Conclusion

Using the generic qualitative approach, I gained the understanding of eight physicians' perceptions of moral distress during the pandemic. The participants discussed their perceptions at their respective locations of treatment. The study's findings revealed that their perception develops into a state of emotional distress that has a cyclic effect and

inhibits a level of self-awareness, leaving them emotionally callused and unable to address internalized burdens. This emotional cancer becomes alive inside their devotion. There has been no current research on physicians being interviewed regarding their perception of moral distress during the pandemic. The study presented all new information on understanding the awareness needed for holistic integration within the healthcare system.

As a scholar-practitioner for positive change, it was essential to understand physicians' perception of moral distress to make positive change for medical professionals who are emotionally suffering. The participants were able to provide insight into a new generation of heroes, or mavericks, who rise from the impact of healthcare worker shortage and devote themselves towards patient care. This study had doctors recorded going through a traumatic change within the past two years, yet still sacrificed regardless of how supportive a system or environment was. The study determined that the wellness of physicians was a new level of holistic integration that needs to start with defining the difference between organizational motive and purpose-based care. Additionally, this study confirmed the awareness necessary for the onset of moral distress and becoming a sustainable option in a surviving system.

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Appendix A: Interview Questions

1. What is it like treating patients during the pandemic?
2. What is it like working in an organization during the pandemic?
3. How did your adjustment to treatment procedures change from pre- to post-pandemic?
4. How is moral distress in your life?
5. How is moral distress compared from pre to post-pandemic?
6. What is it like managing symptoms of moral distress?
7. What would change your perception of moral distress?

Appendix B: CONSENT FORM

You are invited to take part in a research study about the physician's perception of moral distress during the COVID-19 pandemic. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study seeks 8-10 volunteers who are:

- Physicians (medical doctors) who have been treating patients since 2019 (the start of COVID-19 awareness).
- Physicians (medical doctors) who have been treating patients during the pandemic.

This study is being conducted by a researcher named William Washington, who is a Ph.D. Candidate at Walden University.

Study Purpose:
The purpose of this study is to understand the perception of moral distress during the COVID-19 pandemic.

Procedures:
This study will involve you completing the following steps:

- Take part in a recorded confidential videoconference (1 hour)
- Review responses for editing and review a transcript of your interview for any needed corrections (email is available) (10-15 minutes)
- Speak with the researcher for feedback and interpretations (this is considered member checking and it takes 20-30 mins, phone option is available)

Here is a sample question:
How is moral distress compared from pre to post-pandemic?

Voluntary Nature of the Study:
Research should only be done with those who freely volunteer. So everyone involved will respect your decision to join or not. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:
Being in this study could involve some risk of minor discomforts. With the protections in place, this study would pose minimal risk to your wellbeing. If you become distressed

during the study and need further assistance, please use the following national hotline resources for further assistance:

- National Alliance on Mental Illness (NAMI) Helpline
- National Suicide Prevention Lifeline
- Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline

This study offers no direct benefits to individual volunteers. The aim of this study is to benefit society by bringing awareness to more supportive efforts for medical professionals during the pandemic. Once the analysis is complete, the researcher will share the overall results by emailing you a summary of the findings and a link to the full report if the participant wants more information or wants to share it with other colleagues.

Payment:
There will be no monetary compensation.

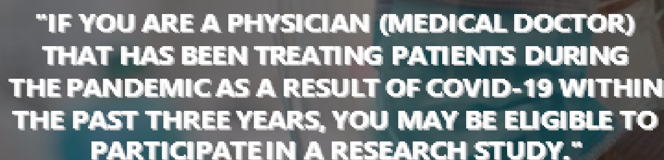
Privacy:
The researcher is required to protect your privacy. Your identity will be kept confidential within the limits of the law. The researcher is only allowed to share your identity or contact info as needed with Walden University supervisors (who are also required to protect your privacy) or with authorities if court ordered (very rare). Overall, your identity will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. You will be given an alias. The researcher will not include your name or anything else that could identify you in the study reports. If the researcher were to share this dataset with another researcher in the future, the dataset would contain no identifiers so this would not involve another round of obtaining informed consent. Data will be kept secure by password protection and data encryption. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You can ask questions of the researcher by email . If you want to talk privately about your rights as a participant or any negative parts of the study, you can call Walden University's Research Participant Advocate at . Walden University's approval number for this study is . It expires on August 24, 2023.

You might wish to retain this consent form for your records. You may ask the researcher or Walden University for a copy at any time using the contact info above.

Obtaining Your Consent
If you feel you understand the study and wish to volunteer, please indicate your consent by replying to this email with the words, "I consent."

Appendix C: Recruitment Flyer



CONTACT

A QUALITATIVE STUDY OF MORAL DISTRESS IN PHYSICIANS' DURING THE PANDEMIC

- Physicians (Medical Doctors) are needed to take part in a study regarding their perception of moral distress during the pandemic.
- Your participation in the study may help healthcare organizations understand healthier ways to support medical professionals.
- As a participant in this study, you would be asked seven interview questions regarding your perception of moral distress during the pandemic.
- If at any point you feel uncomfortable, you may choose not to answer any question(s) or opt-out of the study at any time.
- Participants will not receive compensation for the study.

LOCATION

- Google, Skype, or Zoom Interview appointments may take up to 60 mins of your time.
- You will receive an email notification that you can use to log in.

ARE YOU ELIGIBLE?

- Medical Doctor that currently provides treatment during the pandemic.
- Medical Doctor that has been treating patients for the last three years.

IF YOU'RE UNSURE IF YOU MEET THE REQUIREMENTS, CALL OR EMAIL:

RESEARCHER:

STUDY SUPERVISOR:

MORAL DISTRESS STUDY

STUDY CONDUCTED FOR COMPLETION OF A DISSERTATION UNDER

WALDEN UNIVERSITY

Appendix D: Debrief

Thank you for being a participant to the best of your ability. Being in this experience allows me as a researcher to impact the community and hopefully make changes that support you as well. This was a very specific study, and the questions asked pertained to the importance of your perception. If you need further assistance, please use the following national hotline resources for further assistance:

- National Alliance on Mental Illness (NAMI) Helpline
- National Suicide Prevention Lifeline
- Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline .

If you need to contact me regarding the interview, I can be reached at , or I can be emailed at . My study supervisor, , can be emailed at .