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# Potential sources of moral distress during COVID-19: Perspectives of hospice interdisciplinary teams

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## Original Article

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## Abstract

**Objective.** This study aimed to examine the impact of COVID-19 on hospice Interdisciplinary team (IDT) members' self-reported stress and identify possible sources of moral distress.
**Methods.** A cross-sectional survey was conducted using Qualtrics to understand the impact of COVID-19 on quality improvement initiative implementation and hospice IDT members' general and dementia-specific care provision. Directed qualitative content analysis was used to analyze hospice IDT members' responses from five open-ended survey questions that were indicative of stress and possible moral distress.
**Results.** The final sample consisted of 101 unique respondents and 175 comments analyzed. Three categories related to sources of moral distress based on hospice IDT member survey responses were identified: (1) impact of telehealth, personal protective equipment (PPE), and visit restrictions on relationships; (2) lack of COVID-19-specific skills; and (3) organizational climate. Sources of moral distress were categorized in 40% of all responses analyzed.
**Significance of results.** This study is one of the first to document and confirm evidence of potential stress and moral distress amongst hospice IDT members during COVID-19. It is imperative given the possible negative impact on patient care and clinician well-being, that future research and interventions incorporate mechanisms to support clinicians' emotional and ethical attunement and support organizations to actively engage in practices that address clinician moral distress resulting from restrictive environments, such as the one necessitated by COVID-19.

## Introduction

Interdisciplinary team (IDT) members in hospice, typically nurses, social workers, spiritual care counselors, physicians, and home health aides (HHAs), face unique challenges related to witnessing and supporting the suffering of others, confronting existential questions, and experiencing grief in professional settings. Responding to the suffering of others is considered a central component of serious illness care and has been especially relevant to care throughout the COVID-19 pandemic (Rushton et al., 2016; Greenberg et al., 2020). However, the impact of providing this care, and the emotional response it provokes, can lead to burnout, compassion fatigue, moral distress, and vicarious traumatization (Corley, 2002; Rushton et al., 2016; Lamiani et al., 2017; Maffoni et al., 2019; Corradi-Perini et al., 2020).

IDT members working with patients and families nearing the end of life are particularly susceptible to moral distress (Rushton et al., 2016; Maffoni et al., 2019; Corradi-Perini et al., 2020). In this study, we define *moral distress* as stress or negative emotions that may occur in situations where there is a personally defined ethical correct action and ethical dilemma, within the context of a clinical obligation (Jameton, 1993; Rushton et al., 2016; Dzeng and Curtis, 2018; Maffoni et al., 2019). Moral distress can occur from feeling a moral violation or participating in moral wrongdoing and can lead to negative impacts on clinician mental health, well-being, patient care and safety, job retention, and clinical practice (Rushton et al., 2016; Lamiani et al., 2017; Maffoni et al., 2019; Greenberg et al., 2020). An IDT member may experience moral distress when their own moral values and perceived professional obligations are incompatible with the ethical climate of their work environment. Ethical climate describes the environment in which individual ethical decision-making occurs (Olson, 1998). For example, in palliative and serious illness care where staffing shortages exist, IDT members may feel a lack of support from their organization necessary for the standard of care they feel responsible to provide. They may feel forced to sacrifice care quality to keep up



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with growing caseloads. They may also encounter moral distress in clinical situations where a patient's pain and suffering may be avoidable or poorly managed.

Hospice IDT members may experience new forms of moral distress in the context of the COVID-19 pandemic. Broadly, there are accounts from across the globe of ethical dilemmas and corresponding strain on mental health faced by IDT members as a result of the COVID-19 pandemic (Cacchione, 2020; Robert et al., 2020; Turale et al., 2020; Donkers et al., 2021; Sheather and Fidler, 2021). Specifically, hospice IDT members may face new moral dilemmas related to enforcing restrictions on visitors and allocating scarce resources, such as mechanical ventilators and the re-use of personal protective equipment (PPE), while identifying and maintaining best practices when confronted with a new and unstudied disease in an uncertain and rapidly changing environment (Robert et al., 2020; Williamson et al., 2020). In other settings, studies have found healthcare workers experienced distress due to workload, staffing, constantly changing care environments and protocols, inadequate training, and concerns about personal safety (Fernandez et al., 2020; Robert et al., 2020; Williamson et al., 2020; Donkers et al., 2021; Sheather and Fidler, 2021). One study of hospice specifically found that pediatric hospice clinicians reported moral distress during telehealth visits, due to their inability to hug or be physically present for grieving families (Wiener et al., 2021).

Although the impacts of COVID-19 on ethical dilemmas and moral distress have been documented in healthcare broadly (Robert et al., 2020; Williamson et al., 2020; Sheather and Fidler, 2021), a more detailed understanding is needed of how the pandemic has impacted hospice IDT members' stress related to their unmet needs. This paper uses data from an ongoing, large pragmatic clinical trial to examine the impact of COVID-19 on hospice IDT members' self-reported stress and identify possible sources of moral distress. Specifically, this article aims to answer the following research question: (1) What are some of the main sources of hospice IDT members' moral distress in the COVID-19 environment? Finally, we discuss how these potential sources identified in our data might contribute to the experience of hospice IDT members' moral distress.

## Methods

### Study design

This article is a secondary analysis of a cross-sectional survey conducted as part of a larger multi-site embedded pragmatic clinical trial (IRB#: i19-01186 NCT04175977). The survey was designed to understand the impact of COVID-19 on a quality improvement initiative implementation and hospice IDT members' general and dementia-specific care provision and was conducted using Qualtrics from June to July 2020. All of the hospice sites that were involved in the larger clinical trial in June 2020 were invited to participate in the cross-sectional survey. This article focuses on five open-ended survey questions that, although not designed to target moral distress, elicited responses from participants that revealed expressions of stress related to COVID-19 that made it possible to extract potential sources of moral distress. Using a post-positivist research paradigm, directed qualitative content analysis was used to analyze hospice IDT members' responses. The COREQ guidelines for qualitative research were followed (O'Brien et al., 2014).

### Participants and procedures

A link to the COVID-19 survey was emailed to 643 active employees including nurses, Certified Nursing Assistants (CNAs), HHAs, social workers, spiritual care counselors, and physicians at five participating hospice sites. Participating hospices were located in Nevada, North Carolina, Maryland, California, and Florida. One was for-profit and four non-profit and cover urban, rural, and suburban areas. The average daily census ranged from 146 to 942. We identified employees using staff lists provided to us by the hospices. The survey link was forwarded to an additional 13 employees who were not included on the hospice staff lists ($N = 658$). The survey was accessible online between June 1 and July 15, 2020 and consisted of close-ended and open-ended questions. Duplicate submissions from the same respondent were discarded. We received 442 responses to five open-ended questions (see Table 1) from 101 unique individuals. Of these, we identified and analyzed 175 responses related to moral distress. The unit of analysis was individual comments within responses. Of the three researchers conducting data analysis, two were Implementation Specialists and one an Operations Administer in the larger pragmatic clinical trial.

### Data analysis

Data analysis of the present study followed published guidelines for directed qualitative content analysis (Assarroudi et al., 2018). Directed content analysis is an appropriate methodology for validating a theory or relevant findings the researcher feels would benefit from further description (Hsieh and Shannon, 2005). In directed content analysis, findings related to existing research or theory help to determine research questions, code categories, and relationships between codes (Hsieh and Shannon, 2005). Accordingly, our codes and definitions of moral distress were derived from existing theory and research. Specifically, the present study derives the understanding of moral distress from Jameton's (1993) conceptualization of moral distress in nursing. Themes specific to moral distress experienced by healthcare professionals in COVID-19, such as lack of COVID-19 related resources, were informed by existing research (Burston and Tuckett, 2013; Rushton et al., 2013, 2016; Atabay et al., 2015; Whitehead et al., 2015; Dzeng and Curtis, 2018; Maffoni et al., 2019; Cacchione, 2020; Corradi-Perini et al., 2020; Donkers et al., 2021; Sheather and Fidler, 2021). The first author was the primary coder who applied Assarroudi's four steps to directed

**Table 1.** Selected survey questions

| Survey Questions | |
|---|---|
| 1. | What additional resources you would like us to provide to help you support your patients living with dementia during the COVID-19 pandemic? |
| 2. | How has COVID-19 affected your ability to support the family caregivers of your patients living with dementia? |
| 3. | Are there other unmet needs of family caregivers that you have observed? If so, please describe. |
| 4. | What additional resources would you like us to provide to help you support the family caregivers? |
| 5. | What resources would you like us to provide to support your coping, stress management, and/or self-care as a hospice provider/care team member during the COVID-19 pandemic? |

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**Table 2.** Categories, subthemes, and related quotations to the sources of moral distress theme

| Category | Subthemes | Quotations |
|---|---|---|
| Impact of COVID-19 on relationships (Feelings of distress related to constraints on the development of clinical relationships) | Telehealth | *I have not been able to visit patients as often during COVID-19. Support has been done mostly by phone. I do not feel I have the personal relationship or the trust and rapport that I have when I visit in person.*<br>*It is more difficult to build rapport and a sense of trust when you are talking to the family member on the phone.* |
| | PPE | *When I do visits in person, I have to wear a mask and they don't recognize me and the masks scare some of them.* |
| | Visit restrictions | *Limited my ability to go into some homes. Unable to hug/hold hand for support.*<br>*Not being able to provide in person visits (supportive presence, comforting touch, non-verbal cues to show empathy).*<br>*Families are afraid for healthcare workers to come in their homes even with PPE.* |
| Lack of COVID-19 skills (Feelings of distress related to the lack of skills required to do their job during COVID-19) | Training | *Any tips for better communication wearing PPE*<br>*How can we communicate better via video calls to get them engaged.*<br>*How to explain to them why they are not seeing their loved one.* |
| | Information | *Information on how to manage the visit restrictions*<br>*Information on ways to cope with COVID-19 stressors.* |
| | Resources | *Not having enough infection control cleaning supplies*<br>*Don't have proper PPE.* |
| Impact of Organizational Climate | Staffing | *I think more weekly volunteers or have staff at facility assist them more.*<br>*Make sure enough staff available to care for them.* |
| (Feelings of distress related to the lack of support from their organization) | Communication | *… our family caregivers feel out of the loop regarding the care of their loved ones. Some facilities do better at communicating than others, but I would say that the caregivers feel distrustful of the care their loved ones are receiving …* |
| | Lack of resources (PPE, telehealth) | *Basic supplies so I can order them myself to my home currently I am forced to retrieve them from an office giving me one n95 mask per week with is so overwhelming.* |
| | Lack of support | *Support when we have concerns, suggestions for de stressing or outlets to talk with others going through the same things we are.* |

content analysis (Assarroudi et al., 2018). First, immersion in the data through a careful reading of the open-ended clinician responses to the COVID-19 survey revealed and provided an understanding of hospice IDT members' expression of stress and moral distress. Five survey questions with responses related to IDT member stress were selected for further analysis (Table 1). Next, we developed a categorization matrix outlining the main categories and related subcategories deductively derived from Jameton's (1993) conceptualization of moral distress and pre-existing research (Burston and Tuckett, 2013; Rushton et al., 2013; Dzeng and Curtis, 2018; Maffoni et al., 2019; Cacchione, 2020; Corradi-Perini et al., 2020; Sheather and Fidler, 2021; Wiener et al., 2021). Third, we theoretically defined main and subcategories (Table 2). Finally, for data analysis, three reviewers selected and coded content related to the defined categories using Microsoft Excel. Codes were discussed among authors and disagreements were resolved by group consensus.

## Results

### Participant characteristics

The final sample consisted of 101 respondents (95% female; 71% white/Caucasian; mean age: 49 years old). Nurses (48%) represented the largest proportion of respondents, followed by CNAs/HHAs (24%), social workers (20%), spiritual care counselors (7%), and physicians (1%).

### Potential sources of moral distress

We identified three categories related to potential sources of moral distress based on hospice IDT member open-ended survey responses: (1) impact of telehealth, PPE, and visit restrictions on relationships; (2) lack of COVID-19-specific skills; and (3) organizational climate. Categories with related subthemes and quotations are presented in Table 2. The number of responses contributing to each main theme by survey question is presented in Table 3. Although not designed to target moral distress specifically, of the total comments from survey questions utilized for analysis, 40% were categorized as a potential source of moral distress. Responses categorized most often referred to lack of skills.

### Impact of telehealth, PPE, and visit restrictions on relationships

Three questions (Q1–Q3) elicited responses wherein hospice IDT members provided 41 comments that relayed how telehealth, PPE, and visit restrictions negatively impacted their relationships with patients and families. The questions asked about what resources

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**Table 3.** Frequency of responses by theme by survey question

| Survey Question | Theme 1. Impact of telehealth, PPE, and visit restrictions on relationships | Theme 2. Lack of COVID-19-specific skills | Theme 3. Organizational climate |
|---|---|---|---|
| 1. What additional resources you would like us to provide to help you support your patients living with dementia during the COVID-19 pandemic? | 5 | 27 | 6 |
| 2. How has COVID-19 affected your ability to support the family caregivers of your patients living with dementia? | 32 | 0 | 1 |
| 3. Are there other unmet needs of family caregivers that you have observed? If so, please describe. | 4 | 10 | 4 |
| 4. What additional resources would you like us to provide to help you support the family caregivers? | 0 | 21 | 1 |
| 5. What resources would you like us to provide to support your coping, stress management, and/or self-care as a hospice provider/care team member during the COVID-19 pandemic? | 0 | 54 | 3 |

clinicians felt were currently needed to support patients and families during COVID-19, how COVID-19 has affected clinician ability to support patients and families during COVID-19, and unmet needs of family caregivers. Responses related to impact of telehealth were seen in clinicians' expressed challenges connected to engaging with patients and families and building rapport and empathy. One hospice IDT member stated, "I have not been able to visit patients as often during COVID-19. Support has been done mostly by phone. I do not feel I have the personal relationship or the trust and rapport that I have when I visit in person." Another IDT member described the challenge that comes with the lack of personal touch, explaining that the new restrictions "Limited my ability to go into some homes. Unable to hug/hold hand for support."

Many hospice IDT members expressed the challenge of engaging with patients while wearing PPE, particularly when working with patients who have memory impairment: "When I do visits in person, I have to wear a mask and they don't recognize me and the masks scare some of them." In addition to the communication barriers due to PPE, respondents articulated a clear need for guidance in communication and engagement via telehealth: "How can we communicate better via video calls to get them engaged."

Finally, hospice IDT members described the potential for moral distress that accompanies visit restrictions when working with patients and families nearing the end of life: "It can be challenging at times, if the patient is in a long-term facility you can't be there at time of death or when the patient is declining because families and facilities are prohibiting visits." Collectively, quotes from this code underscore hospice IDT members' stress and negative emotions associated with a loss of connection, physical presence, and touch when providing care to patients and families, due to telehealth, PPE, and visit restrictions during the pandemic.

### *Lack of COVID-19-specific skills*

Open-ended responses from four questions (Q1, Q3–Q5) revealed 113 comments from hospice IDT members that conveyed stress and negative emotional experiences related to a lack of COVID-19-specific skills including training, information, and resources. These questions asked about what resources clinicians felt they needed to deal with their own stress and what they needed to support patients and caregivers during COVID-19. One question also asked about unmet needs of family caregivers. The training needs expressed included engaging with patients: "Ideas for engaging patients," "More classes on ways to relate." Comments also articulated a need for training in how to cope or support patients and families in new emotionally challenging situations: "How to cope with Panic [sic]," "Complicated grief during COVID 19 pandemic," and "Information on ways to cope with COVID-19 stressors." In addition, hospice IDT members cited a lack of information and resources related to COVID-19 regarding their own needs — "How to avoid patient burnout and compassion fatigue during this time." — along with the needs of patients or caregivers: "Some don't have proper PPE," "Inability to get necessities such as toilet paper," "Lack of understanding, lack of support." These responses underscore that COVID-19 amplified the complexities of grief and panic felt by families, and hospice IDT members felt underprepared and lacking necessary training to adequately respond, aligning with our understanding of moral distress.

### *Organizational climate*

Fifteen comments from hospice IDT members' responses to all five questions indicated stress experienced from their organizational climate. This includes issues with staffing ("Make sure enough staff available to care for them"), lack of PPE or telehealth resources ("I deserve PPE mailed to my door so I don't have to travel 20–39 miles one way to provide care"), issues in communication ("Some facilities do better at communicating than others, but I would say that the caregivers feel distrustful of the care their loved ones are receiving at the facilities now that they cannot visit and "keep an eye" on things"), and a lack of support for staff or patients/families ("The RNCM's [Registered Nurse Case Managers] at my company are not visiting the patients enough, and when they do visit, they are in & out in a matter of minutes," "Support when we have concerns, suggestions for de-stressing or outlets to talk with others going through the same things we are."). In sum, these responses highlight hospice IDT members' stress related to slow organizational adaptation, or a lack thereof, to the uncertain and rapidly evolving work environment during the pandemic.

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## Discussion

The results of our study document evidence of hospice IDT members' negative and stressful emotional experiences in response to ethical dilemmas (limited resources, training, staffing, etc.) they faced during the COVID-19 pandemic, which can be indicative of moral distress. We sought to identify hospice IDT members' main sources of moral distress during the pandemic and found that in open-ended survey responses, hospice IDT members expressed evidence of potential sources of moral distress related to perceived impact of telehealth, PPE, and visit restrictions on relationships; a lack of COVID-19 training, information, and resources; and the impact of their organizational climate. In the following sections, we discuss how each main theme/potential source identified in our data might contribute to the experiences of moral distress. Our study is one of the first to show hospice IDT members' perspectives on possible sources of moral distress during the pandemic and their related experiences.

Our findings related to the perceived impact of telehealth, PPE, and visit restrictions on relationships highlight the effect of COVID-19 on hospice IDT members' communication and challenges in developing relationships with patients and families. Hospice IDT members expressed feeling that they could not communicate or engage with patients and families in usual ways due to restrictions on in-person visits, reliance on telehealth, and physical barriers created by PPE. These restrictions made it difficult for clinicians to build personal relationships, rapport, and trust essential to high-quality hospice care. Specifically, hospice IDT members reported lack of touch and physical presence as barriers and possible sources of moral distress when caring for patients and families, which aligns with previous reports of challenges working in hospice with increased COVID-19 restrictions (Wiener et al., 2021). While some of the visit restrictions have eased as the pandemic has worn on, the ongoing nature of the pandemic has led to workforce shortages, increasing workloads that can similarly affect visits and IDT member–patient and family relationships.

It may be that COVID-19 restrictions and increased workloads pose unique clinical challenges that impede processes necessary for emotional regulation. Ruston et al.'s (2016) framework for moral distress emphasizes the importance of emotional regulation for clinicians working in serious illness care. This emotional regulation occurs through ethical, emotional, and cognitive attunement and personal experience and is necessary for clinicians to demonstrate resilience when faced with stressors (Rushton et al., 2016). The findings of our study suggest that in COVID-19, IDT members' emotional attunement or empathy may be challenged as they cannot see patients and families face-to-face or provide physical forms of support and connection like hugs or handholds. In addition to the lack of physical touch, PPE creates communication barriers. It is more difficult to express and communicate emotions while wearing protective masks or face shields, interrupting the flow of the interaction. The ability to cognitively attune or understand patient and family perspectives may be challenged by similar COVID-19 physical restrictions. Previous research has shown that a root cause of moral distress for healthcare workers is the experience of diminished care due to poor communication (Whitehead et al., 2015). For example, participants in our study reported feeling that family members were not receiving complete and efficient updates on their loved one's care. In regard to the effects of COVID-19 visit restrictions on communication, Robert et al. (2020) identify that effective and timely communication is a central component of patient and family-centered care and thus COVID-19 communication barriers have created new sources of stress for clinicians and families. For hospice IDT members, feelings of moral distress related to ethical climate may arise when a family's anguish and added stress regarding their loved one's status could be avoided with more support from their organization to facilitate clear, timely, and accurate communication.

Future research must consider how to create environments and processes that foster hospice IDT member adaptability and resilience amidst evolving COVID-19 restrictions and workforce burnout. Research may consider how to support hospice clinician emotional, ethical, and cognitive attunement when working with COVID-19 restrictions to foster empathy-related responses that lead to resilience. Interventions can creatively support hospice IDT members to create and maintain personal relationships with patients and families, building trust and rapport, despite visit restrictions and reliance on telehealth, and PPE. In addition, at the agency level, research may consider how hospices might create emergency staffing plans, trainings focused on organizational communication, and agency-level supports for staff such as mental health services.

Hospice IDT members' responses regarding the perceived impact of lack of COVID-19 training, information, and resources highlight sources of moral distress related to skills deficits. This aligns with previous research showing that clinicians' lack of healthcare knowledge or information is related to their experience of moral distress (Burston and Tuckett, 2013). The feeling that one lacks the skills necessary to manage during the pandemic is a possible source of hospice IDT members' moral distress. Study participants expressed feeling ill-equipped to support caregivers and patients dealing with visit restrictions. Responses expressed a feeling of not knowing what to say or how to explain that patients could not see their families. IDT members who are asked to enforce COVID-19 restrictions while feeling a desire and obligation to emotionally support patients and families in familiar ways may face a moral dilemma. Rushton et al. (2016) explain that in the context of moral distress, feelings of lacking adequate training can lead to clinician apathy and ambiguity, thereby impeding clinician ethical attunement or moral sensitivity. Open-ended responses in our study indicated a need for more training on effectively engaging with patients and family when using PPE and telehealth. Training needs are a source of possible moral distress as hospice IDT members felt that they were unable to provide patients and families with pre-pandemic standards of care. Finally, study participants consistently requested resources on self-care, stress-relief, support groups, and mindfulness, highlighting the urgent need to address the emotional well-being of clinicians.

Our findings regarding the perceived impact of organizational climate highlight the influence of practice site and external factors on hospice IDT members' moral distress. We identified four subthemes under organizational climate as potential sources of moral distress: staffing, lack of PPE or telehealth resources, communication issues, and lack of support for staff or patients. Our study confirms that organizational, and particularly ethical climate, has a significant impact on hospice IDT members' experience of moral distress (Dzeng and Curtis, 2018). Ethical climate acknowledges that how individuals perceive their work environment has a significant impact on the ethical practice of healthcare staff (Olson, 1998). Ethical climate has been associated with clinicians' moral distress: the more positive the perceived ethical

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climate, the fewer morally distressing events reported (Silén et al., 2011; Bayat et al., 2019). The findings of our study suggest that in the COVID-19 pandemic, a perceived lack of support and resources by hospice IDT members may lead to feelings of fear for personal, family, or patient safety. These perceptions may also influence attitudes or behaviors of ambiguity and apathy. Moreover, given the acute staffing problems that hospices are experiencing two-plus years into the pandemic, these findings elicit concern that a downward spiral of moral injury and resignation could occur, exacerbating this challenge.

In the COVID-19 environment, hospice IDT members face standard sources of moral distress associated with serious illness care, along with new sources related to COVID-19 where staff must provide care in constantly changing, and largely unstudied clinical situations. For example, Morris et al. (2020) identified tools and strategies for hospice IDT members to help with family bereavement related to communication, connection, and care processes. To foster communication, hospice IDT members might acknowledge the effect of the pandemic prior to the patient's death and respond to, name, and explore family emotions after death. They may support connection despite telehealth by having families send audio-recorded messages to share with patients. Moreover, interventions targeting the organizational level can help create a more stable organizational climate both during the pandemic and beyond with established processes for care, such as assigning one person as a point of contact for families (Morris et al., 2020), utilizing technology to foster teamwork through messaging apps (Anyanwu et al., 2021), or providing online flexible trainings to better prepare hospice IDT members.

Although our results provide insights into the experience of moral distress for hospice IDT members, we recognize there are limitations. First, the original survey was not designed specifically to capture hospice IDT members' experiences of moral distress and does not include specific questions about it. However, the fact that moral distress appeared as such a prominent theme without direct questions is an indication of its relevance to hospice IDT members' experiences of COVID-19. Additionally, while an important data source, open-ended survey questions are limited in nature. We were unable to probe or follow-up as in an interview. Third, there was a low response rate to the survey. Unsurprising given it was fielded during the initial phase of the pandemic. Nevertheless, participants responded from IDTs at multiple hospices. This survey was administered early during the COVID-19 pandemic, and sources of moral distress for hospice staff may change as we move through various stages of the pandemic. Finally, researcher involvement in the larger study may have influenced the interpretation of participant responses. To increase the trustworthiness of data interpretation, three coders were used.

## Conclusion

Our study builds on previous research identifying potential sources of moral distress during the COVID-19 pandemic (Cacchione, 2020), relating hospice IDT members' perspectives and experiences. We found hospice IDT members encountered possible moral distress related to the impact of telehealth, PPE, and visit restrictions on relationships, which may impede relationship building, empathetic responses, and clinician emotional regulation. Lack of COVID-19-specific skills and organizational climate were additional sources of potential moral distress. Given the likely negative impact of moral distress on patient care and clinician well-being and turnover, and that COVID-19 is likely to factor into healthcare delivery for the foreseeable future, it is important to understand and address moral distress related to COVID-19. Future research and interventions should incorporate mechanisms to train hospice IDT members individually in COVID-19-specific skills and create organizational environments that support clinicians' resilience and emotional and ethical attunement. In addition, clinical environments such as hospice organizations should actively engage in practices to address clinician moral distress resulting from restrictive environments, such as the one necessitated by COVID-19.

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