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Perspective

Moral Distress Among Clinicians During Resource-Constrained Pandemic Care

Zsafia Rossi^{1*}, Alessandro Benitez¹ and Bence Jonsdottir²¹Center for Medical Ethics and Law, Baltic Institute of Medical Humanities, Sweden²Center for Medical Ethics and Law, Baltic Institute of Medical Humanities, Sweden³Department of Philosophy, Nordfjord University Center for Health Ethics, Norway

ABSTRACT

The COVID-19 pandemic exposed frontline clinicians to sustained resource scarcity, forcing rationing and triage decisions that gave the long-standing concept of moral distress a new scale and urgency.

This review examines how moral distress has been defined and measured in pandemic contexts, distinguishing acute, decision-specific triggers such as ventilator triage from chronic, exposure-based harms that accumulate over prolonged periods of understaffing and unmet professional standards.

It surveys the ethical debates over crisis standards of care and triage committees, the empirical literature linking moral distress to moral injury and burnout, and the legal and institutional responses -- liability shields and formal crisis protocols -- that emerged during the pandemic.

We argue that these institutional responses, while necessary, addressed legal exposure more successfully than the underlying moral burden, and that building genuine "moral community" within health institutions is a more promising avenue for reducing harm than individual resilience training alone.

We conclude by identifying open questions about whether pandemic-era ethical infrastructure will persist into ordinary practice and how well its lessons generalize to other forms of chronic resource scarcity.

Keywords: moral distress; moral injury; pandemic ethics; crisis standards of care; clinician burnout

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Corresponding Author: Zsafia Rossi

E-mail Address: z.rossi@bimh.se

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INTRODUCTION

Moral distress is not a new concept in clinical ethics, but the COVID-19 pandemic gave it a scale and intensity that the term was never really built for. The idea, as originally formulated, describes the

psychological injury a clinician suffers when she knows the ethically correct action but is constrained by institutional, legal, or resource barriers from taking it [1]. Under ordinary conditions this arises in discrete, recognizable episodes -- a family insisting on futile treatment, a staffing shortage that delays a needed

intervention. During the acute phases of the pandemic, it became close to a background condition of clinical work itself: ICU beds, ventilators, dialysis capacity, and even staff time were rationed for months at a stretch, and clinicians were asked to make or execute allocation decisions that in normal circumstances would never have reached the bedside [2].

What makes the pandemic experience worth revisiting now, several years on, is not that moral distress occurred -- that was predictable and predicted -- but that the literature that has since accumulated lets us ask harder questions about it. Was moral distress in this period a distinct psychological phenomenon from burnout, or a contributor to it? Did the crisis standards of care and legal liability shields that many jurisdictions adopted actually reduce distress, or did they simply relocate the ethical burden without resolving it? And what, if anything, have health systems learned about building the kind of institutional support -- what some authors call a "moral community" -- that might blunt the harm the next time scarcity returns [3]. This review takes up each of these questions in turn, drawing on the empirical and conceptual literature published during and after the pandemic's peak years.

DEFINING AND MEASURING MORAL DISTRESS IN CRISIS CONTEXTS

The classic definition of moral distress, developed originally in nursing ethics, requires two conditions: the clinician must know what the right action is, and must be prevented from doing it by some constraint external to her own judgment [1]. Pandemic-era scarcity satisfied both conditions in ways that were often difficult to escape. A nurse who knew a patient needed one-to-one attention but was assigned to six critically ill patients at once was not failing to recognize the ethically preferable course of action; she was being denied the staffing to pursue it. The AACN's position statement on moral distress in times of crisis extended the concept explicitly to cover exactly this kind of systemic, rather than individual, constraint, treating chronic understaffing and resource scarcity as moral-distress triggers in their own right rather than as background noise around a more classic ethical dilemma [4].

A mixed methods study of clinicians in US safety-net practices during the pandemic found that moral distress in these settings was driven less by dramatic triage decisions than by a cumulative sense of being unable to provide care that met clinicians' own professional standards, given short staffing, supply shortages, and patients who had delayed care and arrived sicker as a result [5]. This finding matters because it complicates a common assumption in the earlier literature -- that moral distress during the pandemic was mostly a phenomenon of ICU triage committees deciding who gets a ventilator. In practice, it was at least as pervasive among primary care and safety-net clinicians managing chronic scarcity day to

day, without ever confronting a single dramatic rationing decision.

Nephrology offers a useful illustrative case, since dialysis capacity was itself a scarce and rationed resource in several health systems during pandemic surges; clinicians in this specialty reported both moral distress, tied to specific rationing decisions, and the more diffuse moral injury associated with prolonged exposure to conditions they considered unacceptable but could not change [6]. That distinction between an acute, decision-specific form of distress and a chronic, exposure-based form of injury recurs throughout the literature and is worth keeping separate, since the two appear to respond differently to institutional intervention.

SCARCITY, TRIAGE, AND THE ETHICS OF CRISIS STANDARDS OF CARE

Much of the early pandemic bioethics literature focused on how to allocate genuinely scarce resources -- ventilators above all -- fairly. Emanuel and colleagues' widely cited framework argued for maximizing benefits, treating people equally, promoting instrumental value in some circumstances, and giving priority to the worst off, while explicitly rejecting first-come-first-served allocation once true scarcity was reached [2]. The appeal of such frameworks was that they gave individual clinicians a defensible, pre-agreed basis for decisions that would otherwise have to be made ad hoc, at the bedside, under enormous time pressure.

In practice, however, many jurisdictions never activated formal crisis standards of care even when demand for critical care resources came close to overwhelming capacity, which left individual clinicians making informal, unsupported rationing decisions without the institutional cover a triage committee is meant to provide [7]. Triage committees themselves attracted sustained ethical criticism: some commentators argued that shifting rationing decisions from bedside clinicians to a separate committee did not actually resolve the underlying moral problem, since someone still had to make the decision, and the committee model mainly served to distribute psychological responsibility rather than eliminate it [8]. A broader review of clinical ethics and triage practice across the pandemic reached a similar conclusion: institutions varied enormously in whether, and how transparently, they operationalized their allocation criteria, and that inconsistency itself became a source of moral distress for frontline staff who could not be confident their institution's approach was defensible [9].

Medical education researchers used the pandemic as an occasion to test how well-prepared clinicians in training actually were for this kind of decision. One study of preclinical medical students' approach to hypothetical ventilator allocation found substantial

variation in how comfortable students were applying an explicit ethical framework versus relying on intuitive judgment, suggesting that formal ethics training had not, before the pandemic, adequately prepared the incoming physician workforce for scarcity-based rationing [10]. Emergency physicians writing early in the pandemic likewise noted that ventilator allocation protocols, however carefully constructed on paper, still had to be executed by individual clinicians under conditions that made calm, criteria-based deliberation difficult in the moment [11].

Table 1. Reported sources of clinician moral distress during resource-constrained pandemic care, by type and the institutional response most commonly proposed.

Source of distress	Typical trigger	Distress type	Proposed institutional response
Bedside triage/rationing	Ventilator, ICU bed, or dialysis allocation under scarcity	Acute, decision-specific	Pre-agreed allocation criteria; triage committees; legal liability protection
Chronic understaffing	Sustained short-staffing relative to patient acuity/volume	Chronic, exposure-based	Staffing surge protocols; workload monitoring; organizational surveillance
Inconsistent institutional protocols	Ambiguous or unevenly applied crisis standards of care	Both	Transparent, community-engaged, regionally consistent protocols
Witnessing preventable harm	Inability to provide adequate end-of-life care or family contact	Chronic, exposure-based / moral injury	Palliative care integration; communication/visitation accommodations
Perceived legal exposure	Fear of litigation over crisis-era treatment decisions	Acute, decision-specific	State liability shield statutes; institutional legal support

Figure 1. Schematic comparison of the reported burden of acute, decision-specific distress versus chronic, exposure-based moral injury across four phases of pandemic-era clinical practice (illustrative, based on the qualitative emphasis of the reviewed literature, not a pooled empirical dataset).

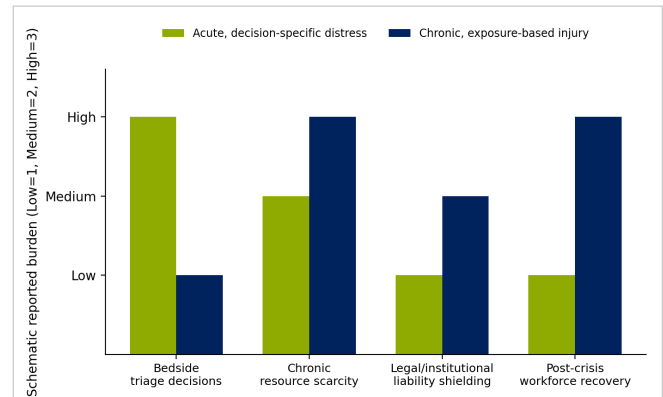


Table 1 summarizes the main sources of moral distress identified across this literature, distinguishing acute decision-specific triggers from more chronic, exposure-based ones, together with the institutional response most commonly proposed for each. Figure 1 presents a schematic, illustrative comparison of the relative burden these different pandemic phases are reported to have placed on frontline clinicians, drawn from the qualitative emphasis of the sources reviewed rather than from a single pooled dataset.

MORAL INJURY, BURNOUT, AND THE TOLL ON THE WORKFORCE

A recurring debate in this literature concerns whether "moral distress" and "moral injury" describe the same phenomenon or two related but distinct ones. Moral injury, a term borrowed originally from military psychology, describes the lasting psychological and sometimes spiritual harm that follows from perpetrating, failing to prevent, or witnessing acts that violate one's own moral beliefs. A philosophical analysis of the pandemic argued that this concept captures something moral-distress language does not: the durable sense of having been complicit in outcomes one finds morally unacceptable, even where no single decision was clearly wrong at the time it was made [12].

Empirical work has generally supported treating moral injury and moral distress as overlapping but separable constructs, with moral injury tending to describe a more persistent, identity-level harm and moral distress a more situational, decision-level one, and with moral resilience -- an individual and organizational capacity to recover ethical footing after such episodes -- proposed as a partial buffer against the transition from one to the other [13]. A scoping review of moral injury and moral distress among healthcare workers and public safety personnel worldwide during COVID-19 catalogued the specific circumstances most consistently associated with both: witnessing preventable deaths, being unable to provide adequate

end-of-life care or family contact, and having to enforce policies clinicians personally believed were harmful to patients [14]. Guidance issued by the American Psychiatric Association during the pandemic explicitly framed moral injury as a distinct occupational health risk requiring organizational-level intervention, not merely individual coping strategies [15].

The relationship between moral distress and burnout has also drawn sustained empirical attention outside the pandemic-specific literature. A recent study of emergency nurses found that hospital ethical climate and individual moral resilience both mediated the relationship between moral distress and burnout, suggesting that the same distressing event can produce very different downstream harm depending on the surrounding institutional culture [16]. An umbrella review synthesizing existing reviews of moral distress among nurses more broadly confirmed that prevalence estimates vary widely across settings and instruments, but that the causes cluster consistently around inadequate staffing, perceived futile care, and constrained decision-making authority -- all conditions the pandemic intensified rather than introduced [17]. Clinical resources compiled by professional nursing organizations since the pandemic have increasingly framed moral distress as an occupational hazard requiring systematic surveillance, not an individual failure of resilience to be managed privately [18].

INSTITUTIONAL AND LEGAL RESPONSES: PROTECTION WITHOUT RESOLUTION

Recognizing the scale of the problem, many US states enacted or expanded legal liability protections for clinicians making crisis-era treatment decisions, on the theory that fear of litigation would otherwise compound the psychological burden of rationing. An analysis of these state-level protections found substantial variation in scope: some shielded only decisions made under an activated, formal crisis-standards-of-care declaration, while others offered broader immunity for good-faith clinical judgment made under pandemic conditions generally [19]. Whether these protections actually reduced moral distress, as opposed to simply reducing legal exposure, is a separate question the liability literature does not fully answer; several bioethicists have noted that the psychological weight of having made a rationing decision does not disappear once the legal risk of that decision is removed.

Foundational guidance on crisis standards of care, developed by the Institute of Medicine well before the pandemic but revisited extensively during it, emphasized that legitimate crisis standards require not just clinical protocols but a transparent process, community engagement, and consistency across institutions within a region -- conditions that were frequently absent during the pandemic's actual rollout of such standards [20]. A follow-up ethical framework further specified that crisis standards must be applied through a fair, non-discriminatory process if they are to

carry moral legitimacy for the clinicians asked to implement them [21]. A more recent review of lessons learned from the pandemic's crisis-standards experience concluded that legal and ethical protections for clinicians, while necessary, were not sufficient on their own to prevent moral harm, particularly where equity concerns arose -- for instance, when triage criteria were later found to disadvantage patients with disabilities or from historically marginalized groups [22]. The American Medical Association's guidance on crisis standards of care similarly stresses that institutional protocols exist to support, not substitute for, individual clinical judgment and conscience, an important qualification given how often triage protocols were treated in practice as simply removing the need for clinician deliberation [23].

TOWARD MORAL COMMUNITY: INTERVENTIONS AND UNRESOLVED QUESTIONS

If moral distress during the pandemic was substantially a product of institutional and systemic conditions rather than individual failures of coping, then interventions aimed only at individual resilience were always going to be partial. The concept of a "moral community" -- an institutional culture in which ethical concerns can be raised, heard, and acted on collectively -- has been proposed as the more appropriate unit of intervention, on the theory that moral distress flourishes precisely where individual clinicians feel isolated in their ethical concerns and unsupported by leadership [3]. Addressing moral distress specifically among family caregivers, rather than only professional clinicians, during the pandemic likewise emphasized structural fixes -- better communication protocols, visitation accommodations, palliative care integration -- over purely individual coping strategies [24].

Several open questions remain. It is not yet clear whether the ethics-committee and liability-protection infrastructure built up during the pandemic will persist into ordinary practice or fade once the acute crisis recedes, leaving the next public health emergency to rebuild it from scratch. Nor is it clear how well pandemic-specific moral distress research generalizes to other forms of chronic scarcity -- understaffed rural hospitals, under-resourced health systems in low- and middle-income countries -- where many of the same conditions exist without ever being labeled a "crisis." What the pandemic literature does make clear is that moral distress is not primarily a problem of individual clinician character or resilience; it is, in the overwhelming majority of the studies reviewed here, a predictable consequence of asking clinicians to practice under conditions their profession's own standards tell them are inadequate.

CONCLUSION

The pandemic did not invent moral distress, but it stripped away the assumption that it is a rare or isolated occurrence in modern clinical practice. Across settings as different as ICU triage committees, safety-net primary care clinics, and dialysis units, clinicians reported a shared experience of being asked to act against their own professional judgment because the resources, staffing, or institutional support to do otherwise simply were not available. The literature reviewed here converges on several conclusions that carry beyond the pandemic itself: that moral distress and moral injury, while related, are distinct enough to warrant separate measurement and intervention; that crisis standards of care and legal liability protections address real needs but do not by themselves resolve the underlying ethical burden; and that institutional culture, not individual resilience training alone, appears to be the more promising lever for reducing harm. Whether health systems retain and build on what this period taught them, or allow the relevant infrastructure to lapse once memory of the crisis fades, will likely determine how much better prepared clinicians are the next time scarcity returns.

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Conflict of Interest

The authors declare no conflicts of interest relevant to this work.

Author Contributions

Zsafia Rossi conceived the review, coordinated the literature synthesis, and drafted the initial manuscript. Alessandro Benitez led the sections on triage ethics and crisis standards of care and critically revised the manuscript for intellectual content. Bence Jonsdottir contributed the sections on moral injury, institutional response, and organizational intervention, and provided final approval of the submitted version. All authors read and approved the final manuscript.

Ethics Statement

As a literature review synthesizing previously published, publicly available research and policy analysis, this article did not involve new data collection from human participants and did not require institutional ethics committee approval.

Data Availability

No new data were generated or analyzed for this review. All sources discussed are cited in the reference list and are publicly available through their respective

publishers.

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