Moral distress: information for physicians and trainees

Note to readers: text document only. Formatting will occur when content finalised post-consultation.

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Introduction

Moral distress can be experienced as an occupational hazard that originates in the workplace by physicians and trainees and other healthcare workers.[1] Physicians and trainees should be assured of sources of support and ethical guidance within their workplaces.

This resource, developed by the Royal Australasian College of Physicians (RACP), aims to:

- Help physicians and trainees understand moral distress, and the context in which it arises, without assuming an individual is lacking in some way.
- Situate moral distress in relation to similar terms, such as moral injury or burnout.
- Describe the causes and impacts of moral distress in working environments.
- Offer pathways for addressing moral distress.

This document is a resource and not a diagnostic, nor definitive, clinical guide. At the time of preparing this document, there was little in published literature on the ethical aspects of moral distress in medicine.[2]

Moral distress for a physician or trainee can be debilitating and its impact far-reaching. Knowledge of the risks and early action without fear of repercussions is important.

The RACP underlines the significance of preventing the workplace circumstances that might give rise to moral distress, promoting practices associated with good mental health and wellbeing, and fostering responsive and supportive workplaces.

Definition of moral distress

This resource defines moral distress as:

> *Ethical unease or disquiet resulting from a situation in which a clinician believes they have contributed to avoidable patient or community harm through their involvement in an action, inaction or decision that conflicts with their own values.*[3]

Moral distress occurs when healthcare workers are unable to provide high-quality patient care consistent with their values and training. For example, due to high demands, resource scarcity, deferment or cancellation of usual care, or restrictions preventing families from visiting dying loved ones.[4] As an occupational hazard, the incidence of potentially morally distressing events will be a function of the health care organisation and its ethical climate.[5] Times of emergency management may impact this.

Health care delivery has four guiding ethical principles: beneficence, justice, autonomy, and non-maleficence.[6] Situations where physicians or trainees feel these are being compromised may contribute to moral distress.

There are two points to note about moral distress:

[1] Kok N, Van Gurp J, van der Hoeven JG, Fuchs M, Hoedemaekers C, Zegers M. Complex interplay between moral distress and other risk factors of burnout in ICU professionals: findings from a cross-sectional survey study. BMJ quality & safety. 2023 Apr 1;32(4):225-34.

[2] Kherbache A, Mertens E, Denier Y. Moral distress in medicine: an ethical analysis. Journal of health psychology. 2022 Jul;27(8):1971-90.

[3] Sanderson, C., Sheahan, L., Kochovska, S., Luckett, T., Parker, D., Butow, P., & Agar, M. (2019). Re-defining moral distress: A systematic review and critical re-appraisal of the argument-based bioethics literature. *Clinical Ethics*, *14*(4), 195–210. https://doi.org/10.1177/1477750919886088

[4] Smallwood N, Pascoe A, Karimi L, et al. Moral distress and perceived community views are associated with mental health symptoms in frontline health workers during the COVID-19 pandemic. Int J Environ Res Public Health 2021;18:16.

[5] Altaker KW, Howie-Esquivel J, Cataldo JK. Relationships among palliative care, ethical climate, empowerment, and Moral distress in intensive care unit nurses. Am J Crit Care. 2018;27(4):295–302 cited in Spilg EG, Rushton CH, Phillips JL, Kendzerska T, Saad M, Gifford W, Gautam M, Bhatla R, Edwards JD, Quilty L, Leveille C. The new frontline: exploring the links between moral distress, moral resilience and mental health in healthcare workers during the COVID-19 pandemic. BMC psychiatry. 2022 Dec;22:1-2.

[6] Rawlings A, Brandt L, Ferreres A, Asbun H, Shadduck P. Ethical considerations for allocation of scarce resources and alterations in surgical care during a pandemic. Surgical endoscopy. 2021 May;35:2217-22.

1. The sense of powerlessness which is a significant element of the experience of moral distress.[7] [8]
2. Moral distress arises at least in part because of complex systemic factors which require healthcare workers (HCW) to act in ways contrary to their personal and professional values.[9]

A few examples of situations that may prompt moral distress (see Section 2 for more detailed examples):

- When inadequate pain relief is available to patients.
- When superiors make decisions that are disagreed with by other clinicians.
- When special circumstantial rules are introduced that impact patient care, eg. during the COVID-19 pandemic, there were strict visitation and contact rules introduced in health care and residential aged care facilities, including for palliative care patients.

Related occupational terms

The published literature frequently refers to 'moral injury' and 'moral stress' alongside 'moral distress.' Each of these are subjects of ongoing research and are briefly addressed here.

Moral distress is distinct from moral injury, burnout and moral stress which are also experienced by healthcare workers. These experiences often coexist. For example, moral distress frequently occurs together with burnout.[10]

Moral injury

This document defines moral injury as the psychological, social, and spiritual trauma/impact that results from acts or exposure that transgress ethical values.[11] It is worth appreciating that there is no agreed definition of moral injury.[12] Some definitions of moral injury can appear similar to or overlapping with those of moral distress.[13] Both moral distress and moral injury result from a perceived sense of powerlessness.[14]

Moral injury results in long-term emotional scarring or damage contributing to potentially permanent numbness, impaired functioning and social isolation.[15] In contrast, moral distress is a potentially reversible situational problem. It is derived from imposed external or internal constraints and could be potentially addressed if external constraints are removed or healthcare workers are enabled to deal with circumstances.

Little empirical research has been published on moral injury in healthcare workers,[16] [17] but it is known to occur in high-stakes situations or environments (such as hospital emergency care) and involves acts that

[7] Buchbinder M, Browne A, Berlinger N, Jenkins T, Buchbinder L. Moral Stress and Moral Distress: Confronting Challenges in Healthcare Systems under Pressure. The American Journal of Bioethics. 2023 Jun 21:1-5.
[8] Buchbinder M, Browne A, Berlinger N, Jenkins T, Buchbinder L. Moral Stress and Moral Distress: Confronting Challenges in Healthcare Systems under Pressure. The American Journal of Bioethics. 2023 Jun 21:1-5.
[9] Smallwood N, Bismark M, Willis K. Burn-out in the health workforce during the COVID-19 pandemic: opportunities for workplace and leadership approaches to improve well-being. BMJ leader. 2023 Mar 10:leader-2022.
[10] Hlubocky FJ, Taylor LP, Marron JM, Spence RA, McGinnis MM, Brown RF, McFarland DC, Tetzlaff ED, Gallagher CM, Rosenberg AR, Popp B. A call to action: Ethics committee roundtable recommendations for addressing burnout and moral distress in oncology. JCO Oncology Practice. 2020 Apr;16(4):191-9.
[11] Ducharlet K, Trivedi M, Gelfand SL, Liew H, McMahon LP, Ashuntantang G, Brennan F, Brown M, Martin DE. Moral distress and moral injury in nephrology during the COVID-19 pandemic. InSeminars in Nephrology 2021 May 1 (Vol. 41, No. 3, pp. 253-261). WB Saunders.
[12] Lindert J. Moral injury and moral distress. European Journal of Public Health. 2021 Oct 1;31(Supplement_3):ckab164-454.
[13] Buchbinder M, Browne A, Berlinger N, Jenkins T, Buchbinder L. Moral Stress and Moral Distress: Confronting Challenges in Healthcare Systems under Pressure. The American Journal of Bioethics. 2023 Jun 21:1-5.
[14] Buchbinder M, Browne A, Berlinger N, Jenkins T, Buchbinder L. Moral Stress and Moral Distress: Confronting Challenges in Healthcare Systems under Pressure. Am J Bioeth. 2024 Dec;24(12):8-22. doi: 10.1080/15265161.2023.2224270. Epub 2023 Jun 22. Update in: Am J Bioeth. 2024 Dec;24(12):29-32. doi: 10.1080/15265161.2024.2416137. PMID: 37347222; PMCID: PMC10758677.
[15] Hertelendy AJ, Gutberg J, Mitchell C, Gustavsson M, Rapp D, Mayo M, von Schreeb J. Mitigating Moral Distress in Leaders of Healthcare Organizations: A Scoping Review. Journal of Healthcare Management. 2022 Sep 1;67(5):380-402
[16] Čartolovni A, Stolt M, Scott PA, Suhonen R. Moral injury in healthcare professionals: A scoping review and discussion. Nursing ethics. 2021 Aug;28(5):590-602.
[17] Buchbinder M, Browne A, Berlinger N, Jenkins T, Buchbinder L. Moral Stress and Moral Distress: Confronting Challenges in Healthcare Systems under Pressure. The American Journal of Bioethics. 2023 Jun 21:1-5.

are inconsistent with operating values.[18] It has been argued that moral distress may lead to an experience of moral injury over time, however, this association needs further research.[19] [20]

Both moral distress and moral injury involve the experience of and exposure to moral stressors. Sources of moral stress (moral stressors) differ in the degree to which they might result in psychological, social and spiritual harm and impairment.[21] Moral stressors, with potential for moderate harm or impairment, and their impact, has been described as moral distress; while those with potential for the most extreme harm or impairment, deemed morally injurious events, can result in harm considered a moral injury.[22]

Moral stress

Moral stress is associated with the systems that generate stressors and arises out of the 'normal' operations of an overstressed system and routine structural features of health care that produce stress. For example, systems that prevent healthcare workers from providing care consistent with clinical standards and patient values and preferences and compromise professional integrity through various constraints.[23]

Compared to moral distress and moral injury, moral stress is less associated with individual clinical encounters or patient-centred decisions. Also, unlike moral distress and moral injury, moral stress does not necessarily involve a perception of powerlessness.

Burnout

The World Health Organization (WHO) defines burnout as an occupation-related syndrome resulting from chronic, unresolved, occupation-related stress.[24] Features of burnout can include physical exhaustion, emotional exhaustion, cynicism, depersonalisation, and a sense of inefficacy or low accomplishment.[25] [26] A person suffering burnout may feel depleted and mentally distanced from their job.

Burnout may occur in all stages of medical training and clinical practice and has serious consequences; these include medical errors, a lower quality of care, substance abuse, and suicide.[27] Burnout can stem from individual characteristics, eg. perfectionism, denial, the tendency to ignore distress, as well as organisational factors, eg. challenging work environments, or leadership not addressing healthcare worker wellbeing.[28]

There is an overlap between burnout and moral distress, eg. the United Kingdom Clinical Ethics Network notes that moral distress can lead to burnout, withdrawal from patients, or resignation.[29]

Administrative harm

[18] Ketchell, M. 2022 Moral injury: what happens when exhausted health workers can no longer provide the care they want for their patients The Conversation 2022 June 28
[19] Čartolovni A, Stolt M, Scott PA, Suhonen R. Moral injury in healthcare professionals: A scoping review and discussion. Nursing ethics. 2021 Aug;28(5):590-602.
[20] Čartolovni A, Stolt M, Scott PA, Suhonen R. Moral injury in healthcare professionals: A scoping review and discussion. Nursing ethics. 2021 Aug;28(5):590-602.
[21] Phoenix Australia – Centre for Posttraumatic Mental Health and the Canadian Centre of Excellence – PTSD (2020) Moral Stress Amongst Healthcare Workers During COVID-19: A Guide to Moral Injury. Phoenix Australia – Centre for Posttraumatic Mental Health and the Canadian Centre of Excellence – PTSD, ISBN online: 978-0-646-82024-*8*.
[22] Phoenix Australia – Centre for Posttraumatic Mental Health and the Canadian Centre of Excellence – PTSD (2020) Moral Stress Amongst Healthcare Workers During COVID-19: A Guide to Moral Injury. Phoenix Australia – Centre for Posttraumatic Mental Health and the Canadian Centre of Excellence – PTSD, ISBN online: 978-0-646-82024-*8*.
[23] Buchbinder M, Browne A, Berlinger N, Jenkins T, Buchbinder L. Moral Stress and Moral Distress: Confronting Challenges in Healthcare Systems under Pressure. The American Journal of Bioethics. 2023 Jun 21:1-5.
[24] WHO: Burn-out an "occupational phenomenon": International Classification of Diseases. https://www.who.int/mental_health/evidence/burn-out/en/
[25] WHO: Burn-out an "occupational phenomenon": International Classification of Diseases. https://www.who.int/mental_health/evidence/burn-out/en/
[26] Lemaire JB, Wallace JE. Burnout among doctors. Bmj. 2017 Jul 14;358.
[27] Bateman EA, Viana R. Burnout among specialists and trainees in physical medicine and rehabilitation: A systematic review. Journal of Rehabilitation Medicine. 2019 Oct 16;51(11):869-74.
[28] Lemaire JB, Wallace JE. Burnout among doctors. Bmj. 2017 Jul 14;358.
[29] UK Clinical Ethics Network 2020 Moral Distress and Moral Injury Information Sheet

Recent research has pointed to the negative effect of administrative harm on patients, the workforce, and organisations. Administrative harm can be defined as the adverse consequences of administrative decisions within health care and directly influences patient care and outcomes, professional practice, and organisational efficiencies regardless of employment setting.[30] Sources of administrative harm include onerous administrative guidelines, national or local overregulation, requirements for the provision of futile care, receiving intense pressure from insurers or employers to reduce costs, or increasing unfairness and demand imposed by certain patients over other patients.[31] Relating to the healthcare workforce, this harm has led to daily workarounds, requiring the workforce to bypass established protocols to provide patients with the care they need.[32]

Vicarious trauma
Mention of vicarious trauma is made here for information only. Vicarious trauma is the transformation or change in a worker's inner experience because of responsibility for and empathic engagement with traumatised children or adults. This can result in feelings of compassion, but also responsibility, coupled with varying degrees of helplessness and control.[33] [34]

The experience of moral distress: risk factors and examples

Healthcare workers and healthcare organisations are required to understand and accommodate a range of factors when making difficult choices between different health priorities, therapies and populations. With multiple factors to consider and sometimes competing issues, situations can give rise to an experience of moral distress. The following highlights the potential for situations to arise that may lead to an experience of moral distress and discusses examples.

The types of healthcare service and practice related factors that need to be accommodated on the job include:[35]

- The legal and regulatory control of healthcare and healthcare practitioners.
- The expectations patients, consumer and advocacy groups, and the community have regarding the treatment they should be offered and the outcomes they can expect.
- The impact of cultural and social determinants on health, health literacy and access to health care.
- The influence of competing interests of government, health care providers, insurers and the healthcare industry on health care costs, preferences and needs.
- Resource constraints.
- That trainees and physicians may have limited opportunity to participate in or authorise hospital or government policies.[36]

1. Risk factors and examples within healthcare services

Health care is delivered in a complex operating context and circumstances can change. Moral distress is more likely to arise in healthcare services where:

- Decisions need to be made under pressure.
- There is a lack of centralised ethical and governance support and guidance.

[30] Burden M, Astik G, Auerbach A, Bowling G, Kangelaris KN, Keniston A, Kochar A, Leykum LK, Linker AS, Sakumoto M, Rogers K. Identifying and Measuring Administrative Harms Experienced by Hospitalists and Administrative Leaders. JAMA Internal Medicine. jamainternal_burden_2024_oi_240035_1718213700.8473.pdf (silverchair.com)
[31] Kherbache A, Mertens E, Denier Y. Moral distress in medicine: an ethical analysis. Journal of health psychology. 2022 Jul;27(8):1971-90.
[32] Burden M, Astik G, Auerbach A, Bowling G, Kangelaris KN, Keniston A, Kochar A, Leykum LK, Linker AS, Sakumoto M, Rogers K. Identifying and Measuring Administrative Harms Experienced by Hospitalists and Administrative Leaders. JAMA Internal Medicine. jamainternal_burden_2024_oi_240035_1718213700.8473.pdf (silverchair.com)
[33] Prevention and Response to Violence Abuse and Neglect Government Relations (PARVAN). (2023). Integrated Trauma Informed Care Framework: My story, my health, my future, NSW Health, St Leonards, NSW.
[34] Isobel S, Thomas M. Vicarious trauma and nursing: An integrative review. International Journal of Mental Health Nursing. 2022 Apr;31(2):247-59.
[35] RACP 2020 Clinical Ethics Services Position Statement
[36] Farrell CM, Hayward BJ. Ethical dilemmas, moral distress, and the risk of moral injury: experiences of residents and fellows during the COVID-19 pandemic in the United States. Academic Medicine. 2022 Mar;97(3):S55.

- There is variability in the (actual or perceived) degree of ethics support and mental health and wellbeing support.

Moral distress is also more likely to arise when organisations change or introduce new work practices, and healthcare workers need to adapt, particularly when changes relate to funding constraints, workforce shortages or the need to practice 'defensive' medicine.[37] [38] Importantly, moral distress can arise too, simply from witnessing these kinds of practices and circumstances in the organisation, even if not directly involved.

Example situations
Practices and circumstances that can increase the risk of moral distress include:[39]

- **Working conditions and culture**
  - Examples include when physicians and trainees:
    - Work under conditions that feel unsafe (eg. excessive workloads, long hours, inadequate supervision, inadequate access to breaks and leave); where one's ability to perform best practice is limited, and/or where taking leave or resignation may worsen the situation for others.
    - Work in an organisational ethos that bolsters the belief that healthcare workers cannot be vulnerable (they "must be heroes").[40]
    - Are expected to take risks but do not feel protected by their organisation/employer.[41]
    - Are subject to a sense of pressure to 'volunteer'. This may mean volunteering for higher workloads or longer hours to contribute to organisational problems of excessive clinical loads, inadequate staffing resources and the absence of co-workers. This can be at the expense of work-life balance, relationships, commitments and nurturing health and wellbeing.
    - Are 'forced' to follow erroneous medical prescriptions or decisions which go against their moral values, and/or being compelled to adhere to another's' decisions despite knowing that they would prove ineffective.[42]
    - Work in an organisation where there is a tendency to 'cover up' incidents or not acknowledge potentially injurious informal practices.
    - Are asked to provide care outside their perceived area of competency or skill level.
    - Are needing to care and support colleagues, or maintain or juggle research and clinical priorities, or bear the fears of becoming ill oneself or causing family illness.[43]
    - Witness repetitive misgendering of a patient, discriminatory comments, overly intrusive questions or dismissal of symptoms related to a patient's rainbow identity. When a physician or trainee needs to consider the impact of speaking up on their relationship with the wider team and system, despite clear harm to doctor-patient relationships and potential missed diagnoses.
    - Are critical of a colleague's clinical practices, ie. when a physician or trainee suspects a person is receiving inadequate medical care from a colleague but is concerned they do not have sufficient information or do not know how to raise this without fear of reprisal.

[37] Olley R. Shield or sword?: Moral distress in Australian aged care employees related to regulation and compliance. Asia Pacific Journal of Health Management. 2022 Jun 1;17(2):1-9.
[38] Dzeng E, Wachter RM. Ethics in conflict: moral distress as a root cause of burnout. Journal of General Internal Medicine. 2020 Feb;35(2):409-11.
[39] See for example, Farrell CM, Hayward BJ. Ethical dilemmas, moral distress, and the risk of moral injury: experiences of residents and fellows during the COVID-19 pandemic in the United States. Academic Medicine. 2022 Mar;97(3):S55.
[40] Sherman M, Klinenberg E. Beyond burnout: Moral suffering among healthcare workers in the first COVID-19 surge. Social Science & Medicine. 2024 Jan 1;340:116471.
[41] Jenkins TM. Physicians as shock absorbers: The system of structural factors driving burnout and dissatisfaction in medicine. Social Science & Medicine. 2023 Nov 1;337:116311.

[42] Gustavsson ME, von Schreeb J, Arnberg FK, Juth N. Being prevented from providing good care: a conceptual analysis of moral stress among health care workers during the COVID-19 pandemic. BMC Medical Ethics. 2023 Dec 9;24(1):110.
[43] Drewett GP, Gibney G, Ko D. Practical ethical challenges and moral distress among staff in a hospital COVID-19 screening service. Internal medicine journal. 2021 Sep;51(9):1513-6.

- Experience inappropriate ways in which team members deal with patient issues that cause them discomfort, eg. senior colleagues may be heard discussing a patient in an inappropriate discriminatory way.

- **Resource allocation**

Where there is inadequate, inequitable or otherwise differential allocation of resources, then the potential for moral distress is open as the use of finite resources for one patient may mean other patients are disadvantaged. Resource decisions also extend to patient care, staffing, and budgets assigned to areas. Frameworks for resource allocations may vary across time and circumstances and may be seen as inequitable to some, for example, a hospital resource might be assigned to a patient with the shortest period of need. In disaster, emergency or pandemic circumstances, the needs of the many may be used to justify the benefit to a few.[44]

Other examples include:

- Decisions about access to life-sustaining procedures, such as transplants.
- Funding decisions that limit access to bariatric surgery, which has meant treatment is limited to those able to access private treatment, even though this surgery has the potential to prevent many serious future health problems such as diabetes, cardiovascular, and renal disease.
- Policies and practices that create or reinforce inequity or discrimination, whether intended.

- **Practice policies**

Organisational policies compel physicians, trainees and healthcare workers to proceed with certain actions in circumstances that can hold a risk of moral distress. Organisational policies can make a clinician feel 'trapped' into acting in ways that go against what they believe to be core values of their profession or personal values. Examples include:

- When there is an 'obligation' to provide treatments that are perceived as ineffective or a poor use of resources in some end-of-life circumstances, such as resuscitation or intensive care unit care. A physician may feel they are delivering clinically futile care that is unlikely to benefit the patient, or that might cause harm or prolong dying.
- When certain patient categories must be prioritised, or medications restricted. This may feel contrary to treating all patients equitably and morally compromising. These actions may need to be done in front of patients or carers.

- **Public health emergencies**

In these temporary circumstances, healthcare workers who bear a 'duty to treat' face situations involving the allocation of scarce resources, coercive social distancing measures, and see the impact of public health policy decisions. Examples include:

- Measures intended to:
  - Help and protect vulnerable patients, such as restrictions for family visits during infectious disease outbreaks.
  - Protect healthcare workers, such as the use of personal protective equipment.
- During the COVID-19 pandemic some healthcare workers:
  - Took on roles that stretched their professional competencies, constrained patient engagement, and fostered professional self-doubt and job dissatisfaction.[45]

[44] Rawlings A, Brandt L, Ferreres A, Asbun H, Shadduck P. Ethical considerations for allocation of scarce resources and alterations in surgical care during a pandemic. Surgical endoscopy. 2021 May;35:2217-22.
[45] Fantus S, Cole R, Hawkins L, Chakraborty P. 'Have They Talked About Us At All?'The Moral Distress of Healthcare Social Workers during the COVID-19 Pandemic: A Qualitative Investigation in the State of Texas. The British Journal of Social Work. 2023 Jan 1;53(1):425-47.

- Had to confront their sense of duty to patients and desire for clinical experience together with the risk of contracting the COVID-19 virus or spreading it to friends or family.[46]

During the COVID-19 pandemic, more frequent ethical dilemmas, together with the intense physical and emotional stress of medical training and the pandemic itself, made it more likely for physician trainees to experience moral distress.[47]

2. Risk factors and examples which are individual physician/trainee-centred

The experience of moral distress will be influenced and moderated by factors that relate to physicians and trainees as individuals. There are a range of such factors:

- Prior experience.[48]
- Personal stressors.[49]
- Degree of moral resilience, or capacity to regain a sense of integrity in response to moral adversity.[50]
- Other personal factors such as age or phase of life, mental health status, existing medical; conditions.[51]
- Co-existence of burnout.

Example situations

- **Experience of powerlessness**. Powerlessness is a significant component of moral distress. A healthcare worker might feel powerless and experience moral distress when they witness what they perceive as an unethical act or decision and feel powerless to intervene. Because a sense of powerlessness is central to the experience of moral distress, moral distress may be likely to affect those who are lower in organisational and professional hierarchies, or those who feel disempowered for other reasons, such as gendered or cultural norms, or discrimination.
- **Work-life balance**. Physicians and trainees can grapple with achieving a balance between their own health and wellbeing needs and their professional responsibilities.
- **Self-identity and image**. If a physician or trainee identifies as a person from a particular population group or sub-group, eg. sexual and/or gender diverse, culturally and linguistically diverse, or other identification, this may influence their experiences or serve as a specific challenge. Seeking assistance from those in a position to understand can be helpful.[52]
- **Hierarchy not a shield**. The experience of moral distress is not limited by a person's level in an organisation, nor the part of the healthcare system in which they work.[53] [54] Leaders (not only frontline healthcare workers) in healthcare organisations can also be susceptible to moral distress when faced with legal liabilities, funding constraints, workforce shortages, safety and quality issues with the care delivered, or an inability to meet consumer expectations.

[46] See for example, Farrell CM, Hayward BJ. Ethical dilemmas, moral distress, and the risk of moral injury: experiences of residents and fellows during the COVID-19 pandemic in the United States. Academic Medicine. 2022 Mar;97(3):S55.
[47] Farrell CM, Hayward BJ. Ethical dilemmas, moral distress, and the risk of moral injury: experiences of residents and fellows during the COVID-19 pandemic in the United States. Academic Medicine. 2022 Mar;97(3):S55.
[48] Millis MA, Vitous CA, Ferguson C, Van Wieren I, Kalata S, Shen MR, MacEachern M, Suwanabol PA. To feel or not to feel: a scoping review and mixed-methods meta-synthesis of moral distress among surgeons. Annals of Palliative Medicine. 2023 Mar 1;12(2):376-89.
[49] Millis MA, Vitous CA, Ferguson C, Van Wieren I, Kalata S, Shen MR, MacEachern M, Suwanabol PA. To feel or not to feel: a scoping review and mixed-methods meta-synthesis of moral distress among surgeons. Annals of Palliative Medicine. 2023 Mar 1;12(2):376-89.
[50] Spilg EG, Rushton CH, Phillips JL, Kendzerska T, Saad M, Gifford W, Gautam M, Bhatla R, Edwards JD, Quilty L, Leveille C. The new frontline: exploring the links between moral distress, moral resilience and mental health in healthcare workers during the COVID-19 pandemic. BMC psychiatry. 2022 Dec;22:1-2.
[51] Spilg EG, Rushton CH, Phillips JL, Kendzerska T, Saad M, Gifford W, Gautam M, Bhatla R, Edwards JD, Quilty L, Leveille C. The new frontline: exploring the links between moral distress, moral resilience and mental health in healthcare workers during the COVID-19 pandemic. BMC psychiatry. 2022 Dec;22:1-2.
[52] Verbal communication 27 May 2024.
[53] Walton MK. Sources of moral distress. Moral distress in the health professions. 2018:79-93.
[54] Hertelendy AJ, Gutberg J, Mitchell C, Gustavsson M, Rapp D, Mayo M, von Schreeb J. Mitigating Moral Distress in Leaders of Healthcare Organizations: A Scoping Review. Journal of Healthcare Management. 2022 Sep 1;67(5):380-402.

- **Lifestyle choices**. A physician or trainee may have certain beliefs and may find it challenging to acknowledge a patient's lifestyle choice and need to deal with personal discomfort during care, ie. if a patient reveals they are in a same-sex relationship or a patient uses alcohol or other substances that are contrary to the physician or trainee's own beliefs and practices.
- **Cultural awareness**. Awareness and respect for cultural practices is important. For example, in some Asian cultures it can be culturally acceptable not to give bad news to older people, and this may pose an ethical dilemma for a physician or trainee.
- **Patient decision-making.** Consenting adult patients have the right to make decisions that could harm their health or shorten their lifespan, such as seeking out or refusing certain treatments. However, if a physician or trainee suspects there is abuse contributing to the ill-health of an adult, a person with disability, a vulnerable older person or a situation of domestic and/or family violence, the physician or trainee may have to carefully balance their patient's autonomy with best-interests and professional obligations. There can be options for reporting these situations to responsible authorities, such as police, or advisory services, such as 1800 RESPECT.
- **Work performance.** Factors that may affect work performance include a health issue or disability of the physician or trainee, such as a hand tremor that limits ability to perform procedures. It may also relate to the challenges posed when a colleague is providing sub-standard care and balancing patient safety with the best interests of the colleague, which includes their health and wellbeing, professional reputation and relationships in the workplace.
- **Discrimination from patients and families/carers.** In addition to potential systemic discrimination from co-workers, physicians and trainees, who may be from diverse cultural or religious backgrounds, or are LGBTQIA+, may also be mistreated by patients and their families/carers in healthcare settings. This can include physicians and trainees who have assumptions made about them based on their appearance regardless of their country of birth.
- **Family/carer decisions**. Family or carers may make health care decisions on behalf of a person. This may occur in patients with reduced decision-making capacity due to their young age or cognitive ability. Culturally and linguistically diverse patients with inadequate or no translation services are also at risk. For example, family/carer decision-makers may reject palliative care while demanding high intensity, invasive and likely non-beneficial treatments for loved ones at the end of life, or parents may reject proven and generally accepted medical treatments for their children due to a perceived risk of harm.
- **Risk of harm.** A physician or trainee will often need to consider treatment impact, for example, a person who has multiple conditions requires a treatment for one issue which risks exacerbating another health issue they have.

3. Risk factors and examples outside organisational control

There are factors outside the individuals' or workplace organisation's control that can lead to or contribute to circumstances involving moral distress. A physician or trainees' inability to act in accord with their individual and professional ethical values may be precipitated or aggravated by changes in the healthcare system and society.[55]

Decision making that impacts patient care is made within a broader context, under which sits an economic platform and legal responsibilities.[56] The RACP 2020 Clinical Ethics Position Statement highlights the influence of the competing interests of government, health care providers, insurers and healthcare industries on health care costs, preferences and needs; and resource constraints, over which neither the employing healthcare organisation, nor the individual, may have influence or means of satisfactory recourse. In stretched times, or public health emergencies, historically disadvantaged groups may be impacted more, sometimes compounded by triage criteria or algorithms that perpetuate inequities.[57] Such groups may already be burdened by comorbidities.

[55] Dzeng E, Wachter RM. Ethics in conflict: moral distress as a root cause of burnout. Journal of General Internal Medicine. 2020 Feb;35(2):409-11.
[56] Mareš J. Moral distress: Terminology, theories and models. Kontakt. 2016 Sep 1;18(3):e137-44.
[57] Laventhal N, Basak R, Dell ML, Diekema D, Elster N, Geis G, Mercurio M, Opel D, Shalowitz D, Statter M, Macauley R. The ethics of creating a resource allocation strategy during the COVID-19 pandemic. Pediatrics. 2020 Jul 1;146(1)

From a moral distress perspective, witnessing disparities in care, because healthcare systems can impact certain population groups more or less because of the way in which systems are structured or organised, can become problematic. Social inequities can be manifest as homelessness, reduced financial capacity and/or substance use among patient groups, and their healthcare needs may not be met due to the way in which systems are organised. Rural and remote communities, where services are either a long way away or in short supply, may be cause for concern for physicians and trainees. The various social determinants of ill health and inequitable access for some patients to healthcare services can contribute to or compound a sense of moral distress for physicians and trainees.[58] [59] [60]

Example situations

- **Legislation.** Legislation may determine healthcare service access or direct certain accountabilities within an organisation,[61] eg. legislation that guides access to gender affirming therapies, voluntary assisted dying, or access to certain drugs for medical purposes.
- **Sector integration**. Where the wider system or operating context impacts patient care when healthcare services interface with other services:
    - When a patient is to be discharged from hospital and requires disability or aged care services or equipment and there is extensive paperwork, referrals assessments and waitlists.
    - Where health care or service delivery requires external authorisation or approval such as guardianship applications, or special funding approvals
    - Where there are disparities arising from differences between states and territories in Australia or between rural and metropolitan centres, which impact patient health care.
- **Public health emergencies.** The COVID-19 pandemic changed the nature of healthcare organisations and healthcare service delivery and there were changes that effected the moral experiences of physicians, trainees and other healthcare workers.[62] Rsearch and awareness of moral distress has been prompted by the COVID-19 pandemic, which has brought various ethical dilemmas to the forefront of health care, including those for junior medical officers and physician trainees.[63]
- **Health care inequity.** Physicians and trainees are aware of poorer health outcomes certain population groups experience, such as those from geographical isolation, or who lack access to culturally appropriate care, or have poor health literacy. Difficult decisions may be involved, for example, for people in remote communities to access the most effective treatment for cancer may involve separation from their family or community, which is difficult and sometimes detrimental, or a physician or trainee may know that a patient needs a pathology test/scan/treatment or specialist appointment that they are unable to afford, or that they have other access barriers for, such as transport.

A note on additional challenges

People may be reluctant to seek health care from, or have felt rejected by, a healthcare facility or healthcare provider that is unable to provide culturally appropriate care. This may include organisations that are linked to religious or cultural groups that may have expressed public views about certain population groups. This involves navigating dual harms of potential exposure to harm but needing to refer a patient for the right expertise or care.

<u>Recognising challenges for Aboriginal, Torres Strait Islander, Māori and Pasifika physicians and trainees</u>

[58] Dzeng E, Wachter RM. Ethics in conflict: moral distress as a root cause of burnout. Journal of General Internal Medicine. 2020 Feb;35(2):409-11.
[59] Varcoe C, Pauly B, Webster G, Storch J. Moral distress: tensions as springboards for action. InHEC forum 2012 Mar (Vol. 24, pp. 51-62). Springer Netherlands.
[60] Berlinger N, Berlinger A. Culture and moral distress: what's the connection and why does it matter?. AMA Journal of Ethics. 2017 Jun 1;19(6):608-16.
[61] Mareš J. Moral distress: Terminology, theories and models. Kontakt. 2016 Sep 1;18(3):e137-44.
[62] Wilson MA, Shay A, Harris JI, Faller N, Usset TJ, Simmons A. Moral Distress and Moral Injury in Military Healthcare Clinicians: A Scoping Review. AJPM focus. 2024 Apr 1;3(2):100173.
[63] Farrell CM, Hayward BJ. Ethical dilemmas, moral distress, and the risk of moral injury: experiences of residents and fellows during the COVID-19 pandemic in the United States. Academic Medicine. 2022 Mar;97(3):S55.

Moral distress can be related to the experience of systemic barriers, including policy decisions that do not align with the needs of Aboriginal, Torres Strait Islander, Māori and Pasifika people and communities. Aboriginal, Torres Strait Islander, Māori and Pasifika physicians and trainees may be working within complex systems yet be advocating for a more holistic approach to health care that better supports the needs of their community. Physicians and trainees may face both personal experiences of racism, bullying, harassment and/or discrimination and witness the impacts on their patients, exacerbating their distress.

We acknowledge that recent changes to the Aotearoa New Zealand healthcare system can be a source of moral distress for Māori and Pasifika physicians and trainees as it impacts the experience of inclusivity and culturally sensitive and safe approaches to health care.

Recognising challenges for the LGBTIQ+ community

A physician may believe they may have contributed to avoidable harm to an LGBTIQ+ patient or community through actions, inactions, or decisions that conflict with their own values. Advice received[64] is to consider any subsequent actions from a lens of integrity. This may involve honest communication with affected individuals or communities or seeking learning opportunities about LGBTIQ+ health needs.

General signs of moral distress

Early detection of moral distress is important for both the individual and the organisation.[65] Note that many of the symptoms and behaviours are similar to those that stem from other causes, such as psychological stress, anxiety and burnout.[66]

It is helpful to note here that doctors with intersectional identities, that is those who may identify with more than one specific population group, may find themselves in distressing situations often and that the reasons for the distress are complex to recognise and then find appropriate support.[67]

Moral distress can manifest as: [68]

- Emotional symptoms (frustration, anger, anxiety, guilt, sadness powerlessness, withdrawal burnout). [69] [70] [71]
- Physical symptoms (muscle aches, headaches, heart palpitations, neck pain, diarrhea, vomiting, insomnia, headaches, muscle aches, heart palpitations). [72] [73]
- Psychological symptoms (depression, emotional exhaustion, loss of self-worth, nightmares, reduced job satisfaction, depersonalization of patients anxiety, depression, substance overuse and misuse, alienation, detachment, avoidance, moral disengagement, cynicism and reduced empathy or engagement with patients, and suicidal ideation.[74].[75]).

[64] From community organisation consultations in the course of developing this resource
[65] Kopacz MS, Ames D, Koenig HG. It's time to talk about physician burnout and moralinjury. Lancet Psychiatry 2019; 6: e28.
[66] Smallwood N, Pascoe A, Karimi L, Willis K. Moral distress and perceived community views are associated with mental health symptoms in frontline health workers during the COVID-19 pandemic. International Journal of Environmental Research and Public Health. 2021 Aug 18;18(16):8723.
[67] Anecdotal information provided by Pride on Medicine July 2024
[68] Saver C. Managing moral distress. New Mexico Nurse. 2022 Apr 1;67(2):8-11.
[69] UK Clinical Ethics Network 2020 Moral Distress and Moral Injury Information Sheet
[70] Sukhera J, Kulkarni C, Taylor T. Structural distress: experiences of moral distress related to structural stigma during the COVID-19 pandemic. Perspectives on medical education. 2021 Aug;10(4):222-9.
[71] Perni S, Pollack LR, Gonzalez WC, Dzeng E, Baldwin MR. Moral distress and burnout in caring for older adults during medical school training. BMC Med Educ. 2020;20:84.
[72] Saver C. Managing moral distress. Georgia Nursing. 2021:14-5. Managing moral distress | NACNS :: National Association of Clinical Nurse Specialists
[73] Lewis S, Willis K, Smallwood N. The collective experience of moral distress: a qualitative analysis of perspectives of frontline health workers during COVID-19. Philosophy, Ethics, and Humanities in Medicine. 2025 Jan 9;20(1):1.
[74] Dzeng E, Wachter RM. Ethics in conflict: moral distress as a root cause of burnout. Journal of General Internal Medicine. 2020 Feb;35(2):409-11.
[75] Lamiani G, Biscardi D, Meyer EC, Giannini A, Vegni E. Moral distress trajectories of physicians 1 year after the COVID-19 outbreak: A grounded theory study. International Journal of Environmental Research and Public Health. 2021 Dec 19;18(24):13367.

A major Australian study during COVID-19 among healthcare workers found moral distress was associated with increased risk of anxiety, depression, post-traumatic stress disorder, and burnout.[76] The researchers also suggest that moral distress could be not only a predictor for, but a compounding factor in, the presentation of mental health symptoms.

For each physician there may also be factors that serve to moderate identifying an experience of moral distress such as:

- A physician's cultural background (for example, one that discourages open discussion of emotional or ethical concerns).
- A workplace culture that does not support ethical discourse or reflection.
- Access to helpful resources, or limited access to support services, such as mental health resources.

Impacts of moral distress

Moral distress can have both individual and organisational repercussions.

Individuals

An individual physician or other healthcare worker's response to moral distress will depend upon several factors, including personal capacities and predispositions, position in the medical hierarchy (e.g., professional role, status, discipline), and external resources within the infrastructure (such as the unit/team level, institutional and system levels) and outside it.[77] However, both frontline healthcare workers and healthcare leaders (higher level decision-makers) can experience moral distress.[78] Further, when there are repeated experiences of moral distress then unresolved moral tensions can accumulate and become "moral residue" which can then impair healthcare workers' ability to cope with additional morally distressing experiences. [79]

Organisations

Moral distress impacts organisations as it compromises clinician health and wellbeing, patient safety and quality of care, through risk of medical error[80], and any negative impact on patient care[81] [82], and the economic strength of practices and institutions. It can also compromise the healthcare workforce and create staff shortages because of increased absenteeism, staff turnover, intentions to leave, presenteeism, or people being at work not performing well or potentially making sub-optimal decisions. [83] [84]

Patients

Moral distress has also been described as an issue impacting patients which may also impact physicians and trainees.[85] A fuller discussion is beyond the scope of this document.

[76] Smallwood N, Pascoe A, Karimi L, Willis K. Moral distress and perceived community views are associated with mental health symptoms in frontline health workers during the COVID-19 pandemic. International Journal of Environmental Research and Public Health. 2021 Aug 18;18(16):8723.
[77] Buchbinder M, Browne A, Berlinger N, Jenkins T, Buchbinder L. Moral Stress and Moral Distress: Confronting Challenges in Healthcare Systems under Pressure. The American Journal of Bioethics. 2023 Jun 21:1-5.
[78] Hertelendy AJ, Gutberg J, Mitchell C, Gustavsson M, Rapp D, Mayo M, von Schreeb J. Mitigating Moral Distress in Leaders of Healthcare Organizations: A Scoping Review. Journal of Healthcare Management. 2022 Sep 1;67(5):380-402.
[79] Dunham AM, Rieder TN, Humbyrd CJ. A bioethical perspective for navigating moral dilemmas amidst the COVID-19 pandemic. J Am Acad Orthop Surg. 2020;28(11):471–76.
[80] Crane MF, Bayl-Smith P, Cartmill J. A recommendation for expanding the definition of moral distress experienced in the workplace. The Australasian Journal of Organisational Psychology. 2013;6:e1.
[81] Henrich NJ, Dodek PM, Gladstone E, Alden L, Keenan SP, Reynolds S, Rodney P. Consequences of moral distress in the intensive care unit: a qualitative study. American Journal of Critical Care. 2017 Jul 1;26(4):e48-57.
[82] Fish EC, Lloyd A. Moral distress amongst palliative care doctors working during the COVID-19 pandemic: a narrative-focussed interview study. Palliative Medicine. 2022 Jun;36(6):955-63.
[83] As summarized in this systematic review from separate research studies: Hertelendy AJ, Gutberg J, Mitchell C, Gustavsson M, Rapp D, Mayo M, von Schreeb J. Mitigating Moral Distress in Leaders of Healthcare Organizations: A Scoping Review. Journal of Healthcare Management. 2022 Sep 1;67(5):380-402.
[84] Greenberg N, Tracy D. What healthcare leaders need to do to protect the psychological well-being of frontline staff in the COVID-19 pandemic. Bmj Leader. 2020 Sep 1;4(3).
[85] Seidlein AH, Salloch S. Who cares about care? Family members as moral actors in treatment decision making. The American Journal of Bioethics. 2020 Jun 2;20(6):80-2.

Responding to moral distress

Responses and support can come from several sources, and remedial steps can and should be taken by both individuals and organisations where an experience of moral distress is suspected. Below are proactive steps for a physician to consider, including seeking peer support and making suggestions for change within working environments. While this is a resource for physicians and trainees, and not healthcare organisations, as employers, physicians might reasonably expect evidence-based support from organisations given the growing body of research. A range of forms this support might take is described here and might be used to prompt further action such as:

- Providing support and moral leadership and changing the ethical culture,[86]
- Providing mental health and wellness frameworks not specific to moral distress.[87]
- Supporting and fostering resiliency in individual clinicians, although it is suggested attention be given to the systemic issues.

The RACP is a strong supporter of Clinical Ethics Support Services and their valuable role for physicians and trainees experiencing moral distress.

Individuals

Although the responsibility for addressing the circumstances that cause moral distress generally needs to come from organisations, healthcare workers can take steps to protect their own health and wellbeing. It may help physicians and trainees to be reminded of the Australian Medical Association Code of Ethics clause 1.5:

> *While doctors have a primary duty to individual patients, they also have responsibilities to other patients, colleagues, other healthcare professionals and the wider community including future generations as well as to themselves in terms of their own health and well-being*.

Here are several self-care strategies:

- Learning the signs and symptoms of moral distress. Broad symptoms of anxiety, anger, and confusion may be related to moral distress.[88]
- Reflecting on the possible source/s of moral distress.
- Considering the elements of a situation that are within an individual's power to address and those that may not be. Where relevant to a situation involving patients, it may be that connecting them to a support organisation is of some benefit and a proactive step.
- Recognising that self-care is a significant responsibility and this may involve taking leave from work or reducing hours.
- Seeking support and assistance, including peer support, leader support, organisational or external support.
- Although this resource does not deem moral distress to be an individual-centred issue, attending a relevant mental health strengthening program or accessing RACP wellbeing resources or podcast series may bolster a sense of support.
- Discussing concerns with a healthcare practitioner or arranging for a health assessment – Doctors Health Services can be a source for support in urgent situations, and to assist in locating suitable treating practitioners.
- Contacting an organisational Occupational and Environmental Medicine Physician.
- Maintaining physical health and avoiding substance use/abuse.
- Raising issues with organisational leaders and proposing alternative ways of addressing sources of distress, including Chief Wellness Officers and similar roles in hospitals focused on workforce wellbeing and culture (the RACP advocates for broader introduction of these roles).
- Raising concerns with a clinical ethics support service.

[86] Banerjee D, Alici Y. Moral distress in physicians. Depression, Burnout and Suicide in Physicians: Insights from Oncology and Other Medical Professions. 2022:127-35.
[87] Hertelendy AJ, Gutberg J, Mitchell C, Gustavsson M, Rapp D, Mayo M, von Schreeb J. Mitigating Moral Distress in Leaders of Healthcare Organizations: A Scoping Review. Journal of Healthcare Management. 2022 Sep 1;67(5):380-402.
[88] Savel RH, Munro CL. Moral distress, moral courage. American Journal of Critical Care. 2015 Jul 1;24(4):276-8.

- Make a learning opportunity and plan for future similar situations and challenges.
- Seek advice from the RACP Support Program - a free 24/7, fully confidential and independent help line for Fellows and trainees.

***Aboriginal and Torres Strait Islander physicians and trainees** are encouraged to connect with other Aboriginal and Torres Strait Islander physicians, trainees or healthcare professionals who may have similar experiences. Organisations such as Australian Indigenous Doctors Association' (AIDA), Indigenous Allied Health Australia (IAHA) and the Australian Indigenous Psychologists Association (AIPA) would be able to provide peer support. In addition, finding an Aboriginal and/or Torres Strait Islander mentor to provide guidance and support, offer culturally relevant advice and/or coping strategies could also be beneficial.

***Māori and Pasifika physicians and trainees** are encouraged to connect with whānau, and relevant support organisations such as the Pasifika Medical Association and Te Ohu Rata O Aotearoa Maori Medical Practitioners .

Collegial support
An important source of support can come from colleagues. Peer support: [89]
- Improves social support.
- Improves help-seeking.
- Improves occupational function.
- Reduces sickness absence.

Mechanisms for tapping into peer support might range from the informal to be more structured. Examples are:
- Workplace buddy systems.[90]
- Informal forums and places where peers gather. Physicians and trainees should understand the boundaries, risks and expectations of sharing experiences.
- Case review meetings.
- Schwartz rounds (or safe places to express feelings).[91]
- Mortality and Mobidity meetings (M&M meetings).
- Peer support programs among healthcare workers, where peers may have received relevant receive training. [92]

Being mindful of colleagues
For all physicians and trainees it is helpful to colleagues if they endeavour to maintain knowledge and understanding of what cultural safety means and what may contribute to moral distress. This might differ for Aboriginal and Torres Strait Islander physicians/trainees and Māori and Pasifika physicians/trainees. Cultural safety refers to an environment that is spiritually, socially, culturally and emotionally safe for First Nations peoples, and where there is no challenge to their identity or needs.

We also encourage awareness of the different experiences and sensitivities of physicians/trainees with disability, sexual and/or gender diversity who identify with the LGBTQI+ community, physicians/trainees who have experienced trauma, physicians/trainees with lived experience of violence, abuse and neglect, physicians/trainees who may have a mental health condition, or physicians/trainees from cross-cultural backgrounds.

[89] Flaherty M, O'Neil VE. Psychological peer support for staff: implementing the trauma risk management model in a hospital setting. Nursing Management. 2022 Feb 3;29(1).
[90] Greenberg N, Tracy D. What healthcare leaders need to do to protect the psychological well-being of frontline staff in the COVID-19 pandemic. Bmj Leader. 2020 Sep 1;4(3).
[91] Pepper JR, Jaggar SI, Mason MJ, Finney SJ, Dusmet M. Schwartz Rounds: reviving compassion in modern healthcare. Journal of the Royal Society of Medicine. 2012 Mar;105(3):94-5.
[92] Simms L, Ottman KE, Griffith JL, Knight MG, Norris L, Karakcheyeva V, Kohrt BA. Psychosocial Peer Support to Address Mental Health and Burnout of Health Care Workers Affected by COVID-19: A Qualitative Evaluation. International Journal of Environmental Research and Public Health. 2023 Mar 3;20(5):4536.

Organisations

This section is included because physicians and trainees often practice in organisations and should be aware of what can be done, or so they may advocate for better working environments in the interests of their own and patient health and safety. Safe work Australia has a comprehensive Code of Practice for the healthcare and social assistance industry which addresses psychosocial hazards at work.[93]

It has been stated that moral distress may continue and can lead to an individual becoming morally numb to ethically challenging situations and/or experiencing burnout.[94] This is both an incentive to act and good reason to encourage organisational address. However, more research is needed on the work environmental factors which reduce or increase the risk of lingering moral distress. [95]

It is in the interests of organisations to reduce the likelihood of staff experiencing moral distress. For organisations, moral distress:

- Compromises healthcare worker health and wellbeing, patient safety and has a negative impact on patient care,[96] [97] including through risk of medical error.[98]
- Increases the likelihood of staff shortages (through increased absenteeism, staff turnover, intentions to leave, presenteeism).[99]

The key is to prevent any psychosocial harm to employees, and to promote work practices that do not harm mental health. A healthy ethical climate in organisations can reduce moral distress, along with supporting guidance on how ethical issues should be handled. Ideally, a culture of ethical reflection and open discussion will ameliorate the potential for moral distress to remain unaddressed. [100]

Ideally, organisations should have in place:[101] [102] [103]

- Explicit workplace policies that are communicated and upheld which will support organisational responses, improvements and potential prevention
- Known, and repercussion-free, supports available.
- The provision of leadership and resources.
- Flexible working hours.
- Informal and formal staff supports.
- Sufficient staffing.
- Transparency and accountability in decision making.
- Involvement of clinical leaders in health care decisions that impact patients and the capacity for patient care.
- Roles such as Chief Wellness Officers or similar which are focused on workforce wellbeing and culture

[93] [also including ref] Safe work Australia 2025 Model Code of practice for the healthcare and social assistance industry URL: https://www.safeworkaustralia.gov.au/sites/default/files/2025-07/model_code_of_practice_for_the_healthcare_and_social_assistance_industry.pdf

[94] Savel RH, Munro CL. Moral distress, moral courage. American Journal of Critical Care. 2015 Jul 1;24(4):276-8.

[95] Bondjers K, Glad AK, Wøien H, Wentzel-Larsen T, Atar D, Reitan SK, Rosseland LA, Zwart JA, Dyb G, Stensland SØ. Moral distress and protective work environment for healthcare workers during public health emergencies. BMC Medical Ethics. 2024 Oct 1;25(1):103.

[96] Henrich NJ, Dodek PM, Gladstone E, Alden L, Keenan SP, Reynolds S, Rodney P. Consequences of moral distress in the intensive care unit: a qualitative study. American Journal of Critical Care. 2017 Jul 1;26(4):e48-57.

[97] Fish EC, Lloyd A. Moral distress amongst palliative care doctors working during the COVID-19 pandemic: a narrative-focussed interview study. Palliative Medicine. 2022 Jun;36(6):955-63.

[98] Crane MF, Bayl-Smith P, Cartmill J. A recommendation for expanding the definition of moral distress experienced in the workplace. The Australasian Journal of Organisational Psychology. 2013;6:e1.

[99] As summarized in this systematic review from separate research studies: Hertelendy AJ, Gutberg J, Mitchell C, Gustavsson M, Rapp D, Mayo M, von Schreeb J. Mitigating Moral Distress in Leaders of Healthcare Organizations: A Scoping Review. Journal of Healthcare Management. 2022 Sep 1;67(5):380-402.

[100] Kherbache A, Mertens E, Denier Y. Moral distress in medicine: an ethical analysis. Journal of health psychology. 2022 Jul;27(8):1971-90.

[101] For example, Bell J, Breslin JM. Healthcare provider moral distress as a leadership challenge. JONA'S healthcare law, ethics and regulation. 2008 Oct 1;10(4):94-7.

[102] Alonso-Prieto E, Longstaff H, Black A, Virani AK. COVID-19 outbreak: Understanding moral-distress experiences faced by healthcare workers in British Columbia, Canada. International Journal of Environmental Research and Public Health. 2022 Aug 6;19(15):9701.

[103] British Medical Association 2021 Moral distress and moral injury – recognising and tackling it for UK doctors

- Opportunities created for healthcare workers to share and process experiences.
- A safe forum to bring forward and discuss ethical situations and incidents. This can serve to alert organisational leadership and reduce delays in addressing such issues.
- Protected time for trainees and their supervisors to address ethical challenges
- Strategies to reduce those factors that give rise to ethical challenges such as resource constraints or policy decisions,[104]
- Strategies that support the mental health of the healthcare workforce.[105] Key factors include supportive leadership and management, strengthening a sense of community to support mental health, and normalising mental health support.[106] Another is making transparent a fair and feasible method to allocate scarce resources across the patient populations.[107]
- Recognising that work environments will have diverse staff who may require additional support structures to address the unique stressors faced by different population groups.
- Infusing a commitment to the health and safety of healthcare workers into the health organisations.

Specific strategies are described below:[108]

- Encouraging a “speak-up” safe culture, reinforcing that people will be empathetically heard.
- Reviewing policies to ensure healthcare workers are encouraged and not deterred from seeking appropriate care for their physical health, mental health, and/or substance use concerns.
- Smoothing ready access to high-quality, confidential mental health care.
- Instituting a process for anonymous complaints and issue raising. For example see the Speak up for safety campaign run in different states, with information through state Worksafe departments.
- Making employees feel valued.[109]
- Ensuring that administrators are accessible to those performing direct patient care, and that they maintain clear communication and transparency regarding institutional challenges.
- Including clinicians as decision makers on all institutional ethics committees.
- Involving clinical leaders in health care decisions.
- Monitoring the clinical and organisational climate to identify situations that could create moral distress.
- Measuring culture and wellbeing and moral distress among staff through evidence-based tools.
- Providing tools to help clinicians recognise the experience of moral distress.
- Creating interdisciplinary forums to discuss patient goals of care and divergent opinions regarding those goals of care in an open, respectful environment.
- Providing critical stress debriefings, Clinical Ethics Support Services, Employee assistance programs, grief counselling.
- Supporting mental health first aid.
- Providing comfortable reflective space.

Employers have relevant Workplace Health and Safety (WHS) legislative responsibilities regarding their general duty of care. Of special note is that health care organisations in Australia under model work health and safety laws, must treat psychosocial hazards and *risks* the same as physical hazards and

[104] Hertelendy AJ, Gutberg J, Mitchell C, Gustavsson M, Rapp D, Mayo M, von Schreeb J. Mitigating Moral Distress in Leaders of Healthcare Organizations: A Scoping Review. Journal of Healthcare Management. 2022 Sep 1;67(5):380-402.
[105] Maple JL, Willis K, Lewis S, Putland M, Baldwin P, Bismark M, Harrex W, Johnson D, Karimi L, Smallwood N. Healthcare workers' perceptions of strategies supportive of their mental health. Journal of Medicine, Surgery, and Public Health. 2024 Apr 1;2:100049.
[106] Maple JL, Willis K, Lewis S, Putland M, Baldwin P, Bismark M, Harrex W, Johnson D, Karimi L, Smallwood N. Healthcare workers' perceptions of strategies supportive of their mental health. Journal of Medicine, Surgery, and Public Health. 2024 Apr 1;2:100049.
[107] Laventhal N, Basak R, Dell ML, Diekema D, Elster N, Geis G, Mercurio M, Opel D, Shalowitz D, Statter M, Macauley R. The ethics of creating a resource allocation strategy during the COVID-19 pandemic. Pediatrics. 2020 Jul 1;146(1).
[108] American Assoc Critical Care Nurses 2020 AACN Position Statement: Moral Distress in Times of Crisis - AACN
[109] Stillman M, Sullivan EE, Prasad K, Sinsky C, Deubel J, Jin JO, Brown R, Nankivil N, Linzer M. Understanding what leaders can do to facilitate healthcare workers' feeling valued: improving our knowledge of the strongest burnout mitigator. BMJ leader. 2024 Apr 22:leader-2023.

risks.[110] Part of the organisational role is to provide 'good work' with all its benefits, and not health risks (see also the RACP Health Benefits of Good Work® (racp.edu.au)). Duty of care obligations include the need to address:[111]

- Bullying and harassment.
- Negative workplace cultures.
- Unsafe hours of work, including shift work.
- Fatigue.
- Violence towards healthcare workers.
- Psychosocial risks.[112]

Clinical ethics support services

For physicians, trainees and other healthcare workers, workplaces are increasingly complex and multidisciplinary environments in which there is social, cultural, political, religious and moral diversity. While the capacity of medicine to prevent, diagnose and treat illness and disease has dramatically increased, healthcare systems and clinical practice are part of their broader changing social, political and economic context.[113]

Clinical ethics support services can play an important role as a mechanism for enhancing healthcare decision making that is defensible. They might also lessen the burden of complex decisions needed, for example during a pandemic.[114] [115]

Clinical Ethics Support Services can contribute to the development of patient-centred policies that involve important ethical considerations, such as resuscitation, end of life care or filming surgeries, offering ethical leadership and a point of reference.[116]

[110] Safe work Australia 2022 WHS code of practice: managing psychosocial hazards at work
[111] Refer Safe work Australia
[112] 2023 Model work health and safety regulations
[113] RACP 2020 Clinical Ethics Services Position Statement
[114] Fritz Z , Huxtable R , Ives J , et al . Ethical road map through the COVID-19 pandemic. BMJ 2020;369:m2033. doi:10.1136/bmj.m2033
[115] Rosenthal MS, Clay M. Initiatives for responding to medical trainees' moral distress about end-of-life cases. AMA journal of ethics. 2017 Jun 1;19(6):585-94.
[116] Machin LL , Wilkinson M . Making the (business) case for clinical ethics support in the UK. HEC Forum 2021;33:371–91. doi:10.1007/s10730-020-09416-6

APPENDIX

Useful resources and further reading

- Australian Medical Association 2020 Health and wellbeing of doctors
- The *Anti-Discrimination and Human Rights Legislation Amendment (Respect at Work) Act 2022* (Commonwealth, Australia)
- Australian Human Rights Commission 2020 *Guidelines on the rights of people with disability in health and disability care during COVID-19* ISBN 978-1-925917-24-6British Medical Association ("BMA"), 2020. *COVID-19 – ethical issues. A guidance note*. London: BMA.
- Drewett GP, Gibney G, Ko D. Practical ethical challenges and moral distress among staff in a hospital COVID-19 screening service. Internal medicine journal. 2021 Sep;51(9):1513-6.
- Gustavsson ME, von Schreeb J, Arnberg FK, Juth N. Being prevented from providing good care: a conceptual analysis of moral stress among health care workers during the COVID-19 pandemic. BMC Medical Ethics. 2023 Dec 9;24(1):110.
- Jenkins TM. Physicians as shock absorbers: The system of structural factors driving burnout and dissatisfaction in medicine. Social Science & Medicine. 2023 Nov 1;337:116311.
- Molinaro ML. Moral distress: A structural problem with individual solutions. *Journal of Health Services Research & Policy*. 2025;30(2):77-78. doi:10.1177/13558196251315330
- Phoenix Australia – Centre for Posttraumatic Mental Health and the Canadian Centre of Excellence – PTSD (2020) Moral Stress Amongst Healthcare Workers During COVID-19: A Guide to Moral Injury. Phoenix Australia – Centre for Posttraumatic Mental Health and the Canadian Centre of Excellence – PTSD, ISBN online: 978-0-646-82024-*8.*
- Royal College of Physicians. 2020 Ethical dimensions of COVID-19 for frontline staff. London: Royal College of Physicians.
- Rushton, C. Oxford University What is the Cause of Moral Distress in Healthcare Professionals? https://youtu.be/i5eN4_R9AAE?si=Ay_7hqtMoRV88hrO
- Sanderson, C., Sheahan, L., Kochovska, S., Luckett, T., Parker, D., Butow, P., & Agar, M. (2019). Re-defining moral distress: A systematic review and critical re-appraisal of the argument-based bioethics literature. *Clinical Ethics*, *14*(4), 195–210.
- Sheahan L, Lamont S. Understanding ethical and legal obligations in a pandemic: A taxonomy of "duty" for health practitioners. Journal of Bioethical Inquiry. 2020 Dec;17(4):697-701.
- Smallwood N, Pascoe A, Karimi L, et al. Moral distress and perceived community views are associated with mental health symptoms in frontline health workers during the COVID-19 pandemic. Int J Environ Res Public Health 2021;18:16.
- The Moral Distress Education Project (United Kingdom bio-ethics project)
- U.S. Centres for Disease Control and Prevention, The National Institute for Occupational Safety and Health (NIOSH). Impact Well-being resources. URL https://www.cdc.gov/niosh/impactwellbeing/ [accessed 24 November 2023].
- World Health Organization. 2020 Charter: health worker safety: a priority for patient safety.

Programs

- The Essential Network (TEN): is a network designed by healthcare experts for the benefit of healthcare professionals, and provides specialised, personalised mental health guidance and prioritized support to connect healthcare workers with the assistance they need for mental health concerns.[117]

RACP materials

- Ethics: The moral impact of practice on clinicians | RACP Online Learning.
- Ethics Curated Collection (Education Learning and Assessment)
- Pomegranate Health Podcasts: Dealing with Uncertainty – Part 1 and Part 2
- Wellbeing resources

[117] APEC Health Working Group 2024 Compendium of Best Practices on Mental Health Resilience of Healthcare Workers in the New Normal apo-nid327612.pdf

- Physician Self-Care and Wellbeing eLearning@RACP Resource
- Occupational and Environmental Medicine physicians have an important role in preventing and addressing workplace illness and injuries, and the associated mental health issues resulting, as outlined in the RACP Health Benefits of Good Work initiative. This initiative is based on compelling Australasian and international evidence that good work is beneficial to people's health and wellbeing and that long term work absence, work disability and unemployment generally have a negative impact on health and wellbeing.

Physician Wellbeing in Challenging Times

- Practical strategies and approaches around leading with compassion, communicating effectively, promoting wellbeing, and mitigating the impact of challenging times on teams and staff members.
- Information and tools to help you effectively set healthy boundaries and prevent burnout.
- Guidance on creating and utilising connections with peers, supervisors, support networks and others.

Lessons from COVID-19: physician wellbeing during a crisis

Health practitioners suffer from high levels of depression and burnout even during regular times. So how can we look after our own wellbeing during a crisis?

Culturally Safe Supervision Suite of Resources:

- Introduction to Culturally Safe Supervision webinar recording & supporting resources
- Culturally Safe Supervision and the Australian Referendum webinar recording & supporting resources
- Additional readings and resources
- Online course: Australian Aboriginal, Torres Strait Islander and Māori Cultural Competence and Cultural Safety
- Curated library of resources: Aboriginal, Torres Strait Islander and Māori Cultural Safety Curated Collection

External resources

Relevant to those with varied cultural backgrounds

- Asian Health Line (AHL) 0800 88 88 30 - Asian/ethnic cultural advice for health professionals in Aotearoa New Zealand
- Cross Cultural Resources | eCALD. Aotearoa New Zealand. All physicians and trainees in Aotearoa to enrol in our courses free of charge by creating a user account through our website Home | eCALD LMS.

Sexual and gender diversity

- LGBTIQ+ Health Australia: Provides comprehensive resources and support for healthcare professionals serving LGBTIQ+ communities. [URL: https://www.lgbtiqhealth.org.au/]
- The Trevor Project: Offers crisis intervention and suicide prevention resources, especially useful for young LGBTQ individuals. [https://www.thetrevorproject.org/]
- GLMA: Health Professionals Advancing LGBTQ Equality: Offers guidelines and best practices for providing inclusive care. [https://glma.org/]
- Rainbow Health Victoria: Offers training and resources for inclusive practice in healthcare settings.
- Human Rights Campaign (HRC) Healthcare Equality Index: A benchmarking tool evaluating healthcare facilities on their LGBTQ policies and practices.
- Pride in Health + Wellbeing: Provides consultancy and membership programs to develop LGBTIQ+ inclusive practices. [URL: https://www.prideinhealth.com.au/]

Trauma informed approaches

- Knight, Carolyn & Borders, L. (2018). Trauma-informed supervision: Core components and unique dynamics in varied practice contexts. The Clinical Supervisor. 37. 1-6. 10.1080/07325223.2018.1440680.
- NSW Government information on trauma informed care (https://www.health.nsw.gov.au/mentalhealth/psychosocial/principles/Pages/trauma-informed.aspx)