

Moral distress amongst palliative care doctors working during the COVID-19 pandemic: A narrative-focussed interview study

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Abstract

Background: Palliative care professionals have had to adapt to rapidly changing COVID-19 restrictions with personal protective equipment and physical distancing measures impacting face-to-face communication with patients and relatives.

Aim: To explore the narratives of palliative care doctors working during the pandemic to understand their experiences at a personal and professional level.

Design: In-depth narrative interviews were carried out via video call. Interviews were transcribed verbatim and analysed using a joint paradigmatic and narrative approach to elucidate common themes and closely explore individual narratives.

Setting/participants: Eight palliative care doctors who had worked on a hospice inpatient unit in the UK before and during the pandemic were recruited from two hospices in Scotland.

Results: Three intersecting themes are described, the most significant being moral distress. Participants articulated a struggle to reconcile their moral convictions with the restrictions enforced, for example, wanting to provide support to patients through physical proximity but being unable to. To differing degrees, this resulted in internal conflict and emotional distress. Two further themes arose: the first concerned a loss of humanity in interaction and a striving to re-humanise communication through alternative means; the second being a change in staff morale as the pandemic progressed.

Conclusions: Restrictions had a considerable impact on palliative care doctors' ability to communicate with and comfort patients which led to moral distress and contributed to decreasing morale. Future research could explore moral distress in palliative care settings internationally during the pandemic with a view to compare the factors affecting how moral distress was experienced.

Keywords

COVID-19, communication, hospice care, moral distress

What is already known about this topic?

- Palliative care was significantly disrupted by the COVID-19 pandemic.
- Restrictions affected communication between doctors and patients.

What this paper adds?

- Reduced ability to comfort patients caused moral distress amongst palliative care doctors.
- Doctors made efforts to re-humanise interactions.

Implications for practice, theory or policy

- Humanisation of communication between doctors and patients should be a priority during disruptions to care delivery.

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Introduction

The COVID-19 pandemic has led to major changes in the way healthcare professionals work and presented unique challenges for both patients and staff. Doctors have had to adapt to new Personal Protective Equipment (PPE) and physical distancing measures, and minimise face to face contact with patients and relatives. These restrictions have altered many tacit and often subconscious non-verbal behaviours such as smiling, communicative touch and physical proximity which are key to relationship formation between doctors and patients.¹ This is especially salient in palliative care where good communication is essential for adequate assessment of symptoms as well as managing expectations of patients and their families with communication that is open and compassionate.² The changes we have seen may be in place long-term and it is therefore important to understand the impact on doctors and to investigate the ways in which they are adapting and coping. Previous literature has explored the experiences of healthcare workers across a broad range of settings during the pandemic^{3,4} and the impact of mask wearing on communication.⁵ Studies in palliative care have shown an increase in anxiety and psychological distress amongst healthcare workers,⁶ and a struggle to communicate and connect effectively with patients due to work pressures and national restrictions.⁷ An emerging consideration in this context is moral distress,^{8,9} which occurs when a person is prevented from taking the action that they believe to be morally right,¹⁰ and has been shown to be prevalent amongst healthcare workers during the pandemic.⁴ This study aims to present the narratives of palliative care doctors practicing during the pandemic and facilitate understanding of their experiences.

Methods

Research question

How do palliative care doctors understand their experiences of working during the pandemic, at a personal and professional level.

Design

Qualitative narrative-focussed interviews provide a flexible framework to understand the subjective experiences of participants. Qualitative methods enable people to use their own terms to articulate responses and can elicit rich contextualised accounts of their experiences of a phenomena.¹¹ A constructivist epistemology that recognises the socially constructed nature of knowledge where individuals 'create, negotiate, and interpret meanings' within a particular context was used for this study.^{12,13} When 'normal' behaviours and interactions are disrupted, investigating narrative can allow us to contextualise and

construct meaning from lived experiences.¹⁴ Narrative can simply be defined as a description of a series of events. Personal narratives can help retrospectively make sense of our experiences by organising events temporally and understanding them in relation to their outcome in order to attribute meaning to them. This study aimed to elicit individual narratives to best understand the participants' experiences and provide rich data for analysis.

Setting

While all aspects of palliative care were impacted by the pandemic, our study focussed on the inpatient unit as this is where doctors had most frequent face to face encounters with patients and relatives and the research team felt this would be the most valuable setting to carry out the study. Participants were recruited from two hospices in central Scotland which provide specialist inpatient and community-based care to those with supportive and palliative care needs referred from both primary and secondary care settings and serve a defined geographical region (NHS Lothian – population 350,000).

Population, sample and recruitment

Eligible participants were doctors who had been working on the in-patient unit for at least 2 months before the pandemic began and had then worked on the in-patient unit during the months of March, April, May and June 2020 when Scotland became affected by the COVID-19 pandemic. A single disciplinary approach was taken due to the focussed nature of the study. Sampling was convenience-based due to the limited numbers of doctors working at the hospices. An email was sent by the research team to all the doctors working in the hospices with a description of the study and its aims with contact details for the researcher – EF a female medical student. Those that were interested in taking part contacted EF and were given information sheets and the opportunity to ask questions. EF did not know any of the participants prior to the study. Written consent was gained prior to the interview. EF received training in qualitative research methods and interviewing and was supported throughout by an experienced qualitative researcher AL.

Data collection

The primary outcome was to explore the experience of hospice-based doctors working during the COVID-19 pandemic in comparison to before. Qualitative research methods focus on meaning and understanding of phenomena rather than aiming to generalise findings.¹⁵ Semi-structured interviews were carried out between October 2020 and February 2021 by EF via video call with only the researcher and participant present. Interviews

are not simply a way to elicit answers from an interviewee but are interactive with knowledge constructed between and dependent on the social relationship between the participant and interviewer.¹⁶ Riessman¹⁷ considered the types of questions that are likely to elicit narratives and identified that open questions such as ‘tell me what happened’ and ‘can you give me an example?’ allow participants to best articulate a narrative. The interview guide (Supplemental Appendix 1) utilised these open questions whilst using probes to guide participants to consider issues pertinent to the research. Follow up questions were generally open, inviting the participant to expand on events as they came up. A participant information sheet outlined the researcher’s background and reasons for doing the study. Interviews were audio-recorded and transcribed verbatim for analysis. Names and places were assigned anonymous identifiers. A research diary was kept to record comments and observations from the interviews; this supported later reflection and analysis. Parallel data analysis was carried out to assess ongoing data saturation and inform future data collection and analysis.¹⁸ The sample size was determined according to qualitative research principles and the aim and scope of the project with recruitment continuing until no new themes were evident in the data.¹⁹ Fewer interviews can provide an opportunity for full exploration of topics with deeper analysis of the data set in comparison to larger samples.¹⁵ Repeat interviews were not carried out and transcripts were not returned to participants for comment.

Analysis

Interviews were initially analysed using a paradigmatic approach which aims to elucidate common themes which hold true across different settings, characters, and plots. Preliminary themes were coded by EF using the NVivo12 software,²⁰ and through repeated listening and reading of the transcripts and discussion with a senior researcher, emerging themes were refined. This approach facilitates broad knowledge of a collection of stories but diminishes the unique aspects of each narrative. Thus, to provide a more in-depth understanding of participant experiences, narrative analysis was then undertaken to explore individual narratives. Polkinghorne²¹ offers guidance around this process encouraging the researcher to consider the ending of the narrative which provides a lens through which further significant parts of the narrative can be identified and connections between events and happenings can be explored. The researcher can question which elements of the narrative are contributing to the outcome, serving to highlight important turning points. EF listened again to the recordings, this time considering the structure and shape of the narratives, how participants spoke about change and for any subplots. Three case stories were compiled to

illustrate the findings and accompanying narratives are presented alongside each case to compare experiences across interviews.

Ethical permissions

Ethical approval was granted by The University of Edinburgh. This study did not involve patients nor any modifications of clinical practice. If the interviewees became distressed they were able to take a break or terminate the interview at any point. They were also able to withdraw from the study at any point without giving a reason.

Results

Eight individuals were interviewed. These were five female and three male doctors who ranged in experience from speciality trainee to consultant. Calls lasted between 17 and 43 min (mean = 27 min). No participants dropped out of the study.

One dominant theme emerged across the interviews: moral distress. Two further distinct but intersecting themes arose: the first concerned a loss of humanity in interaction; the second being a change in staff morale and mental wellbeing.

Moral distress

During the pandemic, restrictions imposed by national government and local management forced doctors to act against their instincts: to reduce communicative touch, limit visiting and spend less time with patients. This experience of being unable to take the action that one believes to be morally right due to institutional constraints is known as ‘moral distress’.¹⁰ ML’s experience best exemplifies this phenomenon.

ML’s story. ML was working with a hospital palliative care team at the start of the pandemic before returning to the hospice. Throughout ML’s account, the effect of patient distress on her own experience became apparent. ML’s experience is inescapably linked with that of her patients.

‘I think one of the most distressing things of the pandemic for me certainly initially was the fact you knew that the patients had no visitors or very few visitors and they were lonely’.

A key source of distress and anxiety for patients, the visiting restrictions, was likewise distressing for ML.

‘They knew that it wasn’t our fault that we were restricting the visiting but nonetheless they were angry, they were upset. You feel a bit helpless really because you can’t make it better’.

In this instance, ML was forced to be the gatekeeper between her patients and their relatives, a role which was new and unsettling for her. She was unable to take the action she believed to be morally right which resulted in a feeling of helplessness.

'And I think you felt you had to give even. . . I guess try and give even more kind of comfort to the patient. But at the same time, you were trying to keep your visits quite short, you were very conscious that you were trying to sit much further away. . . almost feeling you were constantly kind of balancing the risks and the benefits in the individual situation'.

In saying 'you felt you had to'. ML is expressing guilt about the lack of visiting as well as an urge to compensate by providing comfort herself. ML uses the personal pronoun 'you' instead of 'I' which allows her to appeal to the experience of the collective and distance herself from the distressing recollection. Internal conflict is evident throughout ML's account.

'Normally if the patient would get upset you would, your instinct would be to hold their hand or touch them. And you suddenly were thinking oh I don't think I can do that or should I do that. . . It just I guess goes against everything that we normally do in palliative care'.

'I think on one occasion I felt I had to do something because it felt cruel not to do anything'.

Here ML's account is striking in the emotive use of the word 'cruel' to express her urge to comfort an upset patient. She also talks about how the restrictions go 'against everything that we normally do', suggesting a perceived existential threat to the values of palliative care.

'But yeah probably the situations where a patient would start crying and your instinct would be to. . . or at least move closer to them but in moving closer it almost feels as if you're increasing the risk'.

Mary goes to conclude her account but instead flows into the next thought without making sense of the narrative. Stories are expected to have a beginning, middle and end but with the pandemic ongoing at the time of the interview, this absence of resolution is reflected in ML's account.

Accompanying narratives. ML's experience of moral distress was echoed by many of the participants including EY, JR and WL. These accounts allude to a disruption to their role as palliative care doctors. They express not being able to support patients in the way they would normally and the difficulty this caused.

'it's just been more difficult in that it's part of our practice to want to sort of support people and communication is really really important' – EY

'many families are very understanding and accepting but for other families what they want is to see their loved one and so they will continually ask and push and you know try and get things relaxed for them. So having to police that, where normally our philosophy is to facilitate as much visiting [as possible]' – JR

'it's very unnatural to keep a distance from people that are dying in front of you in a hospice. . . it's against all your instincts' – WL

Moral distress can be experienced on a spectrum and two further accounts illustrate the varying effects. As a member of the management team, RW was involved in deciding how restrictions were adopted. It is interesting to note how RW detaches himself from the narrative by using the personal pronoun 'you'.

'I think staff found that hard and they were always trying to say well could you make an exception to this case. . . and the answer was no we couldn't' – RW

'So you think you're not doing the right job or as good a job as you can do if you're not letting patients and family get close to each other'. – RW

It is clear that RW feels that the 'right job' would be allowing visiting and while this does resonate with other narratives, he maintains a degree of objectivity. The influence of EF's position as a young medical student should also be considered here as interviews with more senior clinicians tended to be more formal, possibly due to a difference in age and status. This could further explain RW's use of objective language. In contrast to RW, FJ tended to bend the rules to lessen the impact.

'I kind of decided fairly early on that for a lot of patients it was actually important to see my mouth, so not infrequently now, when I go into the room, I will sit a bit further back, 2 metres back, and take my mask off' – FJ

'There's a lot of touching and I think for all of us it's hard not to do that, when someone's dying, to give them that soothing touch, and again, I sometimes just do' – FJ

RW and FJ do not express as much emotion in response to the moral distress as some of the other participants; for RW, this was likely due to his role in decision-making while for FJ this was due to her willingness to bend the rules.

De-humanising and humanising care

At its heart, palliative care is about the relief of suffering; interacting and forming a connection with patients and their relatives is integral to providing the best care. Participants reflected on the difficulty communicating within the constraints of PPE and physical distancing; this not only represented a challenge in doing their job but at

a more fundamental level it signified a loss of humanity in their interactions, as highlighted in SF's story.

SF's story. SF is a palliative care doctor and researcher who was transferred to full-time inpatient work at the start of the pandemic. She starts by talking about her personal reaction to PPE changes. The initial shock of adapting to the situation is evident.

'I remember having a meeting on the first day that we were to wear masks on the ward and to everybody at the time it was like what! Why are we doing this, it seems ridiculous. . . there was a period where we were wearing the masks and visors on top of the masks. It was very space-age!'

SF's reference to 'space-age' suggests the PPE requirements were almost incomprehensibly unusual and distinctly detached from her experience in palliative care thus far. Having to cover her mouth had a significant impact on SF's ability to use non-verbal communication to connect with patients.

'It changes it a lot because a lot of the communication when you're doing clerk-ins and that kinda stuff is non-verbal communication. You know, you smile at people, you use your face to communicate with people and I think a lot of the time with masks that communication sort of isn't there'

'an important thing is people seeing what you look like. I know that sounds really silly but, you know, that human element really was sort of taken away'.

The PPE also prevented patients and relatives from seeing what SF looked like which, as she alludes to, is an infringement on our instinctive human desire to connect with others. SF wanted people to see that she was trying to connect with them and showed a desire to be perceived as an individual.

'I think it's difficult to form a first impression of somebody when you walk in with all that stuff on so people couldn't really see your face, see that you were trying to communicate with them'.

She demonstrated a positive attitude in adapting to the restrictions, emphasising other non-verbal signals and using humour to humanise the interaction.

'Trying to use other bits of your face to express. . . like eyes, that kind of stuff, trying to emphasise to people that you are. . . there was some expression there'.

'I always just tried to make a joke about it. I said I'm sure this is not how you're usually used to seeing doctors'

The restrictions necessitated more active effort to maintain an individual connection and build a rapport with

the patients. Physical distancing was also a significant change for SF.

'The first thing of really any palliative care doctor or palliative care nurse is to sort of go to the patient a lot of the time. And I suffer from it badly in that I go, I always go and put my hand on somebody's hand . . . so that was an adaption'

In saying 'I suffer from it badly', SF is recognising that connecting through communicative touch is a vital part of her identity as a palliative care doctor with the verb 'suffer' acknowledging the negative connotations now associated with physical proximity.

'I think actually people have got very used to wearing masks it's sort of normal now whereas at the start it felt very very strange wearing them round the wards. So, I think yeah it's become more normal and social distancing has become more normal as well'.

SF concludes by circling back and describing how normalised mask wearing has become. SF's experience demonstrates a subtle dehumanisation of interaction and a striving to maintain humanity through alternative means of communication.

Accompanying narratives. Several participants echoed SF's sentiments on physical distancing and PPE being a barrier to connecting on a human level. WL, AV and FJ touch on the loss of individuality and a formalisation of interaction which detracts from the human element of care.

'it suddenly felt very formalised, you know, having to stand 2 metres away, I think that was the most tricky part of it, at the beginning' – WL

'It just made it less personal. . . less personal and I guess less effective because you're unable to be physically close to people' – AV

'sometimes they just need that bit of human touch' – FJ

'it's that much harder when you can't see someone's, the whole of someone's face, to really have this. . . to connect' – JR

JR expresses a similar notion that in seeing someone's face you are able to connect, suggesting that when faces are visible there is a deeper level of understanding between doctor and patient and a humanity to the interaction.

'where before there was that real life to the hospice with relatives free to come and go, we had shared spaces, the day room, where relatives, patients, could sit, could share time together, so just I think atomized, you know it really felt like everyone was atomized' – JR

The feeling of being 'atomised' implicitly identifies togetherness as central to the human experience. Likewise, individuality can be seen as a representation of humanity which ML alludes to when she talks about wearing scrubs. ML describes an increasing homogeneity perceived by the patient.

'I remember one patient saying 'you all look the same'. Now I'm not sure that's totally true but I think for patients they were just seeing a series of people, particularly once we started wearing scrubs as well, just scrubs and a mask'. – ML

RW talks about adapting to the changes by using alternative communication strategies.

'I remember somebody talking about 'smeyesing', cause it's like smiling with your eyes. And hopefully, people see that a little bit' – RW

Though perhaps unconsciously, many participants described elements of humanity in healthcare that had been taken away as well as their adaptations to overcome this and maintain a connection with patients.

Morale and mental wellbeing

The effect of moral distress in addition to the wider consequences of working during the pandemic had varying effects on participants, with some able to cope while others struggled. WL experienced both coping and struggling during the pandemic.

WL's story. WL is a palliative care doctor who spent the first part of the pandemic working in a hospice before moving to a hospital palliative care team. WL's account suggests that at the start of the pandemic, the changes were manageable owing to a solidarity amongst staff.

'I think that at the beginning, the sense of camaraderie was quite strong, I think that helped people get through it because we were all vulnerable to it, we were all in the same situation'

His use of the word 'vulnerable' alludes to a level of instability triggered by the pandemic which exposed people to a greater risk of harm. WL is very open about the impact on staff morale throughout his account.

'There were changes that sort of impacted on staff wellbeing after a time. . . things that you probably at first couldn't realise that were affecting you'

A major cause of declining morale was continuing moral distress.

'it's very unnatural to keep a distance from people that are dying in front of you in a hospice, it's against all your

instincts. . . having to maintain a 2 metre distance from patients that were distressed. . . not being able to sit and, I know it's a cliché, but hold their hand, you know, have that, that sort of physical contact was very challenging for staff'.

WL's impassioned description of the distancing going 'against all your instincts' gets to the core of the internal conflict that arises when healthcare professionals are unable to take the morally right action. As time went on and the second surge of COVID-19 cases hit, WL found it harder to cope.

'The second time round, this time feels harder, and I think it's because everyone's more worn down, you know, publicly and professionally with the restrictions'.

'it's a bit of a scenario where you got through the first wave on, on your adrenaline almost, or you know sort of heightened level of tension, and then we all relaxed a little bit, and it was hard to put the foot on the gas again'

The second wave is a turning point in WL's narrative, representing a shift from coping to struggling. He goes on to resolve the account by explaining how he dealt with these challenges and providing a positive outlook as he seeks a source of hope from his experience.

'I've taken the opportunity to try and, um, get some more clinical supervision, which is the sort of psychological support which isn't routinely offered to medical staff'

'the sort of culture that has come from it in terms of people being able to talk about their mental health and their resilience and things like that, their wellness being more of a focus. . . is a positive thing'

WL's sincere account of coping and fatigue outlines the impact of the pandemic on staff wellbeing.

Accompanying narratives. Numerous participants referenced the feeling of camaraderie and cited this as a motivating influence in the first wave.

'I enjoyed the camaraderie' – FJ

'we were all in it together so there was that sense of camaraderie initially' – ML

'everybody was around, we were all kind of in it together a bit initially' – RW

As the pandemic progressed, participants differed in their responses and ability to cope. For some, like WL, the camaraderie was outweighed by a feeling of fatigue.

'I'm just tired to be honest. . . and I think everyone is. I think somebody spoke to me recently about this sort of 6-month wall in any sort of difficult situation and I think we've sort of hit that recently' – RW

'with the second wave wherever you've been working that sense of teamwork and camaraderie, it's not that it's not there I think it's just everyone's having to work a lot harder to try and maintain it'. – ML

For others their narratives illustrated a more stable endpoint to the continuing challenges.

'we're all just resigned to this is the way it's gonna be for the foreseeable future. . . and making the best of it really'. – EY

'that was what kept me going during lockdown was the times where we would sort of collect, re-group and just go for a cup of tea downstairs and speak to each other. That's. . . that was the thing that kept us all sane'. – SF

One participant expressed positive sentiments about how she had coped during the pandemic.

'I feel very lucky, just where I am in my life at the minute. Lockdown, the restrictions, they've had some impact. . . but life in some ways doesn't feel very much different. . . it hasn't had the impact on me personally that is has on a lot of people' – JR

'home schooling was a nice opportunity for us. And yeah I guess the challenges at work have been interesting' – JR

JR's account is a noticeable contrast to WL's and while she did describe moral distress to an extent, as discussed earlier, her self-reflection maintains a strong impression of coping. Through these narratives, we can perceive an initial collective experience of camaraderie before individual differences in adapting and coping became apparent.

Discussion

Moral distress

Palliative care doctors faced unique and complex challenges throughout the pandemic, both professionally and personally. Throughout the interviews, the notion of moral distress was pervasive. Jameton¹⁰ first described moral distress as being unable to take the action that one believes to be morally right due to institutional constraints. It has historically been considered within the context of nursing but is increasingly recognised as a widespread phenomenon affecting healthcare professionals, social workers and administrative staff worldwide.^{22–24} During the COVID-19 pandemic, existing challenges were magnified while new constraints were imposed leading to increased levels of moral distress.^{4,8,25} This study found that the limited visitation policy, PPE and physical distancing restrictions had a large impact on staff. Facial recognition and lip-reading are important for interpersonal reassurance in distressed patients and the presence of family and friends is well-known to benefit patients with delirium and dementia.²⁶

Restrictions therefore increased patient distress, which in turn led to moral distress in palliative care doctors as they felt they were not always doing the right thing. The moral distress doctors described had varying effects but at its worst, caused feelings of guilt and ineffectiveness, which supports previous research into the effects of moral distress.^{8,22} Experiencing moral distress can lead to what is termed moral residue, the lingering emotional wound that can result,^{27,28} or moral injury which has been defined as the profound psychological distress that follows when a person's moral or ethical code is violated by actions, or lack of actions, taken.²⁹ The potential for moral injury is evident in the doctors' accounts and may have profound consequences on their professional and personal well-being. Furthermore, the ongoing nature of the pandemic involved repeated waves of infections and associated tightening and easing of various societal restrictions as well as related fears and vigilance necessary in clinical settings. Accordingly, ongoing moral distress risks moral residue building up in a crescendo-like manner ever depleting the capacity to cope and adjust, deepening emotional wounds and increasing the risk of professional burnout.³⁰

De-humanising and humanising care

A subtle loss of humanity in interactions contributed to the experience of moral distress. A number of participants referenced the loss of something 'human' but struggled to explain what exactly 'human-ness' is. Todres et al.³¹ proposed eight core dimensions of humanisation in healthcare, two of which are pertinent here: uniqueness and togetherness. Each of these values can be imagined on a continuum, for example, from homogeneity to uniqueness. The loss of tacit non-verbal cues like smiling and hand-holding could be viewed as a shift from togetherness to isolation. This is supported by Williams and Irurita³² who identified that patients felt devalued by behaviours such as standing at the end of the bed and lack of touch. Similarly, wearing scrubs and facemasks contributes to homogeneity providing less scope for individuality in interactions and thus humanisation. Mitchinson et al.⁷ described similar notions of reduced human connection arising in their interviews with palliative care doctors during the pandemic. Adjustments to compensate such as making jokes and emphasising expression are key to re-humanising interactions and maintaining a personal connection with patients.^{5,7}

Morale and mental wellbeing

Morale shifted for these doctors throughout the pandemic due to continuing moral distress, difficulty communicating with patients and numerous other personal and professional challenges. There were generally positive feelings of camaraderie at the beginning of the pandemic

that mitigated the negative outcomes in the face of increasing vulnerability to stresses. However, as time went on, the effects of the continuing challenges were evident. There was a large spectrum of coping, with some participants remaining relatively unaffected while others were undoubtedly struggling. Previous studies have noted decreasing morale, adverse mental health consequences, and individual differences in coping in healthcare staff globally during the pandemic,^{3,33,34} indicating these findings are not unique to palliative care in Scotland. Vulnerability is an important point here and is considered part of the human condition, yet as Kottow³⁵ argues may be better replaced with the term susceptibility. Doing so deflects the onus away from the individual towards the conditions that societal structures engender, in this situation the working environment and culture within medicine. Thus, capacity for ongoing coping can be tackled at institutional as well as personal levels.

Going forward

Measures to mitigate moral distress should be implemented at a personal and institutional level. Our findings suggest that doctors should be supported to connect with patients at a human level with adaptations involving safely showing their face prior to donning PPE, smiling with their eyes and using hand gestures. Marler and Ditton⁵ propose further adaptations including communicating non-verbal information verbally (e.g. saying 'I'm smiling back at you'), clearly introducing yourself, and minimising distractions. At an institutional level, measures such as transparent facemasks, continued clear communication between staff and providing information on where to seek support should be encouraged. The very real potential for moral residue and injury should also be considered with the need to support doctors both professionally and personally in the aftermath of these exceptional circumstances.

Strengths and limitations

This research provides a novel exploration of moral distress amongst palliative care doctors during the pandemic. Due to the small sample size and limited number of hospices involved, there is reduced applicability to other contexts. Only doctors working in Scotland were included in the study meaning the wider understanding of moral distress across different settings and cultures could not be explored. It is worth noting, however that the small sample size allowed for more in-depth analysis and, due to the focussed topic, a degree of saturation arose. As discussed throughout, the co-creation of narrative is unavoidable and participant responses and data analysis were likely influenced by EF's position as a young female medical student.¹⁶ In particular, as someone who has had to

adapt to some of the same changes (e.g. having to communicate with patients in a mask), EF likely had preconceived views about how this would impact care.

Conclusions

This study explored the experiences of palliative care doctors working amid restrictions during the COVID-19 pandemic in Scotland and adds to the growing body of literature surrounding healthcare workers' experiences of the pandemic. Future research could explore moral distress in palliative care settings internationally with a view to compare the factors affecting how moral distress was experienced by healthcare professionals during the pandemic and stimulate thinking on how best to address it.

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Author contributions

EF carried out the primary research under the guidance and supervision of AL. The initial manuscript was written by EF with AL reading and contributing to refinements. Preparation of the manuscript for submission was carried out by EF.

Data management and sharing

Data are available upon reasonable request.

Declaration of conflicting interests

The author(s) declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: This project was a collaboration between The University of Edinburgh and a local hospice. Authors have full control of all primary data and are agreeable for this to be reviewed by the journal if requested.

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Research ethics and patient consent

Approval was gained from The University of Edinburgh to carry out this study. Informed written consent was taken from all participants prior to interview. This study did not involve patients nor any modifications of clinical practice.

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Supplemental material

Supplemental material for this article is available online.

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