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Ethical Challenges Experienced by Physicians and Nurses in Caring for Patients with COVID-19: A Qualitative Study

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Abstract

Background: Emerging COVID-19 pandemic has posed numerous ethical challenges to frontline healthcare professionals.
Objectives: This study aimed to explain the ethical challenges experienced by physicians and nurses in caring for COVID-19 patients during the early phases of the pandemic.
Methods: This qualitative study was conducted using by content analysis approach. Twenty-two semi-structured in-depth interviews were conducted with 18 physicians and nurses working in medical centers and hospitals of the public or private sectors, in Tehran, the capital of Iran, from July to October 2020. The Graneheim and Lundman approach was applied to analyze the data. MAXQDA 10 software was used to facilitate the data analysis process.
Results: The ethical challenges are categorized into four categories (and 11 subcategories), including poor professional care, preference for public interests over individual care, difficult decision-making, and moral distress. Most participants experienced poor professional care, non-compassionate care, lack of family-centered care, being forced to choose, lack of emotional and anger control and coping skills, an undermined ethical climate, and emotional fatigue during the early phases of the pandemic.
Conclusions: The findings indicate the attenuation of professional care and the need to develop evidence-based ethical and clinical guidelines concerning the resulting insights. In addition, devising appropriate interventions is recommended for their psychoemotional support.

Keywords: COVID-19, Ethical Challenges, Healthcare, Professional Care

1. Background

The emerging COVID-19 pandemic affected all aspects of human life worldwide by posing numerous ethical, social, and economic challenges (1). In a statement on January 30, 2020, the World Health Organization (WHO) announced the new coronavirus outbreak as the sixth leading cause of emergency and a threatening factor to public health worldwide (2). Knowledge about COVID-19 care and management is also restricted due to some special features of the virus, including super-spreading characteristics, recombination, and frequent mutations (3).

In a crisis like the COVID-19 pandemic, health systems face difficulties due to decisions about prioritizing scarce resources in terms of how, when, and where to allocate them (4). In addition, public health systems face significant ethical issues related to protecting patients' rights and public benefits. People crowding in health centers, overcrowding of hospital beds, extreme fatigue of staff, shortage of manpower, psychological reactions, and other concerns due to lack of equipment are some factors that cause challenges (5). The most challenging aspects of this situation are related to ethical issues focused on protecting patients' rights and access to healthcare (6).

The term "ethical challenges" mainly refer to moral dilemmas and ethical conflicts in situations where difficult choices should be made (7).

Healthcare workers are often involved in critical situations and experience ethical challenges. Difficulty dealing with ethical issues and conscious decision-making causes doctors frustration. In contrast, nurses' inability to influence decisions and conflicts with doctors have been reported as causes of moral distress (8).

The inability to make ethical decisions and communicate with patients, shortage of manpower, and inappropriate care cause moral distress (9) and job burnout (10). In these circumstances, the quality of care would be affected

(11).

Like other countries, the COVID-19 pandemic and preventive measures to combat it, such as isolating affected people, quarantine, and social distancing in Iran, imposed various alterations in the health system regarding current plans and activities, which led to the rise of ethical challenges. In the early phase of the pandemic, some essential services such as screening, risk assessment, and case finding were suspended, as well as following up, and care of patients with non-communicable diseases (NCDs) turned into the distance modality by telephone (12). Contrary to expectations, the second wave of the pandemic started in the summer of 2020 in the country, and the third and fourth waves occurred in autumn and winter (13).

In a study on medical ethics related to Ebola, ethical challenges in managing the disease included the duty to care for and fear of transmitting the virus to family members, quarantine and respect for individual autonomy, benefits and harms of intubation and mechanical ventilation, and the use of unauthorized and experimental therapies without a clinical trial protocol (14). In a review study, the most important ethical challenges in managing and responding to COVID-19 were movement restrictions, the refusal of preventive and curative interventions, the rights and duties of healthcare workers, the allocation of scarce resources, and off-label therapeutic measures (1). Most studies on the ethical challenges during the early phase of the pandemic experienced by nurses have reported the threat to professional values, lack of holistic care, and difficulty in decision-making and prioritizing due to scarcity of resources (7, 15, 16).

It is worth noting that healthcare professionals should be trained based on the principles of professional ethics to manage crises like the COVID-19 pandemic. They should also be sufficiently sensitive to ethical issues and be able to make ethical and informed decisions (17). A broad study of the lived experiences of healthcare professionals can provide a deeper insight into the ethical challenges during the pandemic and the adoption of strategies to provide an appropriate response, especially in the early phases of an epidemic or pandemic.

2. Objectives

This study aimed to explain the lived experiences of physicians and nurses of ethical challenges during the primary waves of the COVID-19 pandemic.

3. Methods

3.1. Design

A content analysis approach was used to explain the lived experiences of physicians and nurses regarding ethical challenges from July to October 2020.

3.2. Participants

Key participants were 18 physicians and nurses working in educational centers, medical centers, and hospitals in public or private sectors in Tehran, the capital of Iran. Sampling was conducted by purposive and snowball methods. The participants were purposefully selected among expert and experienced professionals involved in managing and caring for COVID-19 patients. First, 12 experienced people were selected and interviewed. Then, interviews were conducted with 6 people they introduced. Eighteen participants entered the study, whose characteristics are represented in Table 1. In order to observe maximum variation in sampling, participants with diversity in age (28 - 55 years), gender, expertise, and work experience were recruited into the study, and some simultaneously worked in the private sector.

3.3. Data Collection

Data were collected through semi-structured in-depth interviews from July to October 2020. Twenty-two interviews were done with 18 participants, which lasted 30 to 70 minutes and stopped after theoretical saturation. Interviews were done with participants who met inclusion criteria and started with the open question: “What ethical challenges did you experience during the COVID-19 pandemic?” In order to deepen the interviews, some probing questions, such as “what did you experience while taking care of the patients?” and “what did you feel?”, etc. were asked.

The interviews were conducted at the preferred time and place of the participants, both in-person and by telephone, by the first and last researcher. Eighteen interviews were conducted by voice call via cell phone or WhatsApp application, and four were conducted in person due to some participants’ desire to comply with health protocols. The interviews were recorded with the permission of the participants.

3.4. Data Analysis

Data were analyzed by the Graneheim and Lundman approach (18). Immediately after each interview, the recorded interviews were listened to by the researchers and transcribed verbatim. After reading the text several times, semantic units and open codes were extracted. The

Table 1. Demographic Characteristics of the Participants

Participant Number	Specialty	Degree	Gender	Workplace (Ward)	Work Experience (y)
P1	Nursing	MSc	Female	Educational hospital (corona ward)	7
P2	Nursing	BSc	Male	Educational hospital (corona ward)	17
P3	Nursing	BSc	Female	Educational hospital (corona ward)	10
P4	Nursing	PhD	Female	Educational hospital (corona ward)	13
P5	Nursing	BSc	Female	Educational hospital (icu)	15
P6	Nursing	BSc	Female	Educational hospital (icu)	10
P7	Nursing	BSc	Female	Educational hospital (corona ward)	5
P8	Physician	Anesthesia resident	Female	Educational hospital (corona ward)	1
P9	Physician	Sub-specialist in infectious diseases	Female	Educational hospital (corona ward)	14
P10	Physician	Internal medicine resident	Female	Educational hospital (corona ward)	1
P11	Nursing	BSc	Female	Educational hospital (training supervisor)	17
P12	Nursing	BSc	Female	Educational hospital (infection control expert)	16
P13	Nursing	BSc	Male	Educational hospital (corona ward)	13
P14	Medical ethics	MD, PhD	Male	Private hospital (emergency ward)	17
P15	Medical ethics	MD, PhD	Male	Educational hospital (corona ward)	13
P16	Nursing	BSc	Male	Educational hospital (emergency ward)	4
P17	Nursing	BSc	Female	Educational hospital (emergency ward)	19
P18	Medical ethics	MD, PhD	Male	Private clinic	25

open codes were then compared and categorized into more abstract subcategories and categories based on their similarities and differences. MAXQDA 10 software was used to facilitate the data analysis process.

3.5. Rigor

Guba and Lincoln criteria were used to obtain the study's trustworthiness (19). Long-term engagement and peer checks were used to increase the credibility of the data. The lead researcher also resided in a coronavirus medical center for one week and observed the management and care processes. Two participants were asked to confirm the labels and codes regarding the member check strategy. To develop dependability, moreover, peer checking, the experiences of some participants were directly quoted. Bracketing, peer check, and member check were observed to ensure reliability. Variation of expertise and increasing audibility by reporting step by step were ways to incline possible transferability of the findings.

3.6. Ethical Considerations

This research was licensed by the Ethics Committee (IR.SBMU.RETECH.REC.1399.359) of the Vice Chancellor for Technology and Research of Shahid Beheshti University of Medical Sciences. After explaining the research objectives and emphasizing the confidentiality and anonymity of information, verbal consent was obtained from the participants. Participants also had the right to withdraw from the interviews if they felt uncomfortable or insecure.

4. Results

The ethical challenges were categorized into four categories and 11 subcategories (Table 2).

4.1. Category I: Poor Professional Care

Most participants acknowledged that wearing personal protective equipment (PPE) and fear of COVID-19 infection interfered with communicating with patients. This category is made up of 3 subcategories.

4.1.2. Disrupted Communication

Most participants experienced communication problems with patients.

"The doctor covers himself so much and distances himself from the patient so that he did not hear what the patient is saying and did not communicate with the patient." (P7)

Table 2. Main Categories and Subcategories

Main Category, Subcategory and Code	Semantic Unit
Poor professional care	
Disrupted communication	
Not communicating with the patient	The physician talked to the patient from a distance due to fear of getting sick.
The ambiguity of nurses' role	
Not acting to professional duties	The doctor asks the nurse about the patient's history and prescribes based on her report.
Assigning their task to another	According to our report, the doctor ordered; he was not doing his duty.
Uncompassionate care	
Not paying attention to the psychological needs of patients	Because of the fear of getting sick, they did not get close to the patient's bed. The doctor did not listen to what the patient said; some had a mental need to talk.
Preference of public interests over individual care	
Ignorance of family-centered care	
The necessity of the psychological and spiritual support of patients	It became a rule not to be with the patient in the ward, and they helped us a lot to calm the patient.
Impossibility of the presence of a patient's companion in that situation	The presence of the patient's companion in that situation reduces the patient's stress.
Lack of mourning care	
The dilemma of meeting family members with their dying patient	We had a big challenge. The patient would die in a few hours; should his family see him or not? We saw the family begging to say goodbye to their patient.
Difficult decision-making	
Ambiguity in standards of care	
Lack of accurate understanding of the nature of the emerging disease	The complexity of the disease caused doctors to be unable to distinguish the patients with corona and without corona.
Forced to choose	
Facing difficult dilemmas	It was very difficult to choose which patient to take care of.
Moral distress	
High workload and poor evaluation	
Critical situation and lack of proper perception of patients and their families	We are few in number, and sometimes we are late to visit the patient; he also complains about why you came late; what should I tell him?
Concerns about coronavirus transmission to family members	
A kind of value conflict and impact on the quality and quantity of care	We were worried about our family members, for example, my father, because he had an underlying disease.
Undermined ethical climate	
The impact of the situation and non-professional practice on the moral practice of the doctors or nurses	Some doctors look at patients as tools; they quickly visit and order. An inappropriate moral climate had been formed; this act causes anxiety among other employees.
Emotional fatigue	
High emotional and psychological pressure caused by the death of patients	Seeing a large number of patients die was one of the worst days of my work; We got depressed. We are really tired, physically and mentally tired; our patients never die so much.

4.1.3. The Ambiguity of Nurses' Role

Most nurses experience ambiguity in their role and over-demand from physicians:

"I called the physician to report to him the emergency situation of the patient. Instead of visiting the patient, he wanted me to give him a history. When a patient's family member wanted to talk with a physician, they designated this task to the nurses." (P6)

4.1.4. Uncompassionate Care

Most participants perceived that sometimes the care provided by healthcare professionals was uncompassion-

ate:

"Disappointment in patients raised increasingly; I think these patients should be given more psychological care than just treatment because they believe there is no cure and they will die. Sometimes, for example, the patient asks the physician, and he says, 'I don't know!', sometimes clerics came and talked with patients and calm them down". She continued: "Some physicians or even nurses do not take care of patients with COVID-19 who are affected by other underlying diseases like cancer; it does not matter the patients are young or aged. This is annoying." (P7)

4.2. Category II: Preference for Public Interests Over Individual Care

Most participants stated that while there was a need for psycho-spiritual support and the presence of the patient's family, the presence of a companion with the patient was prohibited, and the family could not say goodbye to the deceased patient. This category contains two subcategories.

4.2.1. Ignorance of Family-centered Care

For most participants, the Family Absence Act was a challenge.

"Today I had an elderly Turkish-speaking patient with whom I could not communicate in any way. But his companion talks to him and provides their needs and psychological support." (P4)

4.2.2. Lack of Mourning Care

Most participants experienced the emotional needs of patients' families to say goodbye to their patient during mourning or after the sudden death:

"Patients were in good health, suddenly they needed resuscitation, but families could not believe that their patients had died or connected to the ventilator; they could not accept and say, 'Oh, it is impossible!' They became angry and fought with staff." (P16)

"We had trouble regarding visiting end-stage patients by their family members. The families were begging us to let them see their patients for the last time; we were wondering whether the family could see him." (P5)

4.3. Category III: Difficult Decision-making

Most participants experienced difficulty in decision-making situations due to the complexity of the coronavirus, as well as a lack of resources. This category consists of two subcategories.

4.3.1. Ambiguous Standards of Care

The experiences of most participants indicated the difficulty and ambiguity in the diagnosis and treatment of patients with COVID-19:

"In the early phases, the guidelines were written without considering diabetic patients, prioritization of patients to receive services, and how the mourning process. One challenge was to impose the burden of decision-making for intubation on professionals due to a lack of a clear protocol and insufficient skills and tools." (P15)

"Nurse Manager and anesthesia assistant asked us what we should do now? Whether there is an indication for resuscitation of this patient or not?" (P1)

4.3.2. Forced to Choose

Most participants experienced the challenge of being forced to choose between patients:

"Another challenge that bothered me a lot was choosing between bad and worse; which patient had to be chosen to connect to a ventilator?" (P4)

"Most of the time, we had to make a decision about which patient had to stay alive or not." (P8)

4.4. Category IV: Moral Distress

Most participants experienced heavy workloads that caused them to be fatigued and distressed. This category consists of 4 subcategories:

4.4.1. High Workload and Poor Evaluation

Most participants experienced high workloads and negative emotions.

"My relatives and friends became less in touch with me when they found out I worked where patients with COVID-19 were hospitalized." (P2)

"I witnessed many nurses were working by heart, they ignored their rest time. But someone says that nurses receive money, it is their duty, hearing these, upset us more." (P7)

4.4.2. Concerns About Coronavirus Transmission to Family Members

Most participants experienced stress due to fear and anxiety about the transmission of the infection to their family members.

"We were more worried about our family members. I was really worried about affecting my father with COVID-19 because he has an underlying illness." (P8)

"Staff constantly considered the patient as a threat. I am more worried because my wife is pregnant and I have double stress." (P13)

4.4.3. Undermining the Ethical Climate

Most participants believed that the COVID-19 pandemic, as an unexpected circumstance, undermined the ethical climate:

"I told the emergency unit, I'm busy now, I'm intubating the patient, don't send a patient towards us, they did not listen to me at all." (P4)

"Some doctors look at the patient as a means; they come quickly for visits and write hasty orders." (P7)

"Because of crowding of the patients in the emergency unit and leaving the doors open for proper air circulation and ventilation, their privacy was not fully observed." (P14)

"Some physicians on ICU wards desire to give an alternative drug and evaluate its effect. They prescribed the drugs without the patient's consent because the patient was unconscious, there was no companion with patients, and there was no supervision by the ethics committee." (P15)

4.4.4. Emotional Fatigue

Most participants experienced emotional exhaustion since their colleagues or patients were affected or dying of COVID-19 unexpectedly:

"One of the worst things we experienced was many deaths during a workday. We got depressed, the patient was dying, we were crying with their family; I felt burnout in some situations, and I wanted to resign from work." (P1)

"It was very hard to see the death of 10 patients together in one day, and it was harder when all of them died simultaneously. I still have a nightmare. We became like people coming back from the war. We need psychiatric counseling." (P8)

5. Discussion

In this study, ethical challenges emerged in 4 categories: Poor professional care, preference for public interests over individual care, difficult decision-making, and moral distress. Threats to professional values, lack of holistic and family-centered care, and difficulty in decision-making were also the most ethical challenges reported by similar studies (7, 15, 16).

In our study, poor professional care was the first category that emerged. According to the participants, the unknown and contagious nature of COVID-19 disease disrupted communication with patients due to fear of infection and the use of PPE and caused failure to play their professional role and to provide compassionate care. Studies also showed that the elements of nonverbal communication and reassuring touch were inhibited by using PPE, while these patients needed more psychological support (20).

Professional integrity and compassion with patients and families as key moral virtue and feature of compassionate care helps build a trustful relationship and alleviate their suffering (21).

Thus, holding compassion-focused care education courses and developing protocols to alleviate the ethical challenges arising during care for patients with COVID-19 is recommended (15).

The second category was the preference for public interests over individual care. The COVID-19 pandemic raises important ethical questions about balancing public interests with individual, respectful and holistic care (20). The experience of a lack of a holistic approach and family-centered care during the pandemic was also reported by some scholars (15). These findings indicate the need to set specific criteria for the presence of a patient's companion in some cases, based on balancing the benefits and harms during the pandemic.

Difficulty in decision-making was the third category. The participants stated they were not trained to make ethical decisions. Other scholars also reported these experiences in their studies in the early phases of the pandemic (7, 16). Researchers found that in the absence of ethical guidelines, healthcare workers are strongly influenced by the emotional atmosphere of the crisis and the guidance of their opinions (22). These findings notify the need to develop national guidelines for day-to-day care decisions in critical situations.

The last category was moral distress. High workload, the stress of transmitting the infection to family members, emotional fatigue, and poor evaluation were experienced by the participants, especially the nurses. In the opinion of most participants, the COVID-19 pandemic undermined the ethical climate. In similar studies, most nurses also found themselves afraid, confused, and nervous, and at the same time, committed to their professional role (23). They experienced a lack of emotional regulation, anger management, and coping skills, role ambiguity, and emotional support (7). Nurses' inability to influence decisions and conflicts with doctors are also causes of moral distress (8). Thus, planning comprehensive training courses for physicians and nurses is recommended to cope with such critical situations, develop a safe and ethical climate, and devise psychosocial and supportive interventions.

Overcoming repeated waves of COVID-19 requires rearranging organizational and clinical capacities (20). Although in the early phases of the pandemic, the analysis focused on resource allocation among people with COVID-19 (24), in the rearrangement phase, how to generate more benefits and promote public interests requires careful ethical considerations (20).

Difficulty in conducting face-to-face interviews due to

the contagious nature of COVID-19 and refusing to interview was our study limitations. However, some participants were interviewed in person due to their willingness.

5.1. Conclusions

The participants experienced numerous ethical and moral dilemmas that could undermine professional care. Given the preference of public interests over individual preferences in responding to the pandemic of infectious diseases and the attenuation of professional care, developing evidence-based ethical and clinical guidelines with regard to the resulting insights plays an important role in access to comprehensive quality care services. In addition, devising appropriate interventions is recommended for psycho-emotional support of the physicians and nurses.

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Footnotes

Authors' Contribution: K. R., and F. A., contributed to the research conceptualization, study design, data collection and analysis, and manuscript drafting. All authors contributed to data analysis and interpretation and critically reviewed and revised the manuscript.

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