Empirical Paper

Double distress: women healthcare providers and moral distress during COVID-19

Nursing Ethics
2022, Vol. 0(0) 1–12

DOI: 10.1177/09697330221114329
journals.sagepub.com/home/nej


Julia Smith
Faculty of Health Sciences, Simon Fraser University, Burnaby, BC, CA

Alexander Korzuchowski
Faculty of Health Sciences, Simon Fraser University, Burnaby, BC, CA

Christina Memmott
Bloomberg School of Public Health, Johns Hopkins University, Baltimore, ML, USA

Niki Oveisi
Pharmaceutical Studies, University of British Columbia, Vancouver, BC, CA

Heang-Lee Tan
Bloomberg School of Public Health, Johns Hopkins University, Baltimore, ML, USA

Rosemary Morgan
Bloomberg School of Public Health, Johns Hopkins University, Baltimore, ML, USA

Abstract

Background: COVID-19 pandemic has led to heightened moral distress among healthcare providers. Despite evidence of gendered differences in experiences, there is limited feminist analysis of moral distress.
Objectives: To identify types of moral distress among women healthcare providers during the COVID-19 pandemic; to explore how feminist political economy might be integrated into the study of moral distress.
Research Design: This research draws on interviews and focus groups, the transcripts of which were analyzed using framework analysis.
Research Participants and Context: 88 healthcare providers, based in British Columbia Canada, participated virtually.
Ethical Considerations: The study received ethical approval from Simon Fraser University.
Findings: Healthcare providers experienced moral dilemmas related to ability to provide quality and compassionate care while maintaining COVID-19 protocols. Moral constraints were exacerbated by staffing shortages and lack of access to PPE. Moral conflicts emerged when women tried to engage decision-makers to

Corresponding author:
Julia Smith, Faculty of Health Sciences, Simon Fraser University, 11806 Blusson Hall, 8888 University Drive West, Burnaby, BC V5A 1S6, CA.
Email: jhs6@sfu.ca

improve care, and moral uncertainty resulted from lack of clear and consistent information. At home, women experienced moral constraints related to inability to support children's education and wellbeing. Moral conflicts related to lack of flexible work environments and moral dilemmas developed between unpaid care responsibilities and COVID-19 risks. Women healthcare providers resisted moral residue and structural constraints by organizing for better working conditions, childcare, and access to PPE, engaging mental health support and drawing on professional pride.

Discussion: COVID-19 has led to new and heightened experiences of moral distress among HCP in response to both paid and unpaid care work. While many of the experiences of moral distress at work were not explicitly gendered, implicit gender norms structured moral events. Women HCP had to take it upon themselves to organize, seek out resources, and resist moral residue.

Conclusion: A feminist political economy lens illuminates how women healthcare providers faced and resisted a double layering of moral distress during the pandemic.

Keywords

COVID-19, gender, women, moral distress, healthcare, mental health

Introduction

The COVID-19 pandemic has posed unprecedented challenges to healthcare providers (HCP), including heightened moral distress—the experience in which one knows the ethically right action to take but is systemically constrained from taking it.[1] Hossain writes, "During this era of COVID-19, frontliners from every part of the world are facing moral distress. Moral distress occurs while delivering care, allocating resources, and maintaining professional integrity."[2] Examples of COVID-19 related moral distress include not being able to provide quality care due to lack of time, resource constraints, and COVID-19 restrictions.[2–4] Not only is moral distress contributing to a mental health crisis among HCP during the pandemic, the relationship between moral distress and burnout threatens to exacerbate already troubling human resource shortages. This study explores experiences of COVID-19 related moral distress among women HCP in British Columbia Canada between December 2020 and March 2021.

Background

The concept of moral distress originally developed in the nursing literature and has increasingly been applied to understand the experiences of other HCP.[5] While there are varying definitions, we adopt Morley et al.'s definition of moral distress as "the combination of (1) the experience of a moral event, (2) the experience of 'psychological distress', and (3) a direct causal relation between (1) and (2)."[6] Morely et al. identify multiple types of moral events, arguing this broadening of legitimate events leading to moral distress supports the development of preventive and responsive interventions.[7]

A number of studies indicate higher levels of moral distress among women HCP compared to men.[8] Such differences may reflect the gendered structures of health systems, wherein more women than men fill positions requiring close contact with patients, but have less access to decision-making, and/or reflect dominant gender norms within which women are expected to seek personal development by caring for others.[9] Psychological studies have found women have higher levels of moral sensitivity, potentially making them more vulnerable to moral distress.[10] Gender differences may also reflect norms which encourage women to foster and express emotional sensitivity and discourage men from doing so, potentially biasing responses.

However, beyond these suppositions, there are few critical inquiries into the determinants of unequal experiences of moral distress.

Greater engagement within feminist approaches has the potential to rectify this gap. Peter and Liaschenko[11] argue that "feminist ethics share a number of common features that can inform the recognition of the work–life elements that lead to moral distress," noting feminist moral theory offers a "richer explanation" of both the individual and institutional components of moral distress. Morely et al. apply feminist phenomenology to analyze and classify experiences of moral distress among nurses, but do not analyze the gendered nature of these experiences.[10] Brassolotto et al.[12] apply feminist political economy (FPE) perspective to analyze moral distress among private care aids, emphasizing how the structural feminization of the care sector creates conditions of moral distress. They further point out the majority of research documents, but does not analyze, moral distress, and argue that FPE provides a framework for analysis of determinants of moral distress. In this way FPE positions moral distress as an organizational problem experienced on an individual level.[13] We draw on these approaches, while adding to them in two ways.

First, FPE offers a further opportunity to deepen the study of moral distress, particularly in the context of COVID-19, as it emphasizes the need to include unpaid care work in health system analysis.[14] Unpaid care, also termed reproductive labor or the care economy, refers to the work of cooking, cleaning, caring for dependents and the ill, as well as other tasks that are essential to social and economic development.[15] FPE have documented how this work is primarily performed by women and, while rarely acknowledged, is essential to all other economic and social activity.[16] Scholarship during COVID-19 has particularly exposed the relationship between gender inequality at work and the crisis in unpaid care at home, resulting from school and service interruptions. Recognizing women's multiple roles, an FPE lens poses the possibility of moral distress in response to unpaid care, as well as paid care responsibilities, illuminating the often-ignored impacts of unpaid care burdens on women's wellbeing.

Second, a common critique of moral distress scholarship is that it denies HCP agency, positioning them as helpless or not responsible in situations where patient care suffers.[17] Such positioning denies HCPs power to resist constraints and obscures their resilience. FPE provides an approach that both analyzes the structural constraints that create the conditions of moral distress and resistance to them. It positions health systems and social care sectors as sites of struggle within which women, among other equity deserving groups, continue to resist inequality. Struggles may be individual and private (i.e., challenging gendered distribution of labor at home or work) or collective and public (i.e., organizing for worker rights). As feminist theorists have argued, it is crucial to document these struggles, even those that have not yet affected change, to better understand persistent structures of oppression, and inform ongoing resistance[18]—in this case resistance to the constraints that structure moral events and resulting distress.

Research objectives

We aim to better understand the types of moral distress experienced by women HCPs and explore how FPE might be integrated to better understand and illuminate gender differences in moral distress. Results suggest women HCP experienced a layering of distress and pose future directions for the study of moral distress related to unpaid care.

Research design

The research was initiated within a larger project that aimed to better understanding of the experiences of women HCPs during COVID-19. Moral distress emerged as a key theme within this broader project.

Research Context

Moral distress occurs in a context shaped by political and economic forces, and in this case, policy decisions in response to a crisis. British Columbia (BC), Canada, had some of the highest COVID-19 case numbers (84,569 confirmed cases) in the country during the first year of the pandemic.[19] The majority of outbreaks and deaths occurred in health or long-term care (LTC) facilities, putting HCP, over 80% of whom are women, at the centre of the response.[20] Pre-COVID-19, many of these women already worked in environments where external constraints—related to the increasing privatization and marketization of healthcare over the past three decades—restricted their ability to provide quality care.[21] In 2019, the province had the lowest number of registered and licensed practical nurses working in direct care in Canada leading to sever staffing shortages,[22] and the LTC sector was already reliant on overtime scheduling.[23] Over a third of midwives considering leaving their profession due to unsustainable work burdens and lack of access to benefits, being designated as allied, as opposed to essential, healthcare works.[24] The sector also had a notable gender wage gap, of 15.8% in 2020, with a disproportionate number of women fulfilling lower paid positions, such as care aids, while positions in leadership remained men dominated.[25]

Women in Canada also remain the primary care providers within households and families, doing two to three times more unpaid care work than men, as gender norms continue to position unpaid care as women's responsibility.[26,27] Unpaid care responsibilities forced a disproportionate number of women out of paid work during the first year of the pandemic, particularly during the initial lockdown from mid-March to mid-June 2020, when most schools and childcare facilities were closed. For example, over 90% of those who left work in the health and social care sector, in Canada, during the first 3 months of the pandemic, were women.[20] Subsequent temporary closures and isolation periods have continued to impose heightened care burdens on women, with impacts on their paid work and wellbeing. A survey conducted in April 2021 found 71% of mothers were "at the breaking point" due to stress and anxiety.[28]

Participants

Between December 2020 and March 2021, we conducted 16 focus groups with 66 participants, 12 semi-structured interviews (SSI), and 10 key informant interviews (KII) with those in management positions in the health system, and representatives of unions and professional organizations ($n = 88$). As shown in Table 1, we included a range of professions, selected based on gender composition (all women dominated), and having close contact with patients, residents, or clients. Most participants worked in the public health system, except for some LTC employees who worked in privately owned facilities.

Participants were recruited purposefully through advertisements emailed by unions and professional associations. Inclusion criteria included identifying as a woman[1] and currently working in one of the professions listed. Focus groups and interviews were held virtually through Zoom, lasted approximately 1 hour, and were audio recorded. Both were semi-structured with questions related to women's experiences at home and work during the pandemic, participation in decision-making, and recommendations for strengthening the health workforce. Key informant interviews, also held virtually, addressed similar themes, plus aimed to clarify contextual and policy questions.

We approached the initial research from a broad gender-based analysis lens that recognized gender as a social construct and sought to better understand how its structures interacted with women HCP's experiences and wellbeing.[9] We initially sought to analyze effects at the individual, household/family, and health system level, applying framework analysis to transcriptions coding content based on these categories.[29] Four authors (AK, NO, CM, and HL) separately applied this framework to transcripts through manual coding (pasting content from transcripts into a table with columns representing codes), regularly convening to discuss the process. The tables were then reviewed to identify themes, with moral distress constructed as a theme across

Table 1. Research Participants.

Participants	Focus groups	FG participants	Interviews
Community healthcare	4	22	4
Midwives	3	9	4
Long-term care	5	24	2
Nurses	4	11	2
Key informants	—		10
Total	16	66	22

all codes. To deepen the analysis within this theme, another author (JS) then conducted a further layer of charting, applying a FPE lens to organizing data according to type of moral event, as defined by Morley et al.,[6] whether it pertained to paid or unpaid care work, and if/how women resisted the conditions of these experiences (see Table 2). This analysis was reviewed by co-authors with discussion leading to consensus.[1]

Ethical considerations

The study received ethical approval from Simon Fraser University. Participants provided informed consent, and anonymity was preserved throughout the analysis and presentation of findings.

Results

Moral constraint – at work

Moral constraint refers to the inability to carry out one's preferred moral requirement due to external or internal constraints.[7] Participants spoke about how lack of adequate staffing led to moral constraints related to quality of care. LTC workers noted staffing shortages forced them to reduce care to residents, with one explaining, "there is multiple times where people are missing their baths for four plus weeks. So, when it gets to that point, and it's been a month and that's on the residency, you feel bad because they are people and this is their home and their lives. And they're not getting the care that they need" (07_FGLTC). Another participant agreed, "It doesn't feel good to not put that lipstick on that one lady who it just brightens up her whole day. And so again there is that mental burden that I've seen" (07_FGLTC).

Table 2. Coding framework.

Moral event	Paid healthcare work	Unpaid care work	Resistance
Constraint	- Staffing shortages	- Unable to ensure children's education and wellbeing	- Union organizing
	- Unable to ensure safety due to lack of access to PP	- Lack of care infrastructure	- Advocating for PPE supply
Conflict	- Unable to advocate because of distanced decision-making	- Lack of flexibility at work	- Supporting childcare campaigns
Dilemma	- COVID-19 protocols impact on care	- Between unpaid care responsibilities versus COVID-19 risk	- Counseling
Uncertainty	- Lack of and constantly changing information	—	- Professional pride

Midwives experienced moral constraints related to their inability to ensure parent and infant safety. Designated as allied HCP, as opposed to essential workers, midwives were not eligible to access PPE from the government supply chain and so had to source their own, which was challenging during the initial months of the pandemic due to shortages. Midwives described sewing their own masks and washing out gloves to be reused. One midwife described the "constant stress of balancing my fears and thinking of the women and babies I work with" (02_FGMW). Another described having two homebirths in one night with only enough PPE for one. Lack of PPE for midwives, resulted in increased risks for families, which in turn increased moral distress among midwives.

Moral constraint – at home

All participants noted that they, as women, were the ones primarily responsible for unpaid care in their families and that unpaid care work had increased dramatically due to COVID-19 related childcare, schooling, and service interruptions, as well as due to the needs of vulnerable family members. These perceptions are supported by research indicating that while men took on more care responsibilities during the initial COVID-19 related lockdown in Canada than previously, women continued to do the majority of unpaid care work.[27] Participants who were mothers described increased unpaid care as not only adding to their work burden, but also to experiences of moral constraint over their perceived inability to adequately support their children's wellbeing and education. A midwife explained, "You always feel guilty, especially at the beginning of the pandemic when there was no school. You're constantly feeling guilty because [children] don't have friends to play with, they're missing school, you should be reading with them, you should play with them because they're upset too over COVID, and it's just not possible to do it all" (01_FGMW).

Increased paid work reduced parents' time to provide unpaid care, just as those demands also increased. Another midwife noted, "And then I'm spending more time away from my kids because it takes time to don and doft, and clean, and spread out your appointments, and do all the things that you need to do, so you're just pulled away so much more than you would like" (01_FGMW). A nurse who contracted COVID-19 at work felt guilty about the impact it had on her children, "I was in isolation. They didn't know how I was doing. So they were super stressed, anxious around is mom going to be OK?" (23_SSI). Paid work burdens and risks-imposed constraints on unpaid care work, which led to mothers' distress, causing feelings of frustration, powerlessness and guilt. One nurse admitted, "When your home life is out of kilter and you don't have your support people, you don't have things to put back into your emotional bank, then you start to run on empty and then you take Benadryl and wine and hope that everything goes away" (03_FGNU).

Many respondents felt lack of care infrastructure exacerbate moral constraints, describing finding childcare as "a nightmare" and "impossible" (03_FGNU). A 2019 report found over 40% of families in British Columbia did not have access to the childcare needed.[24] Challenges accessing childcare were particularly acute for those working outside regular hours, which most HCP do. One participant explained, "[I] would say childcare is not easy to find normally as a midwife, and then add the pandemic on top of it, it's just it's virtually impossible" (01_FGMW). Participants noted childcare provided for essential workers during the initial months of the pandemic did not correspond with shiftwork and described how the inability to rely on family, due to physical distancing, prevented them applying previous coping mechanisms.

Moral conflict – at work

Moral conflict occurs when HCP assert what they feel/know is the correct moral action but remain constrained in effecting change.[7] Moral conflict occurred when HCP felt those making decisions were too distanced from the realities of care work to understand the consequences of COVID-19 protocols. A LTC care aid noted that when she tried to communicate concerns regarding standards of care, she was dismissed by her supervisor

who was working from home. She noted, "they weren't on the ground with us working. They didn't know what was happening. So there's a disconnect in that" (09_LTC). When a hospital manager asked a superior, located in a city over 100 km away, if changes in a policy could be delayed until the following day as her colleagues were already stressed due to multiple changes and conflicting information, she was told "if people die it's your fault" (03_KII). At the time of the interview, the respondent was recovering from a heart attack, which she attributed to the pressure from such moral conflicts, stating, "I've never had a heart issue in my life, but the moral distress, the moral distress was so great" (03_KII). Respondents felt they were inhibited from acting on their moral agency as decisions were being made by those without intimate knowledge of the situation.

Moral conflict – at home

HCP experienced moral conflict when they identified opportunities to adapt paid care work to better meet unpaid care responsibilities but were denied permission to do so. One nurse's request to partially work from home (which she felt was possible with her responsibilities) was denied and she was told to "figure out childcare or take leave." A community health worker who had taken time off due to childcare closures described receiving "threats from my employer that if I didn't get back to work then what? Not an overt threat but there was always the threat of 'You need to get back to work and figure this out.' So I felt like I was drowning every single day." These conflicts reflect the assumption that women should be able to manage both paid and unpaid labor, even when both are increased due to exceptional circumstances, like a pandemic.

Moral dilemma – at work

Moral dilemmas result from having to choose between two or more non-negational moral requirements.[7] Participants described moral dilemmas over their inability to both provide an ethical standard of care and maintain COVID-19 prevention protocols. A nurse described being unable to get into a patient's room on time to incubate them due to the need to don PPE: "It's upsetting because there's a few moments, on my last couple of sets, where I couldn't get into the room on time… I have to properly protect myself with a mask and the gloves. But meanwhile, the patient is crashing. And I just can't get there on time. So, she ended up dying. And so, I've gone into counseling, so I can make sure I don't feel the guilt" (03_SSI). A community healthcare worker described how COVID-19 policies restricted her ability to respond to toxic drug overdoses, "We can no longer use Ambu bags anymore and it's so hard because you're watching somebody deprived of oxygen and you know you have the equipment to do it, but you can't because it's a health risk" (13_SSI). The dilemma of having to provide substandard care, often risking lives, to protect themselves and others from COVID-19, weighed on HCP.

Moral dilemmas were acute when respondents had to enforce COVID-19 protocols they recognized as negatively impacted patient/residents' emotional wellbeing. A hospital manager described the burden of having to prevent family from visiting patients with dementia as "that moral distress, knowing that they have a valid point that their parent needs them—that's probably the only person they recognise" (03_KKI). A manager of an LTC facility noted, "The residents were sad that they couldn't see their families, the families were upset that they couldn't see their loved ones. And I had no control over any of it. I just didn't have the solutions for them" (09_FCLTC). The isolation of patients/residents created a further layering of moral dilemma—care providers felt they should increase the comfort they provided but remained restricted by COVID-19 protocols. Nurses described being instructed to spend as little time as possible with patients, to reduce risk of transmission, at the same time as patients needed greater emotional support because they had no family present. Midwives described physical distancing as conflicting with "the essence of midwifery care" (01_FGMW), which is based on building relationships and providing holistic support, during a time expectant

parents needed additional reassurance due to fears around COVID-19 and inability to access other support networks. A LTC care aid explained, "I think the frustrating part was not being able to help somebody who's inconsolable because they're crying, missing a spouse, or just being exhausted" (11_FGLTC). Respondents expressed feelings of powerlessness as they tried to weigh multiple harms. One care aid explained, "When I went off work, I would come home and I'm like people are dying, there's nothing I can do about it. I became obsessed with death. I couldn't eat, I couldn't sleep… I'm like 'People are dying I've got to do something.' But there's nothing I can do" (05_FGLTC).

Moral dilemma – at home

Moral dilemmas emerged around balancing occupational risk and responsibility for dependents' wellbeing. While all participants spoke of anxiety around the possibility of transmitting COVID-19 from work to home, those with elder care responsibilities were particularly conflicted, describing high levels of guilt when they decided against caring for their elders out of concern for their safety and anxiety when they had to continue to provide care due to lack of alternatives. Participants noted that moral dilemmas over how to reduce COVID-19 risk for those they provided both unpaid and paid care to affected relationships with family members: "I feel I've – I was worried that I was going to be the one to take it into work. So I walked around, as we all have, with so much angst that every day there would be tears and hoping that I didn't have it and I wanted to not be around my family, because I didn't want them to give me something and me take it into work" (11_FGLTC). Such dilemmas resulted in feelings of isolation and guilt.

Moral uncertainty – at work

Moral uncertainty results from being unable to decide between two or more non-negotiable moral requirements.[7] HCP described moral uncertainty, particularly during the initial months of the pandemic, when constantly changing information regarding COVID-19 made it difficult to know how to best protect patients/residents. One nurse described bringing up concerns regarding mask regulations and being told to just do her best with what was available. Midwives described "having to find [their] own way" and conflicting advice around homebirth safety (07_SSI). A care aid described how, "When the outbreak first happened, there was no communication about what floor had it or where it was affected. It was kind of by word of mouth" (11_FGLTC). In such instances, HCP felt they did not have the information needed to keep those they cared for safe. Respondents linked this uncertainty and lack of communication to distress, "There's just a lot of disconnect, miscommunication that I think resulted in burnout" (13_SSI). Respondents did not describe instances of moral uncertainty at home, perhaps reflecting their power within the home to develop the responses they felt were best based on what information was available.

Resisting conditions of moral distress

While sources of moral distress directly related to the pandemic, such as physical distancing policies and information uncertainty, were recognized as beyond their control, participants shared instances of challenging other constraints and seeking to overcome moral residue. Midwives successfully advocated for access to government supplied PPE by working with hospital managers and other HCP, while lobby members of the provincial legislature and Ministry of Health. Within the LTC sector, an increasing number of facilities and workers joined unions to strengthen their ability to advocate for improved staffing policies. A key informant from one of the largest unions explained: "These women took on the role of organizing co-workers to join the union in the middle of a pandemic, because they care about the safety of their co-workers, they care about the safety of the family, they care about the safety of the residents. . . . I think organizing is really a brave thing to

do. Even braver to do in the middle of a pandemic" (17_KII). Meanwhile campaigns for greater investments in childcare, supported by healthcare worker unions, have capitalized on the awareness created by COVID-19 to secure unprecedented provincial and federal investments.[30]

In order to address the long-term effects of moral distress, such as moral residue, some participants either increased their counseling sessions or began therapy during the pandemic. Midwives were the only HCP that did not have access to employer provided mental health supports or extended benefits. Consequently, one midwife explained: "I also have increased my counseling in the last few months cause I'm like, you know what, we can't afford it, but I also can't afford not to do it, so we're just going to go into debt and I'm putting it all on my credit card because I need to speak to someone because it's just too much" (01_FGMW). In this case, committing to selfcare generated new vulnerabilities.

Respondents also spoke of how they resisted moral residue by drawing on professional pride and fulfillment. A midwife explained, "we will keep working in the pandemic and we'll keep working as underpaid people, we'll keep being undervalued by our communities, our hospital, and we'll keep doing it because we love what we do" (09_SSI). Similarly, a nurse explained, "I was willing and able to go to work in that completely broken state because I'm a nurse and that's what nurses do" (05_FGNU). While such expressions convey the continued exploitation of the essential work these women provide, they also express a recognition of its value beyond its commodification, and a determination to continue to strive for the ethical standards of care they deem essential.

Discussion

COVID-19 has led to new and heightened experiences of moral distress among HCP. Findings here confirm research that identifies physical distancing policies, isolation, and information uncertainty as sources of moral distress during COVID-19.[31] Results suggest that lack of adequate staffing and access to PPE contributed to moral constraints, while lack of consultation between decision-makers and healthcare providers led to moral conflict. Uniquely, we argue health and social care workers experienced moral distress in response to both paid and unpaid care work. Participants described moral distress in response to their inability to provide quality care to dependents and education to children, as well as from fear of passing the virus from work to their family, or vice versa. While the structure of our analysis has separated moral distress in response to paid and unpaid care work, participants in this study did not experience two separate forms of moral distress. Mothers returned from overtime shifts exhausted due to staff shortages to feel further guilt when faced with demands from children. Those with elder care responsibilities lived with the fear of passing the virus to the people they cared for both at work and at home.

While many of the experiences of moral distress at work were not explicitly gendered, and therefore may be experienced by HCP of all genders, implicit gender norms structured these events. How care—as a feminized act—is valued, both as paid labor and an often invisible contribution to social relations, is reflected in inadequate staffing policies and expectations that those providing care will continue to do so despite lack resources, including basic supplies like PPE and infrastructure like childcare.[32] Women's own recognition of the importance of the care they provide, despite lack of formal recognition and support, compelled guilt when care burdens became impossible to manage.[21] The distress women felt when they could not have meaningful relationships with those they provide care to, due to physical distancing, reflect the relational aspects of moral decision-making often associated with women.[33] Masculine dominance in health system leadership combined with the command-and-control style of decision-making, common in emergency response, privileged hegemonic masculine norms that dismissed input, generating situations of moral conflict.[34] The layering of moral distress at work, on to distress experienced at home, may have a multiplying effect less likely among men. Such findings pose critical questions around gender differences in moral distress, asking not only how but why women HCP experience moral distress differently.

The FPE lens applied here not only enables gender analysis of health systems and the inclusion of unpaid care but offers a framework for understanding relationships between individual experiences and structural constraints of moral distress.[12] This approach bridges FPE literature, which demonstrates that when institutional investments in care are inadequate women bear the costs individually, with gendered analysis of health systems.[9] In turn, the moral distress analysis adds to the FPE literature on the care economy, demonstrating that the costs of unpaid care born by women during COVID-19 are not only material in terms of lost wages and opportunities, as has been demonstrated elsewhere,[35] but also psychological in terms of the long-term effects of moral distress. Such findings suggest further potential for the application of FPE to moral distress research questions and vice versa.

FPE further centers the agency of women by considering how they sought to resist constraints. Notably, women had to take it upon themselves to organize, seek out resources and resist moral residue. What external supports were provided, such as access to counseling, were not only unequally available, but responded to the individual effects of moral distress, such as anxiety and trauma, as opposed to the structural determinants, such as lack of staffing, despite moral distress being increasingly documented as a collective experience among HCP, particularly during COVID-19. Such individual approaches to structural problems will only go so far in preventing the burnout and attrition that threatens health systems in BC and elsewhere in the wake of the pandemic.

Documenting how women resisted the conditions of moral distress not only acknowledges their agency within the broader political and economic context but advances moral distress research beyond simply recording experiences of suffering, to understanding how it might be prevented and mitigated. Respondents' resistance provides guidance on what structural changes should be prioritized in pandemic recovery and preparedness. These include increased investments in human resources for health and social care, as well as in the services women need if they are going to staff the frontlines, such as childcare, and robust physical and mental health services for all frontline workers, including staffing and childcare options that allow time for selfcare. Pandemic response plans need to be developed that facilitate meaningful input from those providing frontline care.

We recognize more research is needed to test the expansion of the concept of moral distress to include unpaid care, as well as broader application of FPE. This qualitative study is limited in scope and is not meant to be generalizable. Instead, it adds to the literature by documenting the lived experiences of a specific group identified as at risk of moral distress and contributing meaningful inquiry into discussions around moral distress.[36] Further research is need that includes all genders and applies intersectional analysis. This could include adapting pre-existing moral distress surveys to include questions about unpaid care.

Conclusion

Considering the well documented effects of moral distress on healthcare worker mental health and burnout, and therefore secondary effects on human resources for health, it is imperative to address the moral distress experienced by women on the forefront of the COVID-19 response. Responses must go beyond short-term mental health interventions, to address the underlying constraints, many of which pre-date COVID-19 and are notably gendered, around working conditions and investments in the care economy. Such structural change will not only strengthen COVID-19 recovery efforts but it will also better prepare health systems for future pandemics.

Authors' contributions

JS and RM led the research to inform this article with JS conceptualizing this specific paper. All authors participated in data collection and analysis. JS wrote the first draft of the paper with the other authors contributing to subsequent drafts and agreeing to the final draft.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by the Canadian Institutes of Health Research under grant number OV7-170639 and by the BC Women's Health Research Foundation

Ethical approval

This research received ethical approval from the Office of Research Ethics at Simon Fraser University

ORCID iD

Julia Smith https://orcid.org/0000-0002-5175-1109

Notes

1. We use the terms both female and women to include those who self-identify as such regardless of sex assigned at birth, including those who fit outside of the biological binary of female-male.

References

1. Jameton A. Dilemmas of moral distress: moral responsibility and nursing practice. *Clin Issues Perinatal Women's Health Nurs* 1993; 4(4): 542–551.
2. Hossain F. Moral distress among healthcare providers and mistrust among patients during COVID-19 in Bangladesh. *Developing World Bioeth* 2021; 21(4): 187–192.
3. Godshall M. Coping with moral distress during COVID-19. *Nursing* 2021; 51(2): 55–58.
4. Morley G, Sese D, Rajendram P, et al. Addressing caregiver moral distress during the COVID-19 pandemic. Cleve Clin J Med 2020. Available from: https://pubmed.ncbi.nlm.nih.gov/32518134/
5. Pauly BM, Varcoe C, Storch J, et al. Framing the issues: moral distress in health care. *HEC Forum* 2012; 24(1): 1–11.
6. Morley G, Ives J, Bradbury-Jones C, et al. What is 'moral distress'? A narrative synthesis of the literature. *Nurs Ethics* 2019; 26(3): 646–662.
7. Morley G, Bradbury-Jones C, Ives J, et al. What is 'moral distress' in nursing? A feminist empirical bioethics study. *Nurs Ethics* 2020; 27(5): 1297–1314.
8. Pinquart M and Sörensen S. Gender Differences in Caregiver Stressors, Social Resources, and Health: An Updated Meta-Analysis. *Journals Gerontol* 2006; 61(1): P33–P45.
9. Morgan R, George A, Ssali S, et al. How to do (or not to do) gender analysis in health systems research. *Health Policy Plan* 2016; 31(8): 1069–1078.
10. O'Connell CB. Gender and the experience of moral distress in critical care nurses. *Nurs Ethics* 2015; 22(1): 32–42.
11. Peter E and Liaschenko J. Moral distress reexamined: a feminist interpretation of nurses' identities, relationships, and responsibilites. *J Bioethical Inq* 2013; 10(3): 337–345.
12. Brassolotto J, Daly T, Armstrong P, et al. Experiences of moral distress by privately hired companions in Ontario's long-term care facilities. *Qual Ageing Old Adults* 2017; 18(1): 58–68.
13. Pijl-Zieber E, Hagen B, Armstrong-Esther C, et al. Moral distress: An emerging problem for nurses in long-term care? *Qual Ageing* 2008; 9(2): 39–48.
14. Rai S and Waylen G. *New Frontiers in Feminist Political Economy*. Taylor & Francis, 2013.New frontiers in feminist political economy.

15. Folbre N. Measuring care: gender, empowerment, and the care economy. *J Hum Develop* 2006; 7(2): 183–199.
16. Lokot M and Bhatia A. Unequal and invisible: a feminist political economy approach to valuing women's care labor in the COVID-19 Response. *Front Sociol* 2020; 5: 588279.
17. McCarthy J and Gastmans C. Moral distress: a review of the argument-based nursing ethics literature. *Nurs Ethics* 2015; 22(1): 131–152.
18. Robinson F. Care ethics, political theory and the future of feminism. In: Engster D, Hamington M and Hamington M (eds). *Care Ethics & Political Theory*. Oxford: Oxford University Press, 2015, pp. 291–310.
19. Government of British Columbia. *COVID-19: One Year of the Pandemic in BC*. VIC, 2021.
20. Shrma L and Smith J. *COVID-19's effects on the healthcare and social assistance workforce in Canada: Gendered employment loss and wage inequality 2020-2021*. Vancouver, 2021. Available from: https://www.genderandcovid-19.org/resources/covid-19s-effects-on-the-healthcare-and-social-assistance-workforce-in-canada-gendered-employment-loss-and-wage-inequality-2020-2021/
21. Held V. *The Ethics of Care: Personal, Political, and Global*. Oxford University Press, 2006.
22. BCNU 2015. *Final Report – BC Nurses Workload Impact Study*. Available from: https://blogs.ubc.ca/bcnwis/final-report/
23. Banerjee A. *An Overview of Long-Term Care in Canada and Selected Provinces and Territories*, 2007. Available from: https://www.researchgate.net/publication/284652528
24. Stoll K and Gallagher J. A survey of burnout and intentions to leave the profession among Western Canadian midwives. *Women Birth* 2019; 32(4): e441–e449.
25. Tricco AC, Bourgeault I, Moore A, et al. Advancing gender equity in medicine. *CMAJ* 2021; 193(7): E244–E250.
26. Statistics Canada. *Time Use: Total work burden, unpaid work, and leisure*. Government of Canada, 2018. Available from: https://www150.statcan.gc.ca/n1/pub/89-503-x/2015001/article/54931-eng.htm
27. Shafer K, Milkie M, Scheibling C, et al. The Division of Labour Before and During the COVID-19 Pandemic in Canada. *Can Rev Sociol* 2020; 57: 523–549.
28. Faraday F. *Resetting Normal: Women, Decent Work and Canada's Fractured Care Economy*, 2020. Available from: https://canadianwomen.org/wp-content/uploads/2020/07/ResettingNormal-Women-Decent-Work-and-Care-EN.pdf
29. Gale NK, Heath G, Cameron E, et al. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Med Res Methodol* 2013; 13(1): 117.
30. Government of Canada. *Canada announces historic first early learning and child care agreement*, 2021. Available from: https://pm.gc.ca/en/news/news-releases/2021/07/08/canada-announces-historic-first-early-learning-and-child-care
31. Anderson-Shaw LK and Zar FA. COVID-19, Moral Conflict, Distress, and Dying Alone. *J Bioeth Inq* 2020; 17(4): 777–782.
32. Vosko L, MacDonald M and Campbell I. *Gender and the Contours of Precarious Employment*. Toronto: Routledge, 2009.
33. Gilligan C. Reply to critics. *Ethic Care Feminist Interdiscip Perspect* 2016; 1: 207–214.
34. Aolain FN. Women, Vulnerability, and Humanitarian Emergencies. *Mich J Gend L* 2011; 18.
35. Morgan R, Tan HL, Oveisi N, et al. Women healthcare workers' experiences during COVID-19 and other crises: A scoping review. *Int J Nurs Stud Adv* 2022; 4: 100066.
36. Sallee MW and Flood JT. Using qualitative research to bridge research, policy, and practice. *Theor Into Pract* 2012; 51(2): 137–144.