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Moral Distress and Moral Injury in Nephrology During the COVID-19 Pandemic

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Summary: Across the world, challenges for clinicians providing health care during the coronavirus disease 2019 (COVID-19) pandemic are highly prevalent and have been widely reported. Perspectives of provider groups have conveyed wide-ranging experiences of adversity, distress, and resilience. In understanding and responding to the emotional and psychological implications of the pandemic for renal clinicians, it is vital to recognize that many experiences also have been ethically challenging. The COVID-19 pandemic has prompted rapid and extensive transformation of health care systems and widely impacted care provision, heightening the risk of barriers to fulfillment of ethical duties. Given this, it is likely that some clinicians also have experienced moral distress, which can occur if an individual is unable to act in accordance with their moral judgment owing to external barriers. This review presents a global perspective of potential experiences of moral distress in kidney care during the COVID-19 pandemic. Using nephrology cases, we discuss why moral distress may be experienced by health professionals when withholding or withdrawing potentially beneficial treatments owing to resource constraints, when providing care that is inconsistent with local prepandemic best practice standards, and when managing dual professional and personal roles with conflicting responsibilities. We argue that in addition to responsive and appropriate health system supports, resources, and education, it is imperative for health care providers to recognize and prevent moral distress to foster the psychological well-being and moral resilience of clinicians during extended periods of crisis within health systems.

Keywords: Moral distress, moral injury, COVID-19, nephrology, ethics

As the coronavirus disease 2019 (COVID-19) pandemic unfolds, a rapid transformation of health care provision has occurred across the globe. For people working in health care, this has meant dramatic changes in daily care provision; working in environments with heightened infection risks, surging demands, and resource and workflow pressures.[1,2] Non–COVID-19 care provision also has changed, including routine treatments of noncommunicable[3] and chronic diseases,[4] suspended elective surgeries,[5,6] and physically distant care to minimize virus transmission with widespread implementation of telehealth.[7,8] Health care providers have been essential in instituting these changes, and have reported a range of experiences: for some, there has been a heightened sense of autonomy, competence, and altruism,[9,10] while others have experienced the seemingly opposite consequences of anxiety, fear, grief, and physical and emotional exhaustion.[11,12]

During a period of crisis, it is essential to acknowledge how changes in health care delivery have affected health care professionals. As the severe acute respiratory syndrome coronavirus 2 (SARs-CoV-2) virus infection has surged and receded in several countries, supplies of medical resources have remained precarious, and health priorities, policies, and procedures have changed rapidly. In addition to dealing with these challenges, clinicians may have struggled to balance obligations to patients, their families, and themselves.[12] This shifting, stressful, and uncertain environment could lead to situations in which ethical values or duties are perceived to be compromised. Clinicians may experience circumstances in which they are unable to act in accordance with their deeply held ethical beliefs owing to external factors, such as unfamiliar resource constraints, new health

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policies, or guidelines that mandate novel models of care. Clinicians may recognize a conflict in their ethical obligations, however, because of these external pressures, feel unable to act according to ethical standards and thus unable to preserve their professional integrity.[13] This experience is known as moral distress, in which individuals perceive they must compromise their ethical values and feel powerless to change their circumstances.[14] If constant and repeatedly experienced, this can result in "moral injury,"[15] exacerbating emotional distress, burnout, and disillusionment[16] with significant functional, social, and psychological consequences leading some professionals to leave the workforce entirely.[17]

In this review, we explore potential sources of moral distress for clinicians providing nephrology care in the context of the COVID-19 pandemic and consider potential responses for individuals and services seeking to reduce such distress. We present four international clinical cases that may precipitate moral distress in the setting of nephrology; allocating life-saving treatments in the setting of rationing, providing care that is inconsistent with local prepandemic best practice standards, compromised values in end-of-life care, and managing dual professional and personal roles with conflicting responsibilities. These clinical cases aim to highlight situations that may precipitate moral distress in health care workers. In conclusion, we provide recommendations and strategies that may help to minimize moral distress and prevent moral injury.

MORAL DILEMMAS, MORAL DISTRESS, MORAL INJURY, AND MORAL RESILIENCE IN HEALTH CARE

Ethical issues of varying complexity and severity are encountered commonly in nephrology, and sometimes may constitute a moral or ethical dilemma, meaning a situation in which individuals must choose between irresolvably conflicting ethical principles or values.[18,19] Complex ethical decision making may be difficult and emotionally distressing, particularly when there are few or no options for action that are expected to achieve the goals of decision makers. Many ethical decisions in health care may necessitate a degree of compromise, with the ethically best choice resulting in some consequences that may be ethically undesirable. In other cases, there may be unavoidable uncertainty regarding the ethically best course of action. Nevertheless, clinicians may recognize that they have made the best decision possible in the circumstances,[19] experiencing regret that those circumstances were not ideal rather than regret or distress that they were compelled to act unethically.

Moral distress, on the other hand, may be experienced when an individual is unable to act in accordance with what they believe is ethically best or right (Table 1). For example, a nephrologist, trainee, or dialysis nurse may judge that the ethically best course of action is to provide end-of-life care to a patient whose death is imminent, however, because of external pressures such as the expectations of senior clinicians, colleagues, or the wishes of the patient or relatives, they may be compelled to continue dialysis in a futile attempt to extend the patient's life. The internal conflict experienced when acting in opposition to ethical values or perceived ethical duties, and resulting feelings of frustration, anger, or remorse, are known as moral distress.[20]

If severe or repeatedly experienced, moral distress can have significant and lasting consequences for individuals, including moral injury (Fig. 1). Moral injury originally was described in the context of military personnel who were exposed to traumatic events that violated moral values and caused severe psychological distress and functional impairment.[21,22] Although the literature does not provide a consensus definition, moral injury is described most broadly as the social, psychological, and spiritual suffering that occurs when moral values are transgressed, characterized by guilt, shame, and existential distress that negatively impacts the ability of an individual to function effectively.[23] Factors increasing the risk of moral injury for health care providers and emergency first responders include unsupportive leadership, lack of preparation for the emotional consequences of decisions, having limited social supports, and a culture of silence.[15,20]

Counterbalancing moral distress and moral injury is moral resilience, defined as the capacity to sustain or restore ethical integrity in response to moral complexity or distress (Fig. 1).[13] In more practical terms, moral resilience is the capacity of an individual to navigate moral adversity without abandoning their core values, sense of integrity, and professional obligations.[24] Individual factors associated with moral resilience in clinicians include having a clear sense of meaning (knowing who you are and what you stand for), being able to articulate boundaries of ethical integrity including when to exercise conscientious objections, capacity for flexibility and responsiveness in complex ethical situations, and the ability to seek meaning in the midst of situations that threaten ethical integrity.[13,25]

IMPACT OF THE COVID-19 PANDEMIC ON KIDNEY CARE AND EXPERIENCES OF MORAL DISTRESS

Increasingly, moral distress and moral injury among clinicians have been reported in the context of the COVID-19 pandemic, with some studies finding a prevalence of moral injury of up to 41% in certain health systems.[26,27] Clinicians have reported moral distress occurring as a result of the scarcity of health care resources such as ventilators, which has led to rationing,[28,29] and when the quality of patient care has been

Table 1. Comparisons Between Terms: Moral Dilemma, Moral Distress, and Moral Injury

	Definition	Example	Issues
Moral dilemma	A situation in which a choice between options is required, with each choice entailing violation of an ethical duty or principle	There are two patients who are both critically unwell and need urgent dialysis and only one available machine. Clinicians must choose who should receive dialysis	The nephrologist must make a choice and all options involve one person having to wait to receive dialysis with risks of imminent deterioration and death
Moral distress	The experience and distress when an individual is unable to act according to ethical values or perceived ethical duties owing to external factors	A patient has a cardiac arrest on dialysis, the nurses know the patient would not want resuscitation, however, because there are no written orders signed, they are required to perform it	The nurses perform resuscitation because of hospital policy, however, they perceive they have violated their ethical values of nonmaleficence and in that moment felt powerless to act in accordance with the patient's wishes
Moral injury	The psychological, social, and spiritual trauma that results from exposure to or acts that transgress ethical values	In a country with significant resource constraints, people with kidney failure who cannot afford to pay for dialysis are not provided it. Staff therefore must repeatedly care for patients who die as a result of insufficient health care resources	Access to dialysis is repeatedly withheld from people owing to resource and financial constraints Nephrologists must follow the hospital resource allocation guidelines and repeatedly deny dialysis for patients who otherwise would benefit They may experience anger, guilt, disillusionment, and question their role because they are unable to provide care that is consistent with ethical values

compromised owing to limited availability of staff, personal protective equipment (PPE), and other resources.[30-32]

The pandemic has impacted acute health care services generally and, in nephrology, the management of chronic kidney replacement therapies in particular. In countries such as India, routine dialysis treatments have been interrupted owing to impaired capacity, disruption of logistics, and supply of staff and equipment resulting from nationwide lockdowns and a lack of transportation.[33] Kidney donation and transplantation activities also have been reduced dramatically in many countries, with suspension of programs aimed at preserving capacity within health services for patients with COVID-19 infections.[34] People living with kidney failure also have a higher mortality risk resulting from COVID-19 infection, increasing concerns about the well-being of kidney patients and efforts to protect them from infection while safely

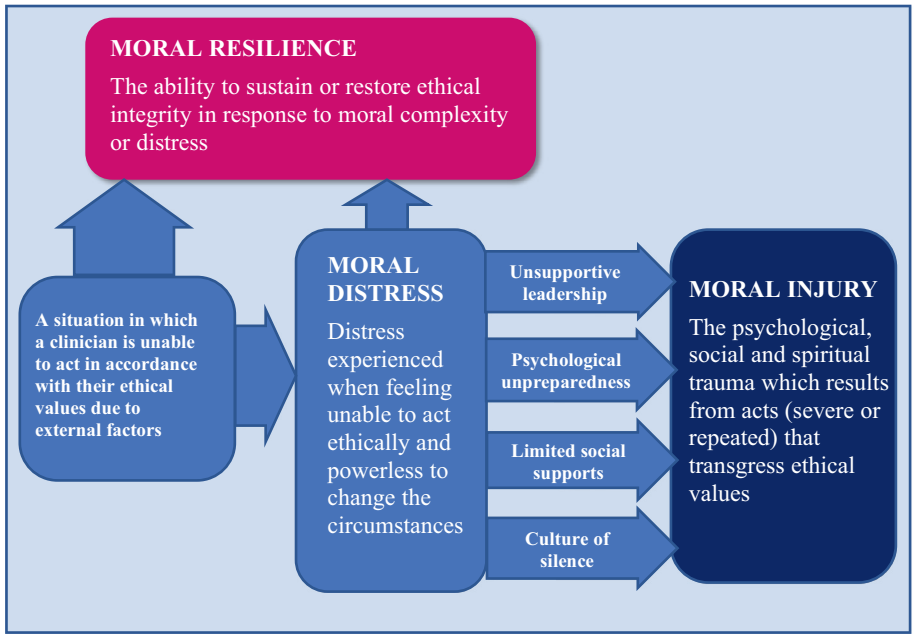

Figure 1. Conceptual relationships between moral distress, moral injury, and moral resilience.

Table 2. Sources of Moral Distress During a Pandemic

Sources	Examples
Situations in which health care systems are overwhelmed with allocation of limited resources	Experiences of insufficient resources to provide necessary care and fulfill the ethical duty of beneficence If allocation guidelines are perceived to be unjust
Rapidly changing policies and practice of clinical care	Impaired communication and care owing to physical distancing in clinical practice. Limited training and clinical skills in providing care in new clinical environments
Fear for personal safety	Risk of virus transmission without adequate personal protective equipment and infection prevention health care systems. Increased risk of violence toward health care workers compromising patient care and decision making

delivering care.[35] The COVID-19 pandemic thus extensively has changed, challenged, and, at times, compromised the way nephrology care is provided. Given this context, it is possible that the pandemic has precipitated situations that could cause moral distress for clinicians (Table 2). In the following sections we explore four examples of the types of ethical challenges that clinicians have faced, and discuss why these circumstances may result in moral distress.

Moral Distress Resulting From the Inability to Provide Necessary Care as a Result of Increased Constraints on Limited Resources

Case 1

A hospital was overwhelmed and had one remaining ventilator in the intensive care unit. However, two patients with COVID had urgent requirements for ventilatory support. One patient was a 25-year-old man who was unemployed and self-funded with dialysis-dependent kidney failure. The man had been unable to attend his usual dialysis unit because this dialysis center did not have the capacity to dialyze SARS-CoV-2−positive patients. He had remained at home until he was critically unwell to conceal his SARS-CoV-2−positive status. If revealed, he would have had to vacate his house because the neighbors would have objected to his infection status. The other patient was a 60-year-old woman with hypertension as her only comorbidity. Her family had been verbally aggressive and threatening to hospital staff and sought a guarantee from the doctors that the woman would recover from her illness. The nephrologist was informed by the hospital resource allocation team that the dialysis patient had too great a burden of comorbidity to warrant ventilation, in addition to potential issues of funding for his care after being abandoned by his family. The outcome was that the woman was ventilated and the man died. The nephrologist reported feeling moral distress given the restrictions imposed and her inability to secure treatment for her patient. She described her distress as follows, "...every day young people are dying, people who would have been treated are now dying because there are not enough resources. I try to support my colleagues who sit and cry at the end of the day."

In locations where COVID-19 care needs have outstripped the health systems' capacity, health professionals have been required to consistently and repeatedly ration resources.[29] If critical and life-sustaining resources are overwhelmed in a pandemic surge, such crises will impact life-and-death decision making and, for example, may necessitate the selective withdrawal or withholding of beneficial interventions from patients to whom it normally would be offered.[36] Various critical care guidelines have been proposed to promote health equity based on factors such as patient preferences, and maximization of benefits based on chance of survival.[29,37,38] Advanced chronic kidney disease is a life-limiting illness and therefore could be an exclusion criterion for intensive care admission in situations of overwhelming pandemic surge.[39,40]

As illustrated in case 1, the presence of end-stage kidney failure may determine who receives life-supporting treatment. Being unable to provide beneficial and necessary treatment to a person because of a lack of available resources can result in moral distress if clinicians believe they were unable to fulfill their ethical duty of beneficence. Moral distress may be greater if a situation occurs in which critical resources must be rationed and decisions are perceived to be unjust, for example, if they are influenced inappropriately by socioeconomic rather than clinical considerations. In these circumstances, the clinician tasked with implementing rationing policies also may believe that they are violating their fundamental duty of respect for justice.

In the case described earlier, it is not clear that the decision to prioritize care for the older woman was unjust; it may not have been possible to save the life of the younger man if dialysis also was not available. However, the case highlights the way that the most vulnerable patients often are doubly disadvantaged when resources are allocated to maximize utility, as measured by expected patient survival. Those who are sickest,

poorest, and those who lack social supports, are most likely to have reduced chances of survival even if they are allocated treatment, in comparison with healthier and wealthier patients. Allocation frameworks thus tend to work to the advantage of those who already are better off; a phenomenon known as *double jeopardy*.[41,42] This may conflict with the moral instincts of health professionals who, in the absence of resource constraints, usually prioritize care for those who are most in need, and who are trained to recognize and address vulnerabilities. In prioritizing treatment for the woman in the earlier-described case, clinicians thus may experience moral distress even if in theory they support the impartial allocation of resources to maximize patient survival.

In addition to life-and-death rationing decisions, clinicians also may experience moral distress when resource limitations impact the work environment and quality of patient care. This may place pressure on clinicians to act in ways that could risk violation of ethical duties such as the obligation to allocate resources fairly according to clinical criteria, resulting in moral distress. Under significant pressure for resources, and increased workload, existing stressors and safety concerns for health care workers have escalated. Case 1 highlights the way that limited resources may increase threats to clinician safety. In India, for example, the incidence of physical and verbal violence against doctors and health care workers reportedly has increased during the pandemic.[43]

Compromised Quality of Nephrology Care Compared With Prepandemic Standards

Case 2

An 82-year-old socially isolated woman was referred by her general practitioner to a renal clinic for management of her long-standing hypertension and chronic kidney disease. Her first review was by telephone because she did not have a computer or access to a digital platform that could have facilitated a video consultation. The patient had a blood pressure cuff at home and during the consultation measured her blood pressure, which was 200/100. The nephrologist was uncertain of the accuracy of this blood pressure and was acutely aware of the limited rapport established on this initial telephone review. He also was concerned that this degree of hypertension risked stroke and permanent end-organ damage and required emergency review and management. The patient, however, said she felt well, was concerned about the risk of COVID-19 infection at the hospital, and would not call an ambulance or attend her local hospital or renal clinic for review. The nephrologist described moral distress because he was unable to effectively communicate given the constraints and limitations of the telephone consultation and was unable to fulfill his perceived duty of care in terms of adequate assessment and management of her hypertension.

This case highlights the potential for moral distress when clinicians feel unable to provide adequate care as a result of communication barriers resulting from physical distance. Even in regions where the COVID-19 case load has been small, communication and treatment decision making with patients, their families, and health professionals have been changed profoundly by the pandemic. Infection control measures including reduced face-to-face contact have exacerbated difficulties that clinicians may experience in communicating effectively with patients and their families about serious illness, risking demoralization for clinicians and poorer patient and family outcomes.[44] Across the world, compromised communication resulting from COVID-19 is more likely to affect the vulnerable and marginalized: the poor, elderly, and culturally and linguistically diverse communities. For kidney care professionals, physically distant care may cause moral distress for those who are unable to act as they have been trained to do, and thus are unable to achieve their goal of optimal and holistic care for patients.

In addition to rapid acquisition of skills to effectively communicate and provide care via telehealth, some clinicians have been redeployed in settings outside their usual area of practice and expertise.[45] In nephrology, a greater demand for kidney replacement therapy in response to the increased incidence of acute kidney injury associated with COVID-19 infections has necessitated acute peritoneal dialysis in intensive care unit settings, where few nurses may have experience or prior training in peritoneal dialysis.[46] In areas where expert staff are scarce, and treatments are perceived to be new or adapted to meet urgent clinical need owing to resource constraints, health care professionals may believe their ability to provide appropriate care is compromised. Therefore, clinicians who are required to work outside their usual scope of practice without appropriate education and support risk burnout, moral distress, and moral injury.[47]

Compromised Values of End-of-Life Care

Case 3

An 82-year-old man with advanced chronic kidney disease was dying of respiratory failure. His wife and four adult children came to the hospital to attend him. However, the hospital visitor policy during the COVID-19 pandemic allowed one visitor only, with a maximum of two visitors for patients receiving end-of-life care. The family was forced to choose which child would accompany their mother to the patient's room. The patient's nurses and physicians petitioned for an exception to the policy, which was declined by the nurse unit manager.

The patient's nephrologist and palliative care physician also contacted the nurse manager. She became exasperated and distressed by the repeated requests. She said, "Every room has a heart-breaking story right now. If I give one patient an exception, I have to give it to them all. I'll lose my moral compass. I just can't do it anymore." The patient's doctors had to enforce and explain the policy to the family. Only the wife and daughter were allowed in, and the patient died a few hours later.

For deteriorating and dying kidney patients with COVID-19, the delivery of ideal end-of-life care may be in direct tension with obligations to reduce risks of infection transmission. Junior medical staff in the United Kingdom have reported experiences of moral distress in which infection control policies and procedures were acknowledged to compromise patient experiences of end-of-life care.[48] During the COVID-19 pandemic, clinicians frequently are confronted with clinical situations and behaviors that are antithetical to customary practice: the absence of human touch, blockage of facial expressions and other visual cues by PPE, and patient isolation.[49] The ability of families and caregivers to sit for extended periods with patients and provision of psychosocial and spiritual support both frequently are hindered by physical distancing. Clinicians may perceive these experiences as compromising the values of end-of-life care. The associated moral distress may be experienced by all involved in care, including physicians, nurses, dialysis technicians, social workers, and chaplains.

More broadly, changes to visitor restrictions in health care facilities in response to the COVID-19 pandemic have affected many clinicians, patients, and their families and caregivers. Visitor restrictions have sometimes led to tension and conflict between hospitals' and clinicians' duties to ensure the safety of patients, staff, and visitors; to prioritize the care and well-being of individual patients; to respect the autonomy (values and preferences) of patients; and to promote justice, for example, in enforcement of visitor policies.[50] If clinicians believe that specific visitor restrictions are unwarranted, and harmful in isolating a patient from their caregivers, friends, or family, they may experience moral distress if they are required to enforce them.[51]

Managing Conflicting Ethical Responsibilities

Case 4

A 55-year-old man on maintenance hemodialysis returned home from overseas and went into mandatory self-quarantine. He had not dialyzed for 5 days, became febrile, and was confirmed to have COVID-19. He was brought to a dialysis center for treatment by the COVID-19 team, dressed appropriately in PPE. As the COVID-19 team entered the ward with the patient, panic ensued. Patients who were waiting to be dialyzed, their caregivers, nurses, and technicians ran out of the facility in fear. After a crisis meeting with the head nephrologist, patients, and dialysis personnel, the other patients finally agreed to be dialyzed, but the nursing staff on duty refused to dialyze the man for fear of infection. Because there was only one center in the city that dialyzed SARS-CoV-2−positive patients, all positive patients on both maintenance and acute hemodialysis were treated in the center by the same head nurse during 2020. The head nurse experienced moral distress because she felt responsible to provide dialysis for the SARS-CoV-2−positive patients because there was no one else, and, given her higher exposure, she worried she may risk infecting herself, other patients, and her close contacts.

During the pandemic, fear of contracting COVID-19 commonly has been reported among health care workers.[52,53] Without adequate infection prevention policies and resources, health care workers may feel unsafe to provide care, particularly when they risk exposing other patients, health care providers, their families, and colleagues to infection. In Bangladesh, where insufficiency of health care resources predated the COVID-19 pandemic, pervasive moral distress was described in which clinicians believed they were unable to adequately protect themselves or their patients from the virus, with limited access to SARS-CoV-2 testing, and scarcity of PPE.[54]

Similar to the head dialysis nurse in case 4, health professionals may work in systems that constrain their ability to act in accordance with their ethical values if there are few others available to perform essential tasks. These staff may feel compelled by a sense of duty to provide care, compromising obligations to reduce their own infection risk because this may jeopardize their own health, their families, and others. The issue of conflicting roles and responsibilities for health professionals in the setting of past pandemics has been explored in the public health literature.[55] Efforts to minimize risks of infection for clinicians and their families during a pandemic are essential both as a matter of reciprocity and, more pragmatically, to ensure health professionals feel safe and are willing and available to fulfill professional roles.[55,56]

STRATEGIES TO ADDRESS AND MINIMIZE MORAL DISTRESS

Management of moral distress in kidney care requires recognition that it exists, response when it occurs, and strategies to minimize it in the future (Table 3). It is possible that clinicians may be unaware that feelings of distress and emotional exhaustion could be manifestations of moral injury.[57] A first step in responding to moral distress is recognizing it is present. Daubman et al[58] provided a framework to identify moral distress during the COVID-19 pandemic according to several stages,

Table 3. Strategies to Address Moral Distress

Strategies to Address Moral Distress	Examples
Recognition	Recognizing and acting on emotions that could be caused by moral distress
	Recognizing situations that may cause ongoing risk of moral distress
Response	Leadership and advocacy
	Psychosocial support
	Ethical support
Prevention	A physically safe working environment
	Adequate skills and training (eg, communication skills for coronavirus disease and telehealth)
	Timely communication to health care workers of resource availability and allocation guidelines

beginning with a feeling of unexpected loss or helplessness, which can progress to indignation and shock, then resignation and disillusionment, and concluding with acclimation through finding a sense of purpose. Recognizing moral distress is particularly important for nephrology trainees who often are working within rigid hierarchies and have limited clinical experience, which can increase risk of moral distress.[59] Once recognized, moral distress has been described as instrumental, focusing clinicians on important concerns and therefore prompting reflection, advocacy, and/or action.[60] Knowledge of moral distress, especially for trainees and fellows, can strengthen moral courage and the future capacity to cope and seek support.[20] Recognition of moral distress also is valuable to identify high-risk situations and thus to prevent future moral injury, particularly in situations of ongoing crisis.

Responses to moral distress involve strategies to resolve it including proper training, individual preparedness, and psychosocial support from the health care organization.[20] Systematic and timely opportunities for all kidney health professionals to discuss concerns and debrief are needed. Unfortunately, because of social distancing, many informal opportunities for discussion are restricted. Therefore, individuals in leadership positions must plan regular time to reflect on, discuss, and articulate underlying ethical issues to reduce risks of moral distress.[61] Leaders also have a responsibility to be available to hear and respond to moral distress with empathy and have a role in advocating for change.[17] Additional supportive interventions including ethical education and debriefs, peer mentors, informal reflective practices with family, friends, and colleagues have been described in recent studies to help reduce moral distress.[62,63] Other interventions such as priority-setting guidelines[62] and designation of clinical teams to support clinicians when making difficult decisions about withholding or withdrawing life-sustaining treatments also have been described as highly valuable and effective in mitigating moral distress.[25,64]

Prevention strategies involve addressing the environmental factors that produce conditions in which moral distress may occur. Maintenance of a safe working environment is a key strategy, for example, ensuring infection prevention systems are in place for dialysis staff to continue caring for dialysis patients who are suspected or confirmed as SARS-CoV-2 positive. A safe environment reduces risks of ethical conflict between personal and professional duties or interests. Internationally, violence toward health care workers increased during the COVID-19 pandemic, prompting some governments to take action such as in Sudan, where police protect health facilities, and in India, where violence against health care workers is now a nonbailable offence with up to 7 years' imprisonment.[65]

Adequate skills training for clinicians engaged in new professional responsibilities also is essential to reduce experiences of perceived failure to fulfill moral duties. Other specific environmental factors relevant to the COVID-19 pandemic include creative approaches to enhance communication and connection through technology, helping to ease the emotional burdens on patients, families, and health care professionals resulting from social distancing.[66,67] More broadly, dynamic and responsive health service communication about changes in resource allocation guidelines is essential to prepare clinicians for the likelihood of rationing resources and to address clinicians' concerns about potential inequities.[68] Finally, steps to address sources of moral distress in the longer term are essential, so health professionals may be confident that current experiences of compromised care will be alleviated when the crisis ends.

Targeted psychological therapeutic approaches may be helpful in supporting individuals who experience moral injury.[22,69] Preliminary recommendations to address moral injury in health care workers during the COVID-19 pandemic focus on early and frequent formal psychological support, including guilt-reduction therapy, assisting individuals to appraise their role in a traumatic event and find positive ways to express their values.[70,71]

CONCLUSIONS

Kidney health professionals have responded to the demands of COVID-19 with courage and conviction. However, moral distress may occur when decisions are perceived to be ethically compromised, for example, when policies conflict with well-established norms and practices. Future work in moral distress is required to analyze the underlying value conflicts experienced in

nephrology, which could assist in formulating targeted strategies for education and support for nephrologists, trainees, and other nephrology health care providers. Moral distress must be recognized, responded to, and minimized to promote well-being and safeguard health professionals against moral injury during the COVID-19 pandemic and other health crises. In doing so, we help to promote ethical policy and practice in kidney care and protect the immediate and future sustainability of an essential workforce.

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