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Silent Burdens: Ethical Distress and Psychological Impact Among Medical Residents During the COVID-19 Pandemic in Brazil: a phenomenological qualitative study

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Research Article

Keywords: moral injury, moral distress, medical residents, COVID-19, ethical loneliness, graduate medical education, qualitative research

Posted Date: November 2nd, 2026

DOI: https://doi.org/10.21203/rs.3.rs-10974007/v1

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Additional Declarations: No competing interests reported.

Abstract

Background.

Ethical analysis of the COVID-19 pandemic has centred on triage and allocation. Far less is known about the everyday ethical experience of frontline medical residents. This study set out to describe that experience from residents' own accounts.

Methods.

In this single-centre phenomenological qualitative study we used the Inductive Process to Analyze the Structure of Lived Experience (IPSE) to analyse semi-structured interviews with 33 medical residents at the Hospital das Clínicas, University of São Paulo (HCFMUSP), a primary COVID-19 referral centre, between July 2020 and January 2021. Interviews were conducted, transcribed and coded in Portuguese. Reporting follows the COREQ and SRQR criteria.

Results.

Six interrelated themes describe a movement from institutional fragility to moral injury: institutional absence, intergenerational and hierarchical tension, ambiguity of responsibility, ethical loneliness, the quiet compromise, and moral injury. Residents repeatedly made morally significant decisions in isolation, without relational spaces for shared deliberation or recognition. Hierarchical asymmetries silenced moral dissent. The cumulative moral residue described in these accounts crystallised into lasting moral injury. Residents consistently identified the absence of structured institutional support as what was missing.

Conclusions.

The ethical difficulty residents described lay in ordinary clinical decisions taken without guidance, within a hierarchy in which disagreement carried a cost, and with no one to deliberate with. In these accounts moral suffering arose from the relational conditions of the work rather than from the resilience of individual clinicians, and what remained afterwards was described as damage to moral identity rather than as fatigue. Medical ethics appears here as a practice enacted within clinical work rather than applied to it from outside, which places structured support for moral deliberation within crisis preparedness rather than after it.

Background

Ethical analysis of the COVID-19 pandemic concentrated on high-profile dilemmas: intensive-care triage and vaccine allocation [1–3]. Far less is known about the everyday ethical tensions frontline residents

faced, or about the institutional conditions that let those tensions harden into lasting harm. Residents are a particularly exposed group. They carry substantial clinical responsibility, hold little formal authority, and depend on supervisors who were themselves overwhelmed. Commentators identified them early in the pandemic as a group at high risk of moral distress for precisely this reason [4]; a comparison of internal medicine residents before and during the pandemic found that fear of retribution for speaking up rose sharply over that period [5]; and a qualitative study of intensive care during the surge described how the supervision on which trainees depend was itself eroded by the reorganisation of the wards [6].

These everyday dilemmas rarely appeared in formal ethics protocols, yet they pervaded clinical practice. Should a mildly symptomatic colleague be reported for continuing to work? Should a vulnerable patient be urged to self-isolate despite the emotional harm it might cause? How should a young physician act when institutional support is absent and official guidance contradicts itself? [7–11] Such questions arise not from universal rules but from the affective, intersubjective fabric of care. This is what Annemarie Mol calls the logic of care, an ethical mode in which decisions emerge from the situated interplay of clinician, patient, and circumstance rather than from autonomy in the liberal sense of isolated decision-making. [12]

Five constructs recur throughout this article: moral distress, moral residue, moral injury, ethical loneliness and moral loneliness. They are frequently used as if interchangeable. They are not. Table 1 gives the working definition adopted here for each; the Discussion returns to the relations between them.

This is the third article in a series on residents working through the most acute phases of the pandemic. The first showed that technology, though indispensable, did not resolve the human dilemmas of clinical care; the second, that residents experienced the pandemic as a limit situation in Jaspers' sense [13, 14]. The present study asks what those residents faced ethically.

We draw on qualitative interviews with residents at the Hospital das Clínicas of the University of São Paulo Medical School (HCFMUSP), one of the largest public hospitals in Latin America [15]. We describe the ethical and emotional weight of the pandemic as the residents recounted it. By bringing these often-overlooked moral disruptions to light, we argue for a broadened conception of medical ethics, one anchored in the lived experience of those who provide care.

Two contributions follow. First, by letting residents recount their own experience, the study brings into view moral suffering as it arose in the routine of care rather than in the exceptional dilemma. Second, it shows medical ethics being enacted as a lived and relational practice rather than applied as a body of principles.

The aim of this study was to describe the ethical experience of frontline medical residents during the COVID-19 pandemic as they themselves recounted it. The institutional conditions discussed below emerged from those accounts; they were not posited in advance.

Methods

We designed a qualitative study grounded in first-person narrative accounts, in order to capture the lived experience of medical residents during the COVID-19 pandemic. We interviewed residents from psychiatry and from a range of other specialties who had been directly involved in the care of patients with COVID-19, together with psychiatry residents who provided psychological support to healthcare professionals at HCFMUSP, and we analysed the narratives they gave us through a phenomenological lens. We conducted the study at the Hospital das Clínicas of the University of São Paulo Medical School (HCFMUSP), a large public university hospital in São Paulo, Brazil, and the primary COVID-19 referral centre for the state. During the study period the hospital reconfigured approximately 900 beds, 200 in intensive care and 700 in wards, from specialised inpatient care to COVID-19 treatment [15].

Data collection

To guide the structure and rigour of this qualitative inquiry, we adopted the Inductive Process to Analyze the Structure of Lived Experience (IPSE), a five-phase method particularly suited for phenomenological investigation. Its stages are: (1) assembling and training a research team; (2) assurance of the study's originality; (3) purposive sampling focused on representativeness and exemplarity; (4) data collection rooted in experiential access; and (5) systematic data analysis.

We selected the IPSE framework for its methodological clarity and for its capacity to uncover the depth and texture of lived experience in a disciplined manner [16]. Two members of the research team, both with prior experience in clinical and qualitative research [17–20], recommended the method and led the training of a broader team of interviewers, so that we could widen the sampling coverage. We then developed a semi-structured interview guide to elicit narrative-rich accounts of the pandemic from the participants' perspectives (see Additional file 1).

We trained the interviewers under the supervision of the lead researcher and, after the initial training sessions, reconvened as a team to review the process: we discussed which techniques had worked, the difficulties we had met, the questions that yielded the richest material, and the points at which the protocol needed refinement. In a final calibration round we interviewed the lead interviewer as a quality control measure. After completing this process, the lead interviewer and the trained team conducted the interviews [21].

Participants and sampling strategy

We used a purposive sampling strategy to reach medical residents who had worked on the front lines of the COVID-19 response [22]. The only exclusion criterion we applied was a decision not to take part. We recruited through a snowball approach, inviting each participant to name other eligible colleagues, which allowed us to include residents from several specialties [23]. We approached forty-one residents: 21 from the psychiatry programme, which had 80 residents enrolled, and 20 from other specialties, drawn from a pool of more than 300. Eight did not take part, citing lack of interest or personal unavailability, which left a final sample of 33. No participant withdrew after being interviewed. All 33 interviews entered the analysis. The quotations presented in the Results come from 29 of these participants, four of whom

are quoted under more than one theme; the corpus contained further passages conveying the same experiential dimensions, and we selected the ones that expressed each dimension most clearly rather than reproducing repetitions of it.

Participants occupied one of two roles during the pandemic, and the distinction matters for how their accounts should be read. Twenty-three delivered direct clinical care to patients with COVID-19: 15 from non-psychiatric specialties and 8 psychiatry residents reassigned to general medical duties because of the surge in demand, whose frontline exposure was therefore comparable to that of the other clinical specialties. The remaining 10, all from psychiatry, provided psychological support to hospital staff and did not care for patients with COVID-19 directly.

Among the 33 participants (20 men and 13 women), the distribution of specialties was as follows: psychiatry (n = 18), general practice (n = 7), paediatrics (n = 3), surgery (n = 2), ophthalmology (n = 1), infectious diseases (n = 1) and haematology (n = 1). Further characteristics are given in Table 2. Interviews lasted between 45 and 70 minutes, with no cancellations or exclusions. All participants gave written informed consent. The study was approved by the Research Ethics Committee (Comitê de Ética em Pesquisa) of the Hospital das Clínicas da Faculdade de Medicina da Universidade de São Paulo (HCFMUSP) under CAAE 30710620.2.0000.0068. The study was conducted between July 2020 and January 2021, a period encompassing the end of the first wave and the onset of the second wave of the pandemic in Brazil [24].

Interview procedures and transcription

We conducted all interviews remotely on an institutional, access-controlled video-conferencing platform, in compliance with pandemic-related safety protocols. We stored the recordings on encrypted institutional storage with access restricted to the research team, in accordance with the Brazilian General Data Protection Law (Lei Geral de Proteção de Dados, LGPD). A professional service with a proven record in handling sensitive material transcribed them under a confidentiality agreement. We conducted 33 interviews and included all of them in the analysis. One recording was affected by a technical fault and could not be transcribed in full; we transcribed and analysed the intelligible portions alongside the rest of the corpus.

We conducted, transcribed and analysed the interviews in the original Portuguese, so that coding was performed in the source language and semantic and affective nuance was preserved. Only the illustrative quotations selected for presentation were subsequently translated into English, by a professional translator experienced in academic and healthcare contexts, and a bilingual member of the research team checked those translations against the Portuguese originals. To protect confidentiality we present the quotations without participant identifiers, and no names, initials or other potentially identifying details appear in them. We interviewed each participant once, in a single session, with no repeat interviews. Interviewers took field notes during and after sessions to record contextual observations, although these did not bear directly on the thematic findings reported here. No non-participants were present during any interview. We did not return transcripts to participants for

verification; instead the full research team reviewed and confirmed the thematic findings collectively across three consensus meetings (see Data analysis).

Data analysis

We analysed the interviews following the structured steps of the IPSE method. Eight members of the research team identified and coded manually, without software, the passages that conveyed the subjective and existential dimensions of participants' experiences. We developed an internal coding language to classify key elements within the narratives, based on recurrent experiential markers, and applied these codes systematically across all interviews to enable thematic organisation [16].

We held three formal consensus meetings to review the coded material, each documented with written minutes to support the audit trail. We assessed thematic saturation after coding all 33 interviews, rather than sequentially during data collection [25–27]. In the second and third meetings we compared the codes generated by the interviews coded last against the thematic structure already established, and found that they reproduced existing experiential dimensions without introducing new ones. On this basis we declared saturation by consensus. We therefore report saturation as a property of the analysed corpus and do not claim a specific interview at which we reached it. These meetings also served the broader project from which the present article derives, in which the same dataset yielded three complementary publications; it was here that we distinguished the six themes reported below from those assigned to the other two articles. We edited the quotations lightly for readability, removing false starts and filler expressions without altering meaning, and checked every edit against the original Portuguese transcripts. We supported the rigour and trustworthiness of the analysis through investigator triangulation, critical reflection on our preconceptions and theoretical commitments, attention to disconfirming cases, and consideration of the transferability of the findings to comparable clinical and institutional contexts [16, 28]. We report the study in accordance with the COREQ 32-item checklist for interviews and focus groups, provided as Additional file 2, and with the Standards for Reporting Qualitative Research, provided as Additional file 3.

Researcher positionality and reflexivity

Several members of the interviewing team were themselves residents at HCFMUSP during the same period, and one team member served both as an interviewer and, in a separate interview, as a participant. This insider position afforded experiential access and rapid rapport, but also posed risks of over-identification and of leading. We addressed these reflexively: interviewers were trained and calibrated, including a round in which the team interviewed the lead interviewer, before data collection; the team bracketed (epoché) prior assumptions during coding; and the analysis deliberately sought disconfirming cases. The research team comprised eleven members (four men and seven women), including residents and faculty from psychiatry and other specialties; the lead researcher is a psychiatrist with training in phenomenology. Throughout, we remained attentive to how our shared professional experience could shape both the elicitation and the interpretation of the narratives. The snowball sampling strategy likewise carries an inherent risk of relational induction, as participants

recruited through peer networks may share similar perspectives or be influenced by the expectations of those who referred them. This risk is acknowledged. This risk was mitigated in part by the epistemological aim of the study. Rather than seeking a demographically representative sample, we sought a group able to provide a rich biopsy of a shared possible experience. In phenomenological inquiry, coherence of context is a resource rather than a limitation. The diversity of specialties and clinical roles represented in the sample (psychiatry, general practice, paediatrics, surgery, ophthalmology, infectious diseases, and haematology, across different wards, floors, and institutional functions) further reduced the likelihood that any single perspective or relational network unduly shaped the corpus of narratives.

A large language model (Claude, Anthropic) was used for language editing, for restructuring the manuscript and for drafting text, in each case working from material and analytic decisions made by the authors. Coding and thematic analysis of the interviews were carried out by the research team without such tools. The full statement is given under Declarations.

Results

Institutional absence

Residents described wanting more structured guidance, visible leadership and dedicated emotional support from the institution. The gap they described was not only procedural, since they acknowledged that the uncertainty was general, but affective: they felt alone at moments of considerable professional strain. One resident recalled: "I kept thinking: where are the supervisors? We were improvising protocols based on WhatsApp messages. Nobody checked in on us. It was like we didn’t exist."

This sentiment of feeling unacknowledged was a common thread across the interviews. Several participants noted a disconnect between their frontline responsibilities amid a global health crisis and the level of communication they received from institutional leadership: "At some point, I realized we were alone. I mean, really alone. Nobody from the coordination came to ask how we were holding up. No psychological support, no rounds, no one to talk to. We became invisible."

The communication gap had practical consequences. In the absence of consistent, formalized updates, residents reported having to navigate rapidly shifting circumstances with little certainty about official policy: "Every day was different. One day they said we could isolate for five days. Then it became ten. Then they said we could come back earlier if asymptomatic. But we never got these changes in writing. We heard from other residents, or from the nursing staff. There was no communication, no structure."

For some, this was described in terms of betrayal: "I thought that working for the state, for a university hospital, meant someone had your back. But when it got really bad, it was like we were disposable. That hurt more than the fear of the virus." Others interpreted the limited communication as a form of institutional detachment, particularly given the significant moral and emotional pressures they were facing: "I cried one day after talking to a family whose relative had died. I didn't even know how to

conduct that conversation. I had no training, no support. And I thought, this isn't right. We shouldn't be doing this alone."

Residents described the hospital, which they had understood as a place of collective purpose and professional formation, as unable during the crisis to offer the support they had expected of it.

Intergenerational tension and powerlessness

Residents described discomfort when they disagreed with a supervisor's decision, and little room to act on that disagreement. This theme runs through the interviews. One resident reflected: "There were times I completely disagreed with the attending physician, but I didn't feel I could speak up. They had twenty years of experience. I had one. And besides, there's this unspoken rule: don't challenge your superior in public." Another described a similar position: "I was in a family meeting where I felt the senior doctor was being too optimistic. The family was clinging to that hope. I felt like it was dishonest, but I said nothing. I didn't want to undermine him, and I didn't know if it was my place."

In many cases, apprehension regarding professional repercussions or potential career damage contributed to silence, even in ethically charged moments: "I had this urge to stop what was happening, to say: this isn't right. But then I thought: he's my preceptor. He's going to be the one writing my evaluation. So I said nothing." Some residents who attempted to voice disagreement reported feeling that their perspectives were not fully considered or were minimised: "I brought up my concern during a round, and the response was: 'You're too young to understand the big picture.' It shut me down. I stopped contributing after that." Others raised concerns through more careful channels and saw nothing change: "I tried to speak privately with a supervisor, very respectfully. But nothing changed. It felt like the system was made to absorb these protests and do nothing with them."

Residents described this less as single episodes than as something that built up over the year. One of them put it this way: "By the end of the year, I wasn't just tired; I was numb. I had stopped fighting. And that, for me, was the hardest part."

Ambiguity of responsibility

Residents described having to act when no rule told them what to do. This theme appeared in most interviews. The dilemmas were rarely formal ethical dilemmas: they were questions about where a resident's own responsibility began and ended, in situations where guidance was absent, contradictory, or plainly outrun by the case at hand.

A recurring dilemma involved whether to report colleagues who showed mild COVID-19 symptoms but insisted on working. One resident reflected: "I knew he wasn't okay, he was coughing, had a fever… but I didn't say anything. I didn't want to become the person who polices others. Who was I to say he couldn't be there? And at the same time, I kept thinking: what if he infects someone? But… I stayed silent." Another reported a similar conflict when advising patients: "I had a patient who lived with his elderly

mother. I knew isolation was the safest path, but she was her mother's only caregiver. What was I supposed to say? That she should abandon her mother? I said the basics: mask, distance; but I knew it wouldn't be enough. I just didn't want to feel guilty."

For some, the tension derived not only from clinical judgment but from hierarchical uncertainty: "I was afraid of being held responsible for something I wasn't trained to handle. We're residents, we're not fully autonomous, but suddenly I was the only one around. I knew I wasn't equipped for that, but there was no one else to ask." Responsibility was also described in terms of emotional burden, as in this account of a moment of uncertainty while handling a high-risk pregnancy: "We had a pregnant patient in critical condition; she was put on ECMO. And I kept thinking: what about the baby? Nobody mentioned the baby. I didn't know if it was my role to bring that up, but I kept thinking about it. He was born with Apgar 1 and died soon after. To this day, I wonder if I did everything right."

In other instances, residents feared overstepping their place in the hierarchy: "I witnessed some really questionable decisions from supervisors, but what could I do? What was I supposed to say? I'd be shut down. So, you stay quiet. And that silence becomes a burden." One participant summarised how this felt at the outset: "At the beginning, no one knew what to do. It felt like everything landed on our shoulders. I kept asking myself: should I have done something differently? Should someone have said something?"

Ethical loneliness

Most residents described making morally significant decisions alone, with no space for dialogue or validation, a condition set out as ethical loneliness in Table 1. One resident shared: "There were shifts when I didn't speak to anyone about what I was feeling. I would leave the room of a dying patient and go right back to answering messages. Nobody asked if I was okay, and I didn't know if I had the right to bring it up." Another recalled a situation in which they doubted a clinical decision but had no one to process it with: "After that night, I didn't sleep. I kept replaying everything in my head, but there was no one to talk to about it. My supervisor wasn't around, and my colleagues were too overwhelmed themselves. So I just kept it to myself."

In several narratives, residents described withholding their doubts or concerns not only from supervisors, but even from peers: "I didn't want to be seen as weak or dramatic, so I didn't share what I was thinking. Everyone looked like they were coping, so I told myself: just keep going. But inside, I felt lost." Some described the absence of any acknowledgement afterwards: "I made a decision that went against my values because I didn't have another option at the time. But there was no one to say, 'That was hard, and I see you tried your best.' It was like the moment never happened."

Across these accounts, what weighed most was not the difficulty of the dilemma but having to carry it alone.

The quiet compromise

Residents also described choosing not to act, because the emotional or relational cost of resistance seemed too high. We refer to this as the quiet compromise. One resident described witnessing protocol violations but remaining silent: "There were times when I saw colleagues skipping protective measures or stretching isolation periods. And I thought: this is not okay. But I didn't say anything. I didn't want to create tension. I told myself: this is not the time to start a war." Another described the same movement over a longer period: "I started to realize that I was adjusting my standards. Things I would never accept before, I began to tolerate. It wasn't conscious at first, but then I noticed: I was bending. And that scared me."

Some compromises were described in relational terms, made to preserve harmony in the team: "Sometimes you agree with something just to keep the peace. We were all so exhausted, and I didn't want to be the one who made things harder. So you say 'okay' even when you're not okay." For others, the compromise came from a place of moral exhaustion: "In the beginning, I would speak up. But then I got tired. Tired of arguing, of being ignored. So I stopped. I just did my job. And that felt like giving up on something important." Others said that speaking up had stopped seeming worthwhile: "There was this case. I knew the decision wasn't right. But I stayed quiet. I thought: saying something won't change it, and it will just isolate me more. So I let it happen. I'm not proud of that."

Moral injury and long-term impact

Many residents said that the ethical conflicts of the pandemic left a lasting mark, emotional and physical, that outlived the shifts in which they occurred. What they described was a conflict between what they did and what they held to be right, in circumstances that gave them little choice. One resident recalled: "There's this one night I still think about. I said something to a patient that I now regret. At the time, I thought I was doing what was best, but it wasn't honest. I was trying to calm him down, but I feel like I lied. That stayed with me." This feeling of having compromised one's professional or personal integrity, even for practical or well-intentioned reasons, was frequently associated with significant emotional consequences: "Some nights I would come home and cry without really knowing why. It wasn't sadness. It was something deeper, like guilt. Like I had done what I could, but it wasn't enough, or it wasn't right."

The long-term effects of such experiences reportedly included persistent rumination, sleep disturbances, and a recurring sense of unease related to their participation in ethically challenging situations: "There are decisions I made that I would make differently today. But back then, everything was chaos. Still, I carry them with me, and sometimes I wonder if I'll ever let them go." Others described how these morally challenging experiences influenced their perspectives on the medical profession, their own professional identity, and the healthcare system: "I used to think of medicine as this noble field. After the pandemic, I still believe in that, but it's more complicated now. I saw how easy it is to become someone you don't recognise."

For some, this sense of moral distress was linked less to their own actions and more to observing situations where they felt unable to intervene effectively: "I saw patients die alone. I saw colleagues break down. And I couldn't do anything. I just kept going. But a part of me shut down to be able to keep going." Some found meaning in the work; others did not: "We were called heroes, but it didn't feel like heroism. It felt like surviving. And now that it's over, we're just left with what we did, and what we couldn't do." Several described carrying these episodes without ever having spoken about them: "Some things I still carry with me. I never talked about them. I wouldn't even know where to start."

Synthesis of thematic axes

The six themes are not independent. Residents described institutional absence and hierarchical tension as the background against which ambiguity of responsibility and ethical loneliness arose; the quiet compromise as how they managed that position from day to day; and moral injury as what remained afterwards. This structure is summarised in Fig. 1. The Discussion takes up each theme in turn.

Discussion

This study set out to describe the ethical experience of frontline residents during the pandemic. What the accounts show is that the ethical weight of that period lay less in the high-profile dilemmas of triage and allocation than in the ordinary decisions of clinical work. Those decisions included whether to report a symptomatic colleague, what to advise a patient who lived with an elderly mother, and whether to voice disagreement with a supervisor. These decisions were rarely covered by protocol, they were made at speed, and they were, above all, made alone. The six themes are discussed below in the order in which the residents' accounts suggest they arose, from the conditions under which they worked to what remained with them afterwards. The phenomenological foundations of this reading are developed in our earlier work and are not restated here [13, 14]. The analysis describes what the residents recounted. The conceptual reading that follows is an interpretation the team developed from those descriptions in dialogue with the literature, and is offered as such. That the moral difficulties of clinical work carry an existential dimension has been argued before [29]. What the present accounts add is a description of what happens to that dimension when institutional support is withdrawn.

Institutional absence: the withdrawal of structured guidance, visible leadership and emotional support at the moment residents most needed them.

Residents did not describe an institution that had never supported them. They described one that had supported them before the pandemic and became unreachable during it: protocols circulating by message, isolation rules that changed from one day to the next, and no one from coordination asking how they were. Some named this betrayal.

Part of this was the operational overload of a hospital complex under extreme strain, which the residents themselves acknowledged. But the accounts point to something the overload does not explain. The institution prepared, with documented success, for two demands: the clinical and logistical demands of

the infection [15], and the mental health of its workforce [30]. What it did not prepare for, and what no account in our corpus describes receiving, was support for the ethical problems themselves, in situ, as they were being faced. The gap was not between need and resources. It was between two kinds of need, one recognised and one not.

This asymmetry reflects a longer pattern in medical training, in which technical proficiency has taken precedence over ethical and affective preparation [31–39]. In a crisis, neither residents nor their supervisors hold a repertoire for moral difficulty, and the difficulty is then experienced as a private failing rather than as a systemic problem with a systemic response.

The absence is not for want of available models. Structured mechanisms for addressing moral difficulty at unit level already exist and have been evaluated. Hamric and Epstein describe a health system-wide moral distress consultation service, requested by staff when moral distress arises, whose purpose is to identify its causes, the barriers to acting on them, and the strategies available for changing the situation [40]. A subsequent quasi-experimental evaluation of that service found a small but significant reduction in moral distress among participants, most clearly among intensive care staff, although their sense of empowerment did not change [41]. In England, an evaluation of Schwartz Rounds, monthly multidisciplinary forums for discussing the emotional demands of care, found poor psychological wellbeing on the GHQ-12 falling from 25% to 12% among attenders, while remaining between 37% and 34% among non-attenders [42]. In a paediatric intensive care unit, structured ethics and communication rounds were associated with reduced moral distress among staff [43]. The reported effects are modest and the designs are not randomised, so these are not solutions in a strong sense. What they establish is narrower and more useful: the problem our residents describe has been named elsewhere, mechanisms for addressing it exist, they fit inside an ordinary hospital week, and their effects can be measured.

Residents interpreted the absence they lived through as a failure of moral recognition, that is, as a missed opportunity for shared deliberation and mutual care [31]. The mechanisms above matter for that reason, and not only because they move a score: they make the moral difficulty a shared object.

Intergenerational tension and powerlessness: the constraint on moral expression produced by hierarchical asymmetry, in which disagreement carried a professional cost.

Residents disagreed with decisions and did not say so. Those who did speak, in rounds or in private conversation, described being told they were too young to understand the full picture, or saw nothing change.

Two features of these accounts deserve emphasis. The silence was not indifference: residents described the impulse to intervene and the calculation that followed it, in which the anticipated cost to their training outweighed the anticipated benefit of speaking. And the asymmetry was not the work of indifferent seniors. Supervisors were themselves under strain and themselves without preparation for moral difficulty, so that attributing blame at this level would misdescribe the situation [10, 44–46]. The

problem is structural. A hierarchy that works for technical decisions has no equivalent procedure for moral ones.

This is the condition Edmondson describes as the absence of psychological safety: where members of a team believe that speaking up carries interpersonal or evaluative risk, they withhold questions and concerns, and the team loses the information that would have corrected it [47]. In the residents' accounts the loss is not only informational. Moral disagreement that cannot be voiced is not resolved but retained by the person who felt it, and the retention is what turns a disagreement into a burden.

Ambiguity of responsibility: being held accountable for an outcome without a rule, a role boundary, or a shared decision to rest on.

Residents described acting when no rule told them what to do, and being afraid of being held responsible for something they had not been trained to handle. The dilemmas they raised were not exotic: a colleague working with symptoms, a patient who lived with his elderly mother, a critically ill pregnant woman on ECMO. What made them heavy was that the resident had to settle them and then own the outcome.

The norms available at the time were sound as public health and insufficient as clinical guidance. Distancing and masking were commendable imperatives, but they could not function as absolute rules at the bedside, where they met patients whose lives did not accommodate them [1, 8, 10]. Norms of this kind do not capture the complexity of the decisions they are meant to govern, and when they are applied without qualification they intensify the guilt of the clinician who could not follow them [31, 48–51]. The accounts under Ambiguity of responsibility describe everyday decisions that do not reduce to correct and incorrect actions, but unfold in zones of indeterminacy. Institutional disarray then displaced onto individuals a burden that, under other conditions, collective deliberation would have carried [10].

Read through Joan Tronto's ethics of care, responsibility is not an allocation of duties but a phase of care itself, inseparable from attentiveness and from a collective answerability that the institution is supposed to hold [49, 52]. What the residents describe is that phase collapsing onto one person: a demand arriving from the patient in the room, with no institutional counterpart to answer it alongside them.

Ethical loneliness: making a morally significant decision alone, and finding afterwards that no one acknowledges it was made.

Residents described leaving the room of a dying patient and moving straight to the next task, lying awake after a decision they doubted, and withholding concerns from colleagues so as not to appear weak or dramatic. Several described the absence of any acknowledgement afterwards. What weighed most, in their accounts, was not the difficulty of the dilemma but having to carry it alone.

This locates the source of the suffering. What the residents described as intolerable was the silence around the decisions rather than the decisions themselves. Uncertainty that finds no space for shared deliberation is not thereby resolved; it is converted into suffering, and the conversion is relational in

origin, arising from the absence of others with whom to think rather than from the difficulty of the decision itself [14, 53–55].

A quantitative study conducted by our group at the same institution points in the same direction. In a one-year monthly follow-up of 1,078 healthcare workers during the pandemic, Carvalho-Alves et al. found that higher levels of institutional support were associated with reduced risk of anxiety, depression and posttraumatic stress symptoms, while greater fear of COVID-19 was associated with increased risk [56]. That study measures associations across a workforce; the present accounts describe what one of those associations consists of from the inside.

Jill Stauffer's concept of ethical loneliness names this condition precisely [57]. For Stauffer it is not a feeling of isolation but a form of injustice: the situation of one who has been harmed and then finds that no one able to hear it will hear it. The moral burden goes unrecognised, and the absence of recognition compounds the original difficulty. This is why, in the residents' accounts, the presence of another person mattered even when that person could offer no solution [58–60].

The quiet compromise: the incremental lowering of one's own standards when the cost of resistance came to seem higher than the cost of acquiescence.

Residents described seeing protective measures skipped and saying nothing, agreeing with decisions in order to keep the peace, and noticing over time that they were tolerating things they would once have refused. Several described having spoken up at first and then stopped, tired of arguing and of being ignored.

Two features distinguish this from ordinary pragmatism. The residents described the movement as a change in themselves rather than in the situation, which is what made it disturbing to them. And no single instance was decisive: each concession was small enough to be defensible on its own, and the pattern became visible only in retrospect. The accumulation is the phenomenon, not any of its parts.

Some residents also described the emotional burden itself producing a kind of paralysis, a freezing in the face of situations that called for a response. Read alongside the previous theme, this suggests that moral loneliness was not confined to an emotional state but bore on moral agency. Residents described questioning their own instincts, hesitating to voice disagreement, and adjusting the values they worked by in order to remain functionally present. The compromises were not reached through deliberation. They were an exhausted and nearly automatic response to environmental pressure [61]. What the accounts describe at this point is no longer the application of principles but the ongoing negotiation of what would still count as acceptable [31].

Moral injury and long-term impact: what remained afterwards, described as damage not to mood alone but to the residents' sense of themselves as moral agents.

Residents described persistent rumination, disturbed sleep, a night still returned to, crying at home without knowing why, and a changed view of the profession. Several described carrying episodes they

had never spoken about to anyone, and would not know how to begin describing.

Epstein and Hamric's account of moral residue is the closest available description of this trajectory [62]. Moral residue is the ethical and psychological weight that persists after one has acted against one's own values, and their crescendo effect describes its accumulation across repeated episodes, each new residue arriving on top of what the previous ones left. The residents' accounts of a year that ended in numbness rather than in exhaustion follow this shape.

Where the suffering is severe, it corresponds to moral injury as Litz et al. define it: not trauma produced by a difficult event, but the suffering that follows a transgression of one's deepest moral convictions [63]. Injury of this kind was widely reported among healthcare workers during the pandemic, in meta-analysis [64] and in survey work examining moral resilience as a moderator of its effects [65]. The residents' accounts suggest one extension of that definition. What they lamented was not only what they were forced to do or to witness, but what they had become in order to endure it, and the damage they described was to moral identity rather than to affect alone [61, 66, 67]. Nor is it burnout. Burnout among residents in this period has been documented longitudinally [68], but burnout names a depletion of energy, whereas what these residents described was a change in their relation to their own values. In this respect the injury is ethical and existential before it is psychiatric, which is also why it did not present itself to them as something to take to a mental health service.

The public language available at the time made this harder to name. Residents were called heroes, and one of them observed that it had not felt like heroism but like surviving. Heroism discourse honours healthcare workers and, in the same movement, obscures the structural conditions that exposed them to moral harm, leaving the harm without a vocabulary in which it could be reported [69]. Brencio's analysis of the war metaphors that dominated pandemic discourse makes the mechanism explicit: such language is not descriptive but formative, casting clinicians as combatants from whom sacrifice is expected, so that exhaustion and refusal come to appear as desertion rather than as reasonable limits [70].

Taken together, the six themes describe medical ethics as it was lived rather than as it is codified. Kleinman's account of moral life is useful here: morality as a practical and social dimension rooted in everyday gestures, interactions and decisions made in real time, rather than as a system of formal rules [71, 72]. What the residents describe is consistent with that account and adds a condition to it. The moral life Kleinman describes is enacted with others. When the others are absent, its ordinary work of negotiating what matters becomes a private burden, and the burden accumulates. The contribution of this study is to portray moral suffering not as an exception or an isolated event, but as a structural and recurring feature of care in crisis. It locates the source of that suffering in the relational conditions of the work rather than in the fragility of the individual clinician. Recognition of moral burden, peer relationships and institutional responsiveness are, on this reading, not additions to medical training but conditions for ethical resilience [73–75].

Implications for medical education and institutional governance

If moral distress in crisis is systemic and recurring rather than idiosyncratic, programmes can prepare for it. Our findings point to four mechanisms, each addressing a specific theme, and each already in use somewhere. First, against institutional absence, programmes can establish standing, protected spaces in which morally difficult decisions are processed collectively rather than carried alone. Structured formats exist and have been evaluated: moral distress consultation [40, 41], Schwartz Rounds [42], and unit-level ethics and communication rounds [43].

Second, against ethical loneliness, brief but reliable check-ins and peer-support structures can restore the relational recognition whose absence converted ethical tension into moral suffering. Third, against intergenerational and hierarchical tension, cultivating psychological safety and legitimate, non-punitive channels for speaking up [47] allows moral dissent to be voiced without fear of evaluative reprisal, and horizontalises power where that is clinically appropriate. Fourth, faculty development is essential: supervisors were themselves under strain and unprepared, so equipping preceptors to recognise moral distress and to hold moral conversations is part of the solution rather than an afterthought.

Embedding these mechanisms, together with explicit curricular attention to moral distress and moral injury, within residency training and institutional governance reframes ethical support from a discretionary extra into a core element of crisis preparedness and trainee wellbeing. This applies across seniority: both the residents' accounts and the literature indicate that supervisors faced the same difficulties without preparation, so ethical formation cannot be addressed to trainees alone [6, 76]. The aim is ethical resilience: an institutional capacity to keep moral deliberation alive precisely when conditions make it hardest.

Limitations

- This was a single-centre study conducted at a large, research-intensive public university hospital that already held teaching structures and a clinical ethics infrastructure. That context shaped both the moral sensibilities of the residents and the discursive resources available to them for articulating those experiences. Transfer to settings with different organisational cultures, resource profiles or training models, including private, rural and non-academic services, should be made with caution.
- The sample was recruited by purposive and snowball sampling, and psychiatry residents predominate within it. That predominance reflects both the recruitment strategy and the central position of psychiatry in the institutional response, but it has an analytic consequence. Training in the relational and intersubjective dimensions of care may have shaped which ethical themes became salient and the vocabulary available for describing them, and the corpus probably underrepresents the concerns of more procedure-oriented or technologically intensive specialties. The themes were also not compared across the two roles the participants occupied. The 23 residents who delivered direct care to patients with COVID-19 and the 10 who provided psychiatric

support to hospital staff were analysed as a single corpus, and these data therefore cannot show whether the six themes were distributed differently between the two groups.

- Each participant was interviewed once, between July 2020 and January 2021, that is, within the period the interviews describe rather than after it; the study window is shown against the course of the pandemic in Brazil in Fig. 2. The theme of long-term impact therefore rests on what residents reported carrying at that moment, and not on longitudinal observation. What persisted beyond the study window is not something these data can establish.
- The study addressed medical residents only. The ethical landscape of nurses, allied health professionals and senior physicians during the same period is likely to differ in ways this corpus cannot show, and warrants its own investigation. Finally, the cascade presented in Fig. 1 is an interpretive reading of how the six themes relate to one another. It is not a causal model and does not assert a temporal sequence.

Future directions

- Four lines of work follow from these findings. Longitudinal designs could follow a cohort of this kind beyond the acute period and establish what persists, which is the question these data raise and cannot answer. Mixed-methods designs could triangulate and extend experiential findings of this type by attaching magnitude to phenomena that qualitative work can only describe. Two instruments have been validated in health professionals: the Moral Injury Symptom Scale for Health Professionals [77], and the Moral Injury Outcome Scale, whose psychometric properties have been examined in acute care nurses [78]. Comparative studies across institutions and health systems could test whether the six themes hold where organisational culture, hierarchy and resources differ. And, since mechanisms for addressing moral difficulty already exist and have been evaluated elsewhere [40–43], their feasibility and effect within residency training in a Brazilian public hospital is an empirical question worth asking directly rather than assuming in either direction.

Conclusions

- Residents at a large public university hospital described the ethical difficulty of the pandemic as lying in the ordinary decisions of clinical work rather than in the allocation dilemmas that dominated public debate. What made those decisions heavy, in their accounts, was that they were taken without institutional guidance, within a hierarchy in which disagreement carried a professional cost, and with no one to think them through with. Small concessions accumulated over the year, and what remained afterwards was described as damage to their sense of themselves as clinicians rather than as fatigue.
- These accounts locate the source of moral suffering in how the work was organised and supervised, that is, in whether a resident facing a moral difficulty had anyone to face it with, rather than in the resilience of individual clinicians. Ethics, on this evidence, is not applied to clinical practice from outside it but enacted within it, and its enactment depends on the presence of others. Where that

presence was missing, ethical tension became moral suffering. That is the contribution of this study.

- The pandemic did not create these conditions. Residents described an institution that had supported them before it, and a training that had prepared them technically but not morally, which describes ordinary medicine under strain rather than an exceptional event. The crisis removed the margin that ordinarily absorbs that deficit and made it visible. This is why institutional support for moral difficulty belongs to crisis preparedness rather than to its aftermath, and why the question it raises does not close when the crisis does.

Figures and tables

Under crisis overload, structural antecedents (institutional absence; intergenerational and hierarchical tension) were interpreted as fostering moral ambiguity and ethical loneliness, and adaptive quiet compromises were understood as accumulating into moral injury when the relational buffer of structured institutional support was absent. The model is the authors' interpretive reading of the accounts and does not imply temporal sequence or causality. The figure was created by the authors and has not been published elsewhere.

The shaded band marks the study period, which spans the end of the first wave and the onset of the second. The panel is schematic and does not represent quantitative epidemiological data; for the empirical record of the pandemic phases in Brazil see Barcellos and Xavier [24]. The figure was created by the authors and has not been published elsewhere.

Table 1
Working definitions of the five constructs used in this article.

Construct	Working definition	Key reference
Moral distress	Knowing the ethically right course of action and being prevented from taking it by institutional or hierarchical constraints.	Epstein & Hamric [62]
Moral residue	What remains after an episode of moral distress that is never resolved. It accumulates with each new episode: the crescendo effect.	Epstein & Hamric [62]
Moral injury	Lasting harm following participation in, witnessing, or failure to prevent an act that violates a deeply held moral commitment. A possible downstream consequence of unresolved moral distress, not a synonym for it.	Litz et al. [63, 66]
Ethical loneliness	The injustice of carrying a morally significant experience that no one acknowledges: a failure of witness on the part of institutions and communities.	Stauffer [57]
Moral loneliness	The first-person side of that condition: making weighty moral decisions with no relational support.	[60]

Table 2
Characteristics of the 33 participating medical residents, HCFMUSP (July 2020–January 2021).

Characteristic	Value (n unless stated)
Total participants	33
Sex (whole sample)	Men 20; Women 13
Age, years	23–40; mean 27.5 (SD 3.3)
Training year (PGY)	R1 7; R2 21; R3 4; R4 + 1
Specialty	Psychiatry 18; General practice 7; Paediatrics 3; Surgery 2; Ophthalmology 1; Infectious diseases 1; Haematology 1
Role during pandemic	Direct COVID-19 patient care 23; Psychiatric support to health-care workers 10
Reassigned to general medical duties	8 (all psychiatry residents)
Interview duration	45–70 minutes

PGY = postgraduate (residency) year. Sex is reported only as a whole-sample total and is not linked to individual quotations.

Abbreviations

COREQ
Consolidated Criteria for Reporting Qualitative Research
ECMO
extracorporeal membrane oxygenation
HCFMUSP
Hospital das Clínicas da Faculdade de Medicina da Universidade de São Paulo
IPSE
Inductive Process to Analyze the Structure of Lived Experience
LGPD
Lei Geral de Proteção de Dados (Brazilian General Data Protection Law)
PGY
postgraduate year
SRQR
Standards for Reporting Qualitative Research.

Declarations

Declarations

Ethics approval and consent to participate

This study was approved by the Research Ethics Committee (Comitê de Ética em Pesquisa) of the Hospital das Clínicas da Faculdade de Medicina da Universidade de São Paulo (HCFMUSP) and by the Brazilian National Research Ethics Commission (CONEP; approval number 4.122.449, 29 June 2020; CAAE 30710620.2.0000.0068). All participants provided written informed consent. All methods were performed in accordance with the Declaration of Helsinki.

Consent for publication

All participants provided written informed consent for the publication of anonymised quotations. No identifying details appear in the manuscript.

Competing interests

The authors declare that they have no competing interests, financial or non-financial.

Funding

The authors received no specific funding for this work.

Author Contribution

FGF conducted interviews, discussed the material with the co-authors, wrote most of the manuscript and prepared Figures 1 and 2. LMO conducted interviews, discussed the material with the co-authors and drafted the Methods. PCN and DCF conducted interviews, discussed the material with the co-authors and drafted the Background. AVC, NOB and DMM conducted interviews and discussed the material with the co-authors. LB reviewed the full text, revised the English and helped reorganise the Results. ECM led the wider research programme that obtained ethics approval for this study and contributed to revising the manuscript. GBC and DCL led the research group, organised the analytic discussions and identified the main themes arising in the interviews. All authors read, critically reviewed and approved the final manuscript.

Acknowledgements

Not applicable.

Availability of data and materials

The datasets generated and analysed during the current study are not publicly available because the interview transcripts contain information that could compromise the confidentiality of participants, but de-identified excerpts are available from the corresponding author on reasonable request.

References

1. Emanuel EJ, Persad G, Upshur R, Thome B, Parker M, Glickman A, et al. Fair allocation of scarce medical resources in the time of Covid-19. N Engl J Med. 2020;382(21):2049-55. doi:10.1056/NEJMsb2005114.

2. Vinay R, Baumann H, Biller-Andorno N. Ethics of ICU triage during COVID-19. Br Med Bull. 2021;138(1):5-15. doi:10.1093/bmb/ldab009.

3. Persad G, Peek ME, Emanuel EJ. Fairly prioritizing groups for access to COVID-19 vaccines. JAMA. 2020;324(16):1601-2. doi:10.1001/jama.2020.18513.

4. Jacobs B, Manfredi RA. Moral distress during COVID-19: residents in training are at high risk. AEM Educ Train. 2020;4(4):447-9. doi:10.1002/aet2.10488.

5. Fisher H, McLaughlin S, Ark T, Zabar S, Lawrence K, Hanley K. Hard then, harder now: internal medicine residents' moral distress pre and amidst COVID-19. BMC Med Ethics. 2025;26(1):139. doi:10.1186/s12910-025-01274-6.

6. van Dam M, van Hamersvelt H, Schoonhoven L, Hoff RG, ten Cate O, Hennus MP. Clinical supervision under pressure: a qualitative study amongst health care professionals working on the ICU during COVID-19. Med Educ Online. 2023;28(1):2231614. doi:10.1080/10872981.2023.2231614.

7. Etzioni A. Micro and macro ethical considerations of COVID-19. J Clin Ethics. 2020;31(4):318-25. doi:10.1086/JCE2020314318.

8. Miller FG. The ethics of everyday life in the midst of a pandemic. Hastings Cent Rep. 2020;50(3):6-7. doi:10.1002/hast.1118.

9. Xafis V, Schaefer GO, Labude MK, Zhu Y, Hsu LY. The perfect moral storm: diverse ethical considerations in the COVID-19 pandemic. Asian Bioeth Rev. 2020;12(2):65-83. doi:10.1007/s41649-020-00125-3.

10. Lewis S, Willis K, Smallwood N. The collective experience of moral distress: a qualitative analysis of perspectives of frontline health workers during COVID-19. Philos Ethics Humanit Med. 2025;20(1):1. doi:10.1186/s13010-024-00162-y.

11. Santos JM, Verdi M. Moral distress experienced by healthcare workers in COVID-19 triage centers, Blumenau-SC, 2021. Cien Saude Colet. 2025;30(6):e08292023. doi:10.1590/1413-81232025306.08292023en.

12. Mol A. The logic of care: health and the problem of patient choice. London: Routledge; 2008.

13. Guimarães-Fernandes F, Benoit L, de Oliveira LM, Neto PC, Feniman DC, Correia AV, et al. Facing the unknown: an inductive analysis of the lived experience of medical residents during the COVID-19 pandemic. Psychopathology. 2024;57(3):169-81. doi:10.1159/000536135.

14. Guimarães-Fernandes F, de Oliveira LM, Neto PC, Feniman DC, Correia AV, Bosoni NO, et al. Beyond technique: the phenomenology of care in medical practice during the COVID-19 pandemic. A qualitative study. The Humanistic Psychologist. 2025;53(1):102-20. doi:10.1037/hum0000335.

15. Pedroso MC, Pires JT, Malik AM, Pereira AJR. HCFMUSP: resilience in response to the COVID-19 pandemic. Revista de Administração Contemporânea. 2021;25(spe):e200245. doi:10.1590/1982-7849rac2021200245.en.

16. Sibeoni J, Verneuil L, Manolios E, Révah-Levy A. A specific method for qualitative medical research: the IPSE (Inductive Process to analyze the Structure of lived Experience) approach. BMC Med Res Methodol. 2020;20(1):216. doi:10.1186/s12874-020-01099-4.

17. Castellana GB, de Barros DM, Serafim AP, Busatto Filho G. Psychopathic traits in young offenders vs. non-offenders in similar socioeconomic condition. Braz J Psychiatry. 2014;36(3):241-4. doi:10.1590/1516-4446-2013-1127.

18. Castellana GB, Schraiber LB, de Oliveira TR, de Barros DM. “I would prefer not to”: assessing competence to consent in a case of refusal of cancer treatment. Clin Ethics. 2019;14(1):42-5. doi:10.1177/1477750919836648.

19. Ceron-Litvoc D, Messas GP. Análise fenômeno-estrutural da temporalidade no primeiro ano de vida. Revista Subjetividades. 2019;19(1):e6970. doi:10.5020/23590777.rs.v19i1.e6970.

20. Ceron-Litvoc D, Soares BG, Geddes J, Litvoc J, Lima MS. Comparison of carbamazepine and lithium in treatment of bipolar disorder: a systematic review of randomized controlled trials. Hum Psychopharmacol. 2009;24(1):19-28. doi:10.1002/hup.990.

21. Sattin-Bajaj C. On the same page: a formal process for training multiple interviewers. The Qualitative Report. 2018;23(7):1688-701. doi:10.46743/2160-3715/2018.3462.

22. Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, Hoagwood K. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. Adm Policy Ment Health. 2015;42(5):533-44. doi:10.1007/s10488-013-0528-y.

23. Parker C, Scott S, Geddes A. Snowball sampling. In: Atkinson P, Delamont S, Cernat A, Sakshaug JW, Williams RA, editors. SAGE research methods foundations. London: SAGE; 2019. doi:10.4135/9781526421036831710.

24. Barcellos C, Xavier DR. As diferentes fases, os seus impactos e os desafios da pandemia de covid-19 no Brasil. Revista Eletrônica de Comunicação, Informação e Inovação em Saúde. 2022;16(2). doi:10.29397/reciis.v16i2.3349.

25. Fusch PI, Ness LR. Are we there yet? Data saturation in qualitative research. The Qualitative Report. 2015;20(9):1408-16. doi:10.46743/2160-3715/2015.2281.

26. Hennink MM, Kaiser BN, Marconi VC. Code saturation versus meaning saturation: how many interviews are enough? Qual Health Res. 2017;27(4):591-608. doi:10.1177/1049732316665344.

27. Fontanella BJB, Luchesi BM, Saidel MGB, Ricas J, Turato ER, Melo DG. Amostragem em pesquisas qualitativas: proposta de procedimentos para constatar saturação teórica. Cad Saude Publica. 2011;27(2):388-94. doi:10.1590/S0102-311X2011000200020.

28. Williams V, Boylan AM, Nunan D. Critical appraisal of qualitative research: necessity, partialities and the issue of bias. BMJ Evid Based Med. 2020;25(1):9-11. doi:10.1136/bmjebm-2018-111132.

29. Barnard D. Love and death: existential dimensions of physicians' difficulties with moral problems. J Med Philos. 1988;13(4):393-409. doi:10.1093/jmp/13.4.393.

30. Fukuti P, Uchôa CLM, Mazzoco MF, Cruz I, Echegaray MVF, Humes EC, et al. COMVC-19: a program to protect healthcare workers' mental health during the COVID-19 pandemic. What we have learned. Clinics (Sao Paulo). 2021;76:e2631. doi:10.6061/clinics/2021/e2631.

31. Beltrão JR, de Haro Figueiredo B, Sachetim GPB, Aihara LT, Aihara LA, Corradi-Perini C. Healthcare professional's moral distress during the COVID-19 pandemic: an integrative review. Research, Society and Development. 2022;11(14):e281111436435. doi:10.33448/rsd-v11i14.36435.

32. Pellegrino ED. The internal morality of clinical medicine: a paradigm for the ethics of the helping and healing professions. J Med Philos. 2001;26(6):559-79. doi:10.1076/jmep.26.6.559.2998.

33. Charon R. Narrative medicine: a model for empathy, reflection, profession, and trust. JAMA. 2001;286(15):1897-902. doi:10.1001/jama.286.15.1897.

34. Chen L, Zhang J, Zhu Y, Shan J, Zeng L. Exploration and practice of humanistic education for medical students based on volunteerism. Med Educ Online. 2023;28(1):2182691. doi:10.1080/10872981.2023.2182691.

35. Hongladarom S, Phaosavasdi S, Taneepanichskul S, Tannirandorn Y, Wilde H, Pruksapong C. Humanistic learning in medical curriculum. J Med Assoc Thai. 2000;83(8):969-74.

36. Suchman AL. Advancing humanism in medical education. J Gen Intern Med. 2007;22(11):1630-1. doi:10.1007/s11606-007-0374-2.

37. Buck E, Holden M, Szauter K. A methodological review of the assessment of humanism in medical students. Acad Med. 2015;90(11 Suppl):S14-23. doi:10.1097/ACM.0000000000000910.

38. Pellegrino ED. Professionalism, profession and the virtues of the good physician. Mt Sinai J Med. 2002;69(6):378-84.

39. Marcum JA. The virtuous physician: the role of virtue in medicine. Dordrecht: Springer; 2012. doi:10.1007/978-94-007-2706-9.

40. Hamric AB, Epstein EG. A health system-wide moral distress consultation service: development and evaluation. HEC Forum. 2017;29(2):127-43. doi:10.1007/s10730-016-9315-y.

41. Epstein EG, Shah R, Marshall MF. Effect of a moral distress consultation service on moral distress, empowerment, and a healthy work environment. HEC Forum. 2023;35(1):21-35. doi:10.1007/s10730-021-09449-5.

42. Maben J, Taylor C, Dawson J, Leamy M, McCarthy I, Reynolds E, et al. A realist informed mixed-methods evaluation of Schwartz Center Rounds in England. Health Services and Delivery Research. 2018;6(37):1-260. doi:10.3310/hsdr06370.

43. Wocial L, Ackerman V, Leland B, Benneyworth B, Patel V, Tong Y, et al. Pediatric ethics and communication excellence (PEACE) rounds: decreasing moral distress and patient length of stay in the PICU. HEC Forum. 2017;29(1):75-91. doi:10.1007/s10730-016-9313-0.

44. Ness MM, Saylor J, DiFusco LA, Evans K. Leadership, professional quality of life and moral distress during COVID-19: a mixed-methods approach. J Nurs Manag. 2021;29(8):2412-22. doi:10.1111/jonm.13421.

45. Latimer AL, Otis MD, Mudd-Martin G, Moser DK. Moral distress during COVID-19: the importance of perceived organizational support for hospital nurses. J Health Psychol. 2023;28(3):279-92. doi:10.1177/13591053221111850.

46. Atli Özbaş A, Kovancı MS. The experience of moral distress by chief nurse officers during the COVID-19 pandemic: a descriptive phenomenological study. J Nurs Manag. 2022;30(7):2383-93. doi:10.1111/jonm.13780.

47. Edmondson A. Psychological safety and learning behavior in work teams. Adm Sci Q. 1999;44(2):350-83. doi:10.2307/2666999.

48. Carvalho LFL, Cornelli G. Virtudes no cuidado sanitário: contribuições de Pellegrino e Thomasma. Revista Bioética. 2025;33:e3813. doi:10.1590/1983-803420253813pt.

49. Tronto JC. Moral boundaries: a political argument for an ethic of care. New York: Routledge; 1993.

50. Jonsen AR. The new medicine and the old ethics. Cambridge (MA): Harvard University Press; 1990.

51. Pellegrino ED, Thomasma DC. The Christian virtues in medical practice. Washington (DC): Georgetown University Press; 1996.

52. Tronto JC. Caring democracy: markets, equality, and justice. New York: New York University Press; 2013.

53. Svenaeus F. The hermeneutics of medicine and the phenomenology of health: steps towards a philosophy of medical practice. Dordrecht: Kluwer Academic Publishers; 2000. doi:10.1007/978-94-015-9458-5.

54. Madeira L, Leal B, Filipe T, Rodrigues MF, Figueira ML. The uncanny of the illness experience: can phenomenology help? Psychopathology. 2019;52(5):275-82. doi:10.1159/000504141.

55. Svenaeus F. Illness as unhomelike being-in-the-world: Heidegger and the phenomenology of medicine. Med Health Care Philos. 2011;14(3):333-43. doi:10.1007/s11019-010-9301-0.

56. Carvalho-Alves MO, Petrilli-Mazon VA, Zuccolo PF, Fatori D, Rocha FMM, Brunoni AR, et al. Trajectories of anxiety, depression, and posttraumatic stress among healthcare workers during the COVID-19 pandemic: one-year monthly follow-up. Braz J Psychiatry. 2025;47:e20243720. doi:10.47626/1516-4446-2024-3720.

57. Stauffer J. Ethical loneliness: the injustice of not being heard. New York: Columbia University Press; 2015. doi:10.7312/stau17150.

58. Ettema EJ, Derksen LD, van Leeuwen E. Existential loneliness and end-of-life care: a systematic review. Theor Med Bioeth. 2010;31(2):141-69. doi:10.1007/s11017-010-9141-1.

59. Lederman Z. The bioethics of loneliness. Bioethics. 2021;35(5):446-55. doi:10.1111/bioe.12870.

60. Han JD, Frush BW, Malone JR. Loneliness in medicine and relational ethics: a phenomenology of the physician-patient relationship. Clin Ethics. 2024;19(2):171-81. doi:10.1177/14777509241246161.

61. Broome MR, Rodrigues J, Ritunnano R, Humpston C. Psychiatry as a vocation: moral injury, COVID-19, and the phenomenology of clinical practice. Clin Ethics. 2024;19(2):157-70. doi:10.1177/14777509231208361.

62. Epstein EG, Hamric AB. Moral distress, moral residue, and the crescendo effect. J Clin Ethics. 2009;20(4):330-42. doi:10.1086/JCE200920406.

63. Litz BT, Stein N, Delaney E, Lebowitz L, Nash WP, Silva C, et al. Moral injury and moral repair in war veterans: a preliminary model and intervention strategy. Clin Psychol Rev. 2009;29(8):695-706. doi:10.1016/j.cpr.2009.07.003.

64. Coimbra BM, Zylberstajn C, van Zuiden M, Hoeboer CM, Mello AF, Mello MF, et al. Moral injury and mental health among health-care workers during the COVID-19 pandemic: meta-analysis. Eur J Psychotraumatol. 2023;15(1):2299659. doi:10.1080/20008066.2023.2299659.

65. Rushton CH, Thomas TA, Antonsdottir IM, Nelson KE, Boyce D, Vioral A, et al. Moral injury and moral resilience in health care workers during COVID-19 pandemic. J Palliat Med. 2022;25(5):712-9. doi:10.1089/jpm.2021.0076.

66. Williamson V, Murphy D, Phelps A, Forbes D, Greenberg N. Moral injury: the effect on mental health and implications for treatment. Lancet Psychiatry. 2021;8(6):453-5. doi:10.1016/S2215-0366(21)00113-9.

67. Rosa D, Bonetti L, Villa G, Allieri S, Baldrighi R, Elisei RF, et al. Moral distress of intensive care nurses: a phenomenological qualitative study two years after the first wave of the COVID-19 pandemic. Int J Environ Res Public Health. 2022;19(22):15057. doi:10.3390/ijerph192215057.

68. Ju TR, Mikrut EE, Spinelli A, Romain AM, Brondolo E, Sundaram V, et al. Factors associated with burnout among resident physicians responding to the COVID-19 pandemic: a 2-month longitudinal observation study. Int J Environ Res Public Health. 2022;19(15):9714. doi:10.3390/ijerph19159714.

69. Cox CL. 'Healthcare heroes': problems with media focus on heroism from healthcare workers during the COVID-19 pandemic. J Med Ethics. 2020;46(8):510-3. doi:10.1136/medethics-2020-106398.

70. Brencio F. Mind your words: language and war metaphors in the COVID-19 pandemic. Psicopatologia Fenomenológica Contemporânea. 2020;9(2):58-73. doi:10.37067/rpfc.v9i2.1083.

71. Kleinman A. The illness narratives: suffering, healing, and the human condition. New York: Basic Books; 1988.

72. Kleinman A. What really matters: living a moral life amidst uncertainty and danger. New York: Oxford University Press; 2006.

73. Monteverde S. Undergraduate healthcare ethics education, moral resilience, and the role of ethical theories. Nurs Ethics. 2014;21(4):385-401. doi:10.1177/0969733013505308.

74. Rushton CH. Moral resilience: transforming moral suffering in healthcare. 2nd ed. New York: Oxford University Press; 2024. doi:10.1093/oso/9780197667149.001.0001.

75. van Oorsouw R, Oerlemans A, Klooster E, van den Berg M, Kalf J, Vermeulen H, et al. A sense of being needed: a phenomenological analysis of hospital-based rehabilitation professionals' experiences during the COVID-19 pandemic. Phys Ther. 2022;102(6):pzac052. doi:10.1093/ptj/pzac052.

76. Keid FB. Bioética clínica como parte integrante de uma medicina dos valores e afetos. Revista Binacional Brasil-Argentina: Diálogo entre as ciências. 2021;10(2):40-52.

doi:10.22481/rbba.v10i02.9895.

77. Mantri S, Lawson JM, Wang Z, Koenig HG. Identifying moral injury in healthcare professionals: the Moral Injury Symptom Scale-HP. J Relig Health. 2020;59(5):2323-40. doi:10.1007/s10943-020-01065-w.

78. Tao H, Nieuwsma JA, Meador KG, Harris SL, Robinson PS. Validation of the Moral Injury Outcome Scale in acute care nurses. Front Psychiatry. 2023;14:1279255. doi:10.3389/fpsyt.2023.1279255.

Figures

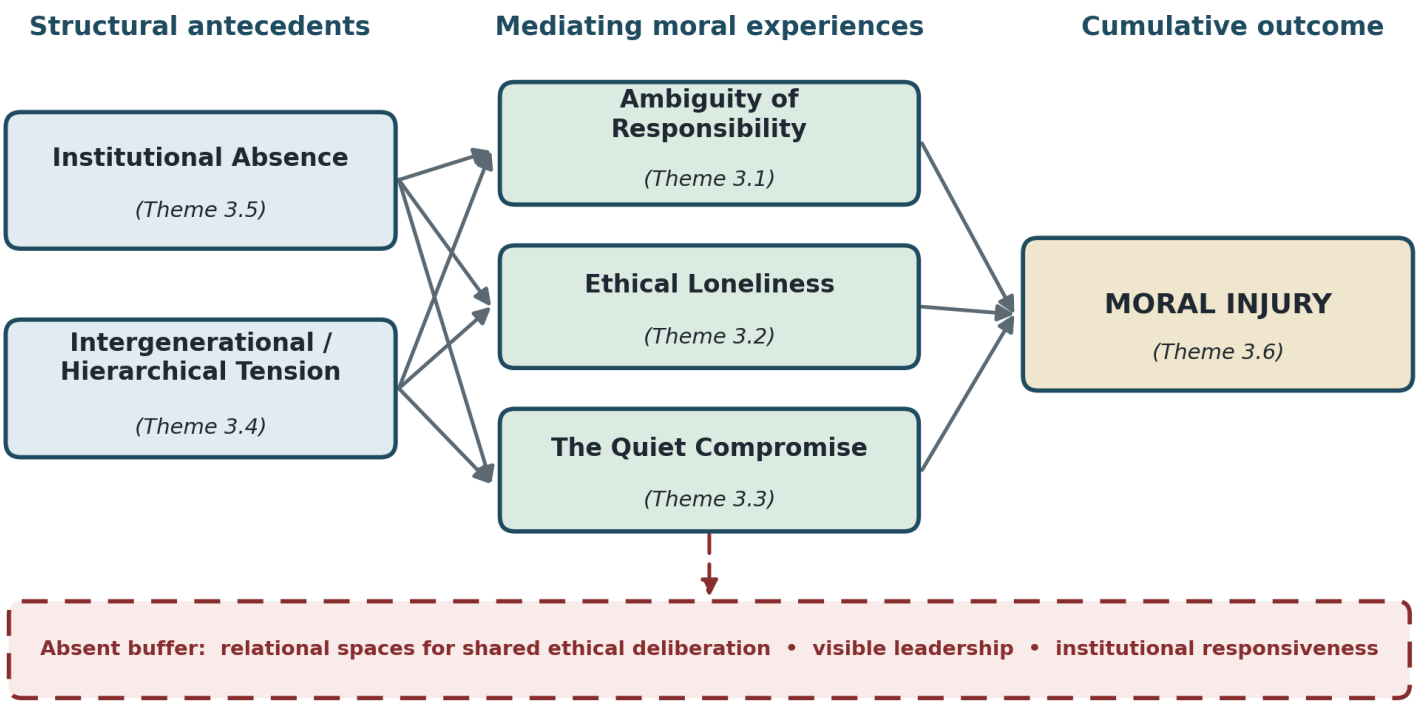


Figure 1

From institutional fragility to moral injury: a conceptual model.

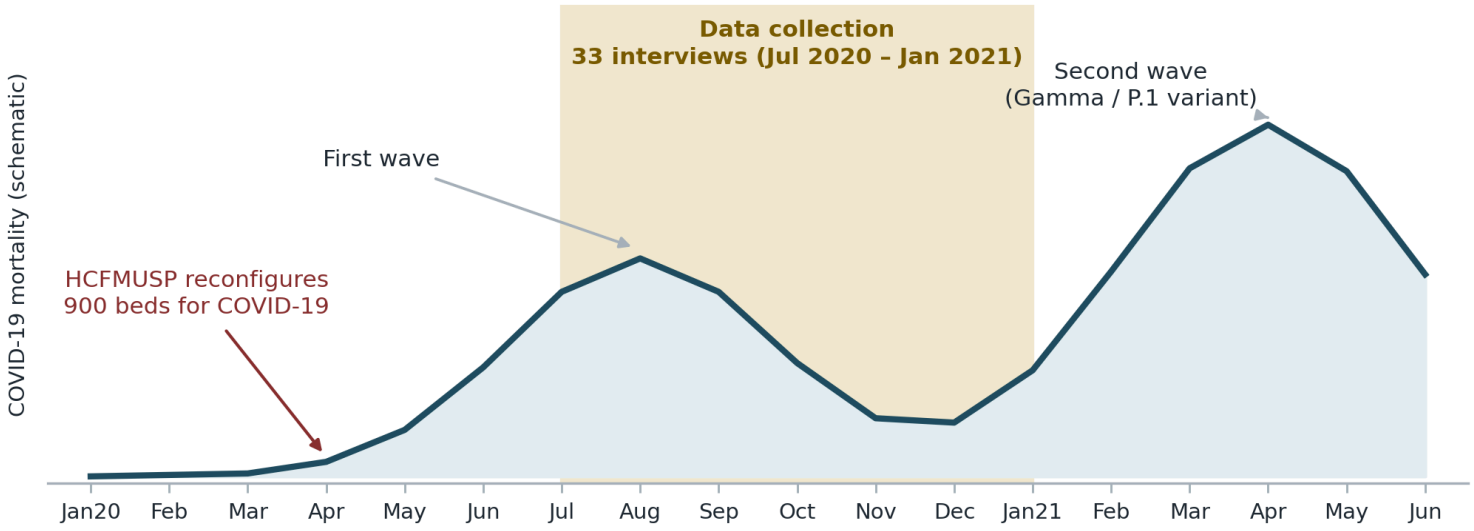


Figure 2

The data-collection window within the course of the COVID-19 pandemic in Brazil.

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