



Ethical conflicts among physicians and nurses during the COVID-19 pandemic: A qualitative study

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Abstract

Rationale, Aims and Objectives: The healthcare system and professionals working in the sector have experienced a high caseload during the coronavirus disease 2019 (COVID-19) pandemic. This has increased the potential for morally harmful events that violate professionals' moral codes and values. The aim of this study was to understand and explore experiences of new moral challenges emerging among physicians and nurses caring for individuals during the COVID-19 pandemic.

Method: The consolidated criteria for reporting qualitative research (COREQ) checklist was used in this qualitative study based on Gadamer's phenomenology. Participants were selected using a convenience sampling method. Thirteen medicine and nursing graduates were interviewed in depth. The participants all worked on the frontline at the start of the COVID-19 pandemic. Data were gathered in two basic healthcare districts in Spain, encompassing both primary care and hospital care.

Results: Four main themes emerged from the data analysis: (1) Betrayal of moral and ethical values as a key source of suffering; (2) Ethical and moral sense of failure accompanying loss of meaning; (3) Lack of confidence in performance; (4) Self-demand and self-punishment as personal condemnation among healthcare workers.

Conclusions: Health institutions must implement interventions for health professionals to help mitigate the consequences of experiencing complex ethical scenarios during the pandemic. In addition, they should promote training in moral and ethical deliberation and prepare them to make decisions of great ethical significance.

KEYWORDS

COVID-19, ethical conflicts, healthcare workers, health crisis, qualitative study

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1 | INTRODUCTION

The coronavirus disease 2019 (COVID-19) pandemic has brought about significant changes to our societies, healthcare systems, and clinical practice.¹ To date, COVID-19 has caused 180 million infections and around 4 million deaths.² The healthcare system and professionals working in the sector have experienced a high caseload and resource shortages, which have forced them to change the way in which they care for patients.³ The system has shifted from comprehensive care to a greater focus on contagion and COVID-19,⁴ giving rise to new decision-making challenges for healthcare professionals that have affected their personal and professional lives.^{5,6}

Healthcare professionals have experienced potentially morally harmful events that violate their moral codes and values.⁷⁻⁹ More specifically, they have been asked to make difficult ethical decisions that run counter to their training and their fundamental human concern for others' wellbeing.¹⁰ They have had to set aside basic patient care to perform other tasks relating to contact tracking and tracing.¹¹ They have been required to keep constantly up to date with recommendations on public health protocols and guidelines such as placing COVID-19 patients in isolation, admitting them to the intensive care unit (ICU) or sedating them, some of which go against the moral principles underpinning ethical care.⁵ This has led to emotional exhaustion, depersonalization and a lack of personal fulfilment, causing chronic stress.^{8,9} Research has suggested that exhaustion is actually a manifestation of moral injury, as a series of erroneous beliefs and cognitive processes emerge that prevent individuals from being able to continue to function at work.¹²

Moral injury is a term most commonly used in relation to members of the armed forces, and especially to war veterans.¹³ In the healthcare sector, it has been defined as difficulties in personal functioning at a moral level that may arise after exposure to potentially morally harmful or traumatic events in the workplace.¹⁴ According to Litz and Kerig, moral injury encompasses the psychosocial, behavioural and even spiritual impacts of 'perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations'.¹⁵ Potentially harmful events tend to occur in high-risk environments and contravene the moral code and values held by healthcare professionals.^{14,16} They have been observed in highly stressful environments, such as intensive care departments.⁹

Moral injury may be caused in a variety of ways: by an individual's own actions (e.g., doing something that they feel they should not have done), by an individual's inaction (e.g., not doing something that they feel they should have done), or by other people's actions or inaction (e.g., feeling betrayed by other people).¹⁷ In other words, it can occur upon witnessing human suffering or failing to prevent outcomes that transgress deeply held moral beliefs.^{8,18} The dimensions of the term *moral injury* are betrayal, guilt, shame, moral concerns, loss of trust, loss of meaning/purpose, difficulty forgiving, self-condemnation, religious struggle and loss of religious/spiritual faith.^{19,20}

In response to events of this kind, people experience moral emotions such as guilt, shame, disgust, anger and contempt, as well as cognitions.¹⁰ The internal conflict caused by psychological and religious symptoms can have a significant impact on people's family, social and occupational functioning.^{18,21} For some healthcare professionals, this rift can challenge their personal values and principles, leading to painful emotions.^{22,23} Despite the importance and repercussions that the new scenarios of ethical conflicts that have emerged in the COVID-19 health crisis may have for professionals, there is little research that delves into these situations.²⁰ Therefore, the aim of this study was to understand and explore experiences of new moral challenges emerging among physicians and nurses caring for individuals during the COVID-19 pandemic.

2 | METHOD

2.1 | Design

A qualitative methodology based on Gadamer's phenomenology²⁴ and following the recommendations of the COREQ checklist was used in this study.²⁵ Qualitative research allows us to describe and understand the reality of the object of study and examine the reasons explaining the facts observed.²⁶ According to Gadamer, language is the basis for understanding phenomena, leading to a fusion of horizons between the speaker's intention and the listener's interpretation.²⁷ Using this methodology, we were able to understand the moral impact of the COVID-19 pandemic on healthcare professionals by exploring their experiences.

2.2 | Participants and study context

The study was carried out in February and March 2021. Data were gathered in two basic healthcare districts in Spain, encompassing hospital care and primary care: one was located in southeastern Spain (Almería) while the other was in central Spain (Segovia). By the time of the study, three waves of COVID-19 infections had been recorded in Spain, which stood among the European countries with the highest incidence on several occasions. Participants were selected using a convenience sampling method.²⁶ The researchers selected key informants and these in turn identified other participants following a snowball strategy. Eighteen healthcare professionals were invited to participate in the study, five of whom refused due to time constraints. The inclusion criteria were: healthcare professionals, including doctors and nurses, who were working in hospital care and primary care during the pandemic and who continued to work in the sector at the time of the study. The exclusion criteria were: healthcare professionals who did not give their informed consent, who did not work in frontline care during the COVID-19 pandemic, or who were retired or unemployed. Thirteen professionals with a mean age of 41 (SD = 11.75) and an average of 16 years' professional



experience (SD = 11.02) participated in the study. Table 1 shows the participants' sociodemographic and occupational characteristics.

2.3 | Data collection

Data were obtained using semistructured in-depth interviews focused on a specific theme. Table 2 shows the interview script. The interviews were conducted by the principal investigator via videoconference on the Google Meet platform. The average length of the interviews was 45–60 min. The sessions were audio recorded after participants had signed the informed consent form, which was sent by email.

2.4 | Data analysis

The interviews were recorded, transcribed and analysed. The transcriptions were sent to participants to check their veracity by emails. Data were analysed according to Fleming's method²⁴: (1) the researchers decided whether or not the research question was appropriate based on the methodological premises; (2) the researchers identified the preunderstanding of the object of study; (3) during the data collection and transcription process, the researchers sought understanding through dialogue; (4) during the data interpretation, new questions arose, codes were categorized into units of meaning, understanding was obtained from the fusion of horizons between participants and researchers, and the units of meaning were grouped into themes and subthemes. Several participants were asked to validate the results and none made any corrections. The data analysis

was triangulated by two researchers. ATLAS.ti 9.0 software was used to support the analysis of the data.

2.5 | Ethical considerations

The study adhered to the ethical standards set out in the Declaration of Helsinki. Approval was obtained from the Research Ethics Committee for the Department of Nursing, Physiotherapy, and Medicine (ENF 113/2021). The data were organized in such a way as to protect participants' identities, integrity and access to the files. Informed consent was sought from all the participants. They were provided with relevant information about the study before signing the informed consent form. Participants' right to privacy was respected under Spanish Organic Law 3/2018, of 5 December, on Personal Data Protection and Guarantee of Digital Rights were not used for any purpose other than those stated in the study objectives.

2.6 | Rigour

Lincoln & Guba's quality criteria were used.²⁸ Credibility was achieved by recording participants' opinions and perspectives. The interviewers confirmed the data with the participants after the interviews. Dependability was deduced from recognition of all stages in the research process. To ensure transferability, a detailed description of the study setting, participants, context and method was produced. In addition, the researchers read the interview transcripts independently before reaching an agreement on the themes and subthemes deriving from them.

TABLE 1 Participants' sociodemographic and occupational characteristics

Participant	Age (years)	Sex	Marital status	Occupation	Workplace	Years of service
P1	33	Female	In a civil partnership	Physician	PC	3 years
P2	62	Female	Married	Physician	PC	32 years
P3	34	Male	In a civil partnership	Physician	PC	8 years
P4	56	Female	Divorced	Nurse	PC	36 years
P5	38	Female	Single	Nurse	PC	4 years, 11 months
P6	49	Female	Married	Physician	PC	22 years, 8 months
P7	22	Male	In a civil partnership	Nurse	PC	9 months
P8	44	Female	Married	Nurse	PC	20 years, 6 months
P9	24	Female	In a civil partnership	Nurse	PC	14 months
P10	47	Female	Married	Nurse	HC	19 years
P11	40	Female	Divorced	Physician	PC	16 years
P12	37	Female	Married	Nurse	HC	15 years
P13	48	Female	Married	Nurse	HC	21 years, 9 months

Abbreviations: HC, hospital care; PC, primary care.

TABLE 2 Script for the interview

Opening question	Can you tell me how your work has affected you (at a personal level) during the COVID-19 pandemic?
Additional questions	How do you think your way of working has changed? Do you think this way of working has gone against your moral values or principles? What does guilt mean to you (if you've experienced it)? How did you feel? Have you ever felt like a failure? Why? How did you feel? How did you react? Have you punished yourself for your way of working during this period? In what way? Do you think it's important to forgive yourself? Have you ever felt like that before? Tell me how you felt about the situation.
Final questions	How would you sum up the pandemic after the last year? Would you like to say anything else?

TABLE 3 Themes and units of meaning

Themes	Units of meaning
Betrayal of moral and ethical values as a key source of suffering	Guilt, overwhelm, empathy, dissatisfaction, unfairness to patients, against our principles, question of personal ethics, decision-making
Ethical and moral sense of failure accompanying loss of meaning	Loss of meaning, personal demotivation, distancing from patients, incomprehension, resignation, failure, frustration
Lack of confidence in performance	Loss of confidence, insecurity/uncertainty in diagnosis, hesitation
Self-demand and self-punishment as personal condemnation among healthcare workers	Self-punishment, not being happy with oneself, self-defence system, work as self-punishment.

3 | RESULTS

The participants described their experiences in the workplace during the COVID-19 pandemic. An inductive analysis of the data revealed four themes allowing nursing professionals' experiences of potential conflict ethics caused by the COVID-19 pandemic to be understood (Table 3).

3.1 | Theme 1. Betrayal of moral and ethical values as a key source of suffering

High caseload, self-demand and hesitation during the pandemic placed a heavy emotional burden on the participants. In many cases, the difficult decisions to be made and the public health protocols to be followed resulted in a moral struggle for healthcare professionals. The cocktail of emotions that they experienced during the onslaught of the pandemic had an impact on their ability to manage their personal lives and on their professional performance. Hesitation, fear and distressing experiences conditioned their personal values.

A sense of betraying their own moral values in complying with the public health measures taken during the pandemic emerged in the participants' narratives. They felt guilty at having been unable to do the right thing or at having done something that they were aware was wrong. The healthcare professionals criticized themselves and felt

guilty for failing to take action based on their experiences before the pandemic. Their inaction when faced with highly difficult situations also led to discomfort among the professionals. For some of them, discomfort was replaced by a sense of powerlessness at having failed to take action in line with their personal or ethical values.

...I feel guilty for not saying anything; I'd go in and whatever happened happened... (P5)

When you didn't do what you should have done. For example, when I tended to the first patients at the start of March... I feel guilty about that, about not being more alert when I suspected that the virus was circulating, because I exposed my colleagues and they caught it (P2)

...because although we had patients who we were meant to turn over, we didn't do it because we had a lot of work (P1)

The avalanche of unexpected events and the uncertainty that they felt in their work pushed the participants to carry out inappropriate interventions because they had no other option, not because they did not know what to do. On a daily basis, they encountered challenges and overwhelming situations that contradicted what they had learned and experienced previously. They were



forced to weigh up the ethics of doing the right thing with the resources and means available.

...sometimes you have to do things that go against, you have to do things that aren't right... (P4)

...you're always left wondering if you could have done it better or differently, when something happens so suddenly like a tsunami... (P6)

The apocalyptic situation experienced by some of the participants at certain points in the pandemic affected them morally. Participants experienced ethical conflicts as a result of issues such as instructions for sedation and decisions on resource allocation based on variables such as age. When they arrived home after work, they found it impossible to disconnect from their experiences in the workplace. They would dwell on what they would encounter the next day and how they were going to address it.

...it's just that, at the nursing home, we went to sedate one patient and then you suddenly realise that you've ended up sedating thirteen because the hospital told us we couldn't send any more patients and we should keep them there however we could, and we're talking about your own patients, assigned to you, and that feeling... (P5)

...[it was] the hardest thing I've seen in my life, I mean, seeing a person who's 55 and because they're 55 they're not eligible for an ICU bed but another person who's 54 is, just because of a few months' difference. That person lived and the other one died... (P3)

3.2 | Theme 2. Ethical and moral sense of failure accompanying loss of meaning

This section presents the consequences of continuous exposure to personally harmful events on participants' professional practice. Participants found themselves engaging in practices that diverged from those they had learned during their training. In many cases, the monotony of the situation and the type of patient led to deteriorating care and worsening personal wellbeing.

In the participants' view, the type of virus made it impossible to offer the same kind of healthcare as before the start of the COVID-19 pandemic. This threw the meaning of their work and their professional identity into crisis. One of the reasons for this loss was the fact that they were unable to touch their patients due to the protective protocols in place, placing a considerable distance between them and resulting in more dehumanized care. They also agreed that their workload and high caseload prevented them from dedicating as much time as they would have liked to

their patients. Moreover, the repetitive diagnoses and the often unconscious state of COVID-19 patients led to ongoing exhaustion among the professionals. Cumulatively, these circumstances led them to lose their sense of purpose in their professional practice.

...the huge numbers of patients arriving each day overwhelmed our services. That avalanche of patients meant that I couldn't see them as I would have liked. I would have liked to have seen each patient by name. The caseload was so high that we were often unable to deliver the appropriate level of care... (P1)

...you don't get up in the morning feeling eager to see patients. You go to work out of obligation, not because you feel like it... (P5)

This loss of purpose led some professionals to consider leaving the profession in pursuit of a more peaceful life. This was exacerbated further by feelings of a lack of fulfilment and by the circumstances outside their place of work. The restrictions and prohibitions imposed in response to the pandemic penalized them even more than their occupational situation, preventing them from escaping the stress of their work.

...yes, I've considered quitting my career, this profession... (P3)

...Yes, I've sometimes thought that this isn't the medicine that I studied, and I've thought about how I like my job less now than I used to... (P2)

The participants expressed a strong feeling of failure, especially with regard to the first wave of the pandemic. They did not expect such a grave situation to occur in Spain. It took them by surprise and left them unable to respond differently. This feeling of failure continues to frustrate them and preoccupy their thoughts.

...yes, but it's a general sense that we failed at the beginning... (P1)

The participants link this experience of failure to the huge efforts that they made in their work, where they prioritized their patients' wellbeing over their own. However, they often made promises to patients to keep their hopes and spirits alive and although they desperately hoped that these promises would come true, in many cases they went unfulfilled because the professionals could no longer control the situation. This considerably increased their sense of ongoing frustration and of personal and professional failure.

...I feel like I've failed in things that I wasn't able to honour... (P10)



3.3 | Theme 3. Lack of confidence in performance

The participants reported a loss of self-confidence due to the substantial changes occurring in the types of conditions that they cared for. In the space of just a few weeks, they began to tend almost exclusively to cases of COVID-19, a completely unfamiliar and deeply threatening virus. The lack of variety in the type of patients that they cared for and the rising numbers of deaths undermined their confidence. They explained that the shock caused by the situation and the lack of resources, in some cases, made them feel insecure about their performance. Moreover, the numbers of people dying sapped their personal motivation because they saw no reward for their efforts.

...personally, I think I've lost my confidence in my abilities, for a long time we only saw respiratory patients... (P3)

...seeing so many people die every day made you doubt your work. It's as if nothing you do has any effect, and that makes you lose confidence... (P7)

On the other hand, some participants explained that although they felt pride in their work, they were not satisfied with the work of some of their colleagues. They had lost faith in their colleagues because they had failed to respond appropriately to the situation, having lost personal motivation, hope and the will to fight for patients in a critical condition.

...but sometimes you do lose [faith] in the people around you. I tell my husband about it, some colleagues actually say to you: 'well, the patient hasn't got long left anyway...' (P10)

3.4 | Theme 4. Self-demand and self-punishment as personal condemnation among healthcare workers

The exposure of healthcare professionals to constant, highly emotionally charged situations where they had to make decisions that went against their values gave rise to strong feelings of guilt and mechanisms of self-punishment. Besides guilt, the professionals' narratives indicate that perceived contradictions between what they thought, felt and did or had to do prompted them to criticize themselves harshly, evaluate their own performance negatively, and place strict demands on themselves. For them, self-punishment was a mechanism for compensating for their perceived poor performance:

...subconsciously, you beat yourself up about not resting, not being able to be alone in silence at home... (P5)

...what got to me the most and made me feel most guilty was not calling all those people, because I didn't feel able to cope with the situation... (P3)

Another source of self-inflicted suffering or self-punishment was the professionals' relationship with the suffering of the people who they cared for in a bonded, close, empathetic manner with elements of self-transfer. In a chaotic situation where death was always present, the professionals identified with the patients and experienced negative emotions at the thought that they could have done better. These thoughts did not dissipate when they finished work and remained present day after day, resulting in constant preoccupation and an inner need for self-judgement and self-criticism.

...it does affect me because I've been on the receiving end. I feel worse somehow. You do feel worse then, when [patients] deteriorate because you've bonded with them... (P12)

...knowing and feeling like things could have been done more effectively for the patient... (P7)

4 | DISCUSSION

The aim of this qualitative study was to explore experiences of new moral challenges emerging among physicians and nurses during the COVID-19 pandemic. Our main findings relate to the feelings that emerged as professionals attempted to adapt to the onslaught of COVID-19.²⁹ They also cast light on the consequences of these feelings and emotions as professionals were forced to make decisions that sometimes contravened their own moral values. According to our findings, feelings of guilt flourished as professionals failed to do what they felt was right or took action that they knew was inappropriate.³⁰ Other studies have shown that high caseloads leading to poor decisions, unkept promises to patients, and repetitive, difficult decision-making can give rise to a sense of guilt, regret, and moral injury.^{23,31,32}

One very important finding in this study is the prevalence of self-punishment. In line with other studies, the phenomenon occurs when the aforementioned stressors go unaddressed and provoke negative feelings.^{5,30} Self-punishment is a mechanism that derives from the desire to punish oneself for making mistakes to compensate for feelings of shame and guilt, and it is important that healthcare professionals work on self-compassion. Self-punishment is a destructive mechanism that provides relief from guilt.³³ Self-compassion is a more constructive response allowing people to recognize their errors and be kind to themselves. Self-compassion is not synonymous with self-indulgence; instead, it focuses on the present and reduces stress, emotional fatigue and shame while simultaneously improving the capacity for empathy.³⁴⁻³⁶



The responsibility for limiting transmission through social distancing imposed by the pandemic led to a restructuring of care.³¹ Our findings show that maintaining distance when caring for patients, having only one type of patient and discrepancies between demand and available resources caused professionals to lose confidence in their work and to lose their sense of purpose.⁵

As for the moral consequences, the professionals experienced frequent ethical conflicts accompanied by intense concern and distress. In our study, these ethical conflicts were found to derive from a lack of resources and a sense of powerlessness at their inability to take action.^{12,30} However, studies have shown that exposure to potentially harmful events leads to an increase in depression, anxiety, psychological distress and poor sleep quality.^{7,37} Moral injury, therefore, is a set of symptoms that can affect mental health^{12,30,38,39} and be brought about by these conflicts. To ensure that the situations described and experienced by professionals do not have similar consequences in the future, they must learn to make ethically and morally charged decisions in a consensual manner amid great uncertainty.⁴⁰ Training in ethical conflicts and moral deliberation in teams is one of the key strategies needed to address day-to-day care and to handle future situations that are similar to the COVID-19 pandemic.⁵ Rushton et al. found that building moral resilience, that is, the ability to maintain or restore personal integrity in the face of moral adversity, can be a valuable personal resource in response to moral and ethical conflicts.⁴¹

This study has a number of limitations. On the one hand, the findings may have been different if the data had been gathered nearer the start of the pandemic in March 2020. In the midst of the public health crisis, the healthcare professionals may have expressed the conflicts ethics that they were experiencing more emphatically. This period has been marked by resource shortages, uncertainty and lack of knowledge of the virus.³¹ Despite this, our study provides valuable information about the suffering associated with the ethical and moral decisions faced by physicians and nurses. The fact that most of the interviews were conducted by videoconference rather than in person is another limitation. Although data collection was carried out online, the strict scientific rigour underpinning the study lends credibility to the findings. We failed to conduct a comparative analysis across professions to ascertain whether there were significant differences between physicians and nurses in terms of the experience of ethical conflicts; however, we intend to do so in the near future. Future lines of research could also identify potential mental health problems caused by conflicts ethics, or examine the implementation of preventive or palliative measures by institutions to lessen the consequences of ethical dilemmas faced by professionals.

5 | CONCLUSION

After exploring the experiences of physicians and nurses in this study, we can conclude that they have suffered as a result of the ethical challenges posed by the COVID-19 pandemic. They display feelings of guilt and failure, which are caused by excessive self-demand in

their work and have led to self-punishment in some cases. This self-punishment can be destructive for physicians and nurses, so it is important that self-compassion programmes are put in place as a healthy strategy for professionals to treat their own difficulties in managing highly ethical and moral scenarios. This would improve wellbeing among professionals and their patients.

5.1 | Relevance to clinical practice

The constant need to make decisions at difficult times and in difficult circumstances has created a rift within healthcare professionals, leading to a loss of personal identity and uncertainty regarding their performance in the healthcare setting. Given the moral and ethical discomfort and suffering caused by the pandemic as a result of healthcare professionals' difficulties in making decisions and managing interventions, it is very important that the question of professional identity is not overlooked and that training programmes involving high-fidelity simulation and addressing different types of ethical conflict, as well as moral deliberation as a team, are developed. Interventions must be put in place to prevent and redress moral harm to health professionals as a result of ethical conflicts, arising in day-to-day care and in possible future pandemics.

AUTHOR CONTRIBUTIONS

All authors have contributed to the drafting and revision of the manuscript until its publication. María D. Ruiz-Fernández, Ángela M. Ortega-Galán and José M. Muñoz-Quiles contributed to conceptualization, formal analysis, methodology, and writing. José M. Hernández-Padilla, José Granero-Molina and Cayetano Fernández-Sola contributed to investigation review and editing.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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