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RESEARCH ARTICLE

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Understanding moral distress among healthcare personnel in end-of-life care hospital settings

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ABSTRACT

Moral Distress (MD) refers to the negative experience that arise when a person cannot act in accordance with their values and principles when caring for patients, associated with individual, social or institutional barriers. This article presents the result of the qualitative research analyzing MD in health personnel of high complexity hospital in Bogotá, Colombia focusing in the attention of older patients with chronic or acute illnesses. The study used qualitative methods that included semi-structured interviews, focus groups and participant observation. The data was analyzed based on a theoretical matrix, considering how MD is configured, the way participants experience it, the contexts in which it happens, whether they consider consequences of this, and whether the education they have received provided them with tools to confront it. Findings include the constant presence of MD among healthcare personnel while confronting death and patient suffering. It is influenced by the level of education, previous work experience, and hierarchies within the healthcare system. Additionally, coping strategies such as emotional distancing and the of seeking knowledge are identified, although there is a noted lack of specific training in managing death and morbidity situations, as well as effective communication skills.

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KEYWORDS Moral distress; death; hospital services; medical education; qualitative research

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Introduction

The care of older patients in critical condition or with terminal chronic illnesses is becoming increasingly common in hospitals. The increase in life expectancy and changes in the care of chronic pathologies have prolonged the lives of people over 60 years old, who now have access to therapies such as dialysis in emergencies and intensive care. Decision-making for the care of this population is complex and often collective, involving the medical team, ethics committees, family members, and, of course, patients. These processes may generate conflicts, regrets, and helplessness, affecting the health of healthcare personnel. During the COVID-19 pandemic, the frequency of ethical dilemmas became evident, with several studies pointing out the distress of healthcare personnel as a relevant phenomenon and highlighting its repercussions on mental health. A narrative review found that in situations of difficult decisions, affective manifestations such as distress and stress symptoms are experienced, generating moral conflicts that interfere with professional practice and cause negative psychological repercussions, such as post-traumatic stress disorder, depression, anxiety, increased substance abuse, and social isolation (Zwielewski et al., 2021).

Distress is considered inherent to human beings, emerging in the face of loss or when contrasting the real with the ideal. In the literature, it is defined as a biological response to stimuli, sometimes as 'fear of' a specific object (such as death) and its temporal projection (fear of dying). Various disciplines have addressed it, equating it with anxiety, fear, and stress, hindering a single definition. Contemporarily, distress is recognized as the result of biological, psychological, and social interactions, manifesting physically, and generating the need or inability to act, a loss of will to alleviate it, and a sense of helplessness that limits freedom (Sierra et al., 2003). MD, on the other hand, is a recent term originally used by Jameton (1984) to specifically designate the response to an experience where institutional barriers or pressures make it practically impossible for a person to follow the course they consider correct for action. In literature, it has been associated with other terms such as moral suffering or MD Medina et al., 2022). Conflict arises when there are external forces or conditions that, real or imagined, prevent the subject from acting in accordance with their own values and judgment of the perceived situation. It can occur at various levels of healthcare and emerge as a relational phenomenon: in the clinical relationship between doctor/nurse and patient, doctor/nurse and families, among healthcare team members, in relation to the healthcare system, or in relation to a particular social context.

To understand MD, various causal elements are considered in the literature, such as power relationships and hierarchies in work, as well as the conflict between loyalty to the patient and loyalty to institutions (Arango Bayer, 2014). For end-of-life and death scenarios in hospital contexts,

communication problems among the various actors are also considered, as well as inconsistency in care plans, moral and legal questioning about the care provided by healthcare professionals, and consideration of what is futile (Conoci et al., 2018). Differences in care objectives between specialties and disciplines of the healthcare team and the limited exposure to death, as well as the lack of experience and training of healthcare personnel in end-of-life care and grief, are other relevant elements for understanding MD. The most frequent scenarios are intensive care units, geriatric and dialysis units and oncology departments (Medina et al., 2022)

This article aims to describe MD experienced by healthcare personnel in a high-complexity hospital, describing how and in what way they perceive and express it, in which contexts or scenarios it occurs, how they explain it, whether they have the tools to face it, and the negative effects on participants.

Methods

This is a qualitative, interpretative study (Elliott & Timulak, 2005, 2021) conducted within a high-complexity hospital in the city of Bogotá, Colombia. The project had approval from the corresponding Ethics and Research Committee (ERC). For this study, it was deemed important to delve into the experiences of healthcare personnel, family members, and patients from units and services attending to older patients in critical conditions or end-of-life situations, including Intensive Care, Geriatrics, Emergency, Internal medicine, Nephrology, Oncology and Palliative care units. Field journals, semi-structured interviews, and focus groups were conducted, allowing methodological triangulation. The project received approval from the corresponding Ethics Committee and from the chiefs of each unit. In all cases, informed and individual consent was obtained from the participants.

Sampling was theoretical (Denzin & Strauss, 1988; Draucker et al., 2007), considering predetermined criteria such as specialty, stage of training, and role in the units, referred in the literature as with greater exposure to death and end-of-life processes. Members of the various units were invited to participate, leaving room for other actors and roles that arise from data analysis. In the study, social workers and other health personnel were not included since they were not identified or mentioned related to the dying process during interviews, even though we acknowledge their contribution in this hospital.

Information was anonymized using identification codes as follows: Unit-Role-Gender and #sequential number (Table 1). For example, the code ICU-S-M-001 refers to the first interview conducted with a male specialist from the intensive care service. The interview guide was tested and modified depending on the discussion of the findings, and

Table 1. Characteristics of participants and anonymization codes.

Characteristic	n
Gender	
Female (F)	11
Male (M)	8
Role and specialty	
Nursing Assistant (NurA)	1
Nurse (Nur)	4
Specialist Physician (S)	7
Fellow Physician (Fw)	1
Resident Physician (R)	5
General Physician (Gp)	1
Specialty	
Palliative Care (PC)	3
Geriatrics (G)	4
Nephrology (N)	1
Oncology (O)	4
Intensive Care Unit (ICU)	4
Emergency (E)	3
Modality	
In-person	11
Virtual	9

the saturation of the topics. (Appendix 1). Subsequently, interviews were conducted and recorded, transcribed, and manually coded with selective and focused coding (Glaser, 2016) based on a matrix (Appendix 2) that was built based on previous theorical reviews of MD and its components (Medina et al., 2022). The information was coded by each member of the team, with periodical reunions to discuss and recode if necessary. At this stage, a semi-structured interview was excluded due to the lack of signed and completed informed consent.

Once information appeared saturated using interviews, two focus groups were developed, each with a predetermined script (Appendix 3). One homogeneous group with a higher proportion of internal medicine residents, and another heterogeneous group comprising family members, undergraduate medical students, residents, and professors. Participation on focus groups was voluntary, and recruitment was done by snowball method within the hospital (Naderifar et al., 2017). Each group had a moderator and an observer. The observer meticulously noted bodily responses and any type of non-verbal language. A code was assigned to each group as follows: FG-HO-001 to identify the homogeneous focus group and FG-HE-001 for the heterogeneous one. During focus groups an end of life case was provided to participants, allowing discussion to identify tensions and power dynamics within the participants. This data was transcribed and triangulated with data from field notes and interviews.

Results and analysis

To present the results, findings associated with the pre-established categories are shown, starting with distress, then delving into MD, its relationship with power relations and hierarchies, communication, inconsistency in care plans, moral questioning faced by healthcare personnel, ethical questioning by healthcare personnel about themselves and futile treatments, and finally its relationship with education. The experiences described may not necessarily correspond to the hospital setting where this research was conducted, but are present from undergraduate training, previous work experiences, and current work, related to their own beliefs and prior knowledge.

Distress, fear, or discomfort?

In general, death confronts them with profound questions about the end of life and pain, and they acknowledge that facing these experiences and reflecting on them produces distress, which, when probed, is associated with fear. 'Considering that nobody wants to die, and that is an absolute truth, it's also true that nobody wants to live with pain or suffering, that causes too much distress'. (G-R-M-002) 'It's something I thought about; I'm afraid of suffering; I'm afraid of all this; many things done here I would doubt for myself'. (ICU-S-M-001).

According to the participants, distress can be reduced with more knowledge and control over the situation. That is, the more study time, work or life experience, or occupying a higher position in the hierarchy, the less distress one will feel: 'The main reason why I can't feel comfortable with something is because I'm ignorant, because I don't know, because I don't have the elements that a person with higher education has to understand why that decision was taken, at that moment, it's ignorance'. (G-R-F-001)

In the interviews, distress emerges as a constant associated with the projection of the ideal of a good death that almost never materializes (Mejía Grueso et al., 2023). For the participants, death should not occur in solitude; there should be open and complete communication with the family, and everyone should understand the information provided. The medical team should have enough time to address doubts and maintain transparent and fluid communication. Participants also believe that the healthcare system should provide comprehensive end-of-life care and palliative care. Medical personnel envision their patients' deaths as events with possible negative consequences for themselves and associate them with potential legal claims or uncomfortable emotional responses from family members. As they are the ones who certify the end of life, they constantly evaluate every step they take because they constantly think that a poorly made decision could generate problems for themselves as well as suffering for the patient or family

members. 'Additionally, I was afraid at the moment I approached the scene because I didn't want to declare a death if I wasn't 100% sure there were no vital signs'. (Field journal G-R). This even leads them to what was identified in this project as 'anti-epicrisis', referring to actions that kept the patient alive long enough to refer them to another service or for another professional to take over the death process on the next shift. An intensive care specialist expresses it as follows: 'To me [referring to other specialists], a patient cannot die in general hospitalization; I bring them to the unit (ICU) so that it becomes someone else's problem (. . .) It's just that doctors themselves have problems with the situation of death'. (ICU-S-M-001). In another section of the interview, they mention that 'There are patients whom you know are not doing well, who do not benefit from many things, and you simply leave them there for someone else to deal with. . . hopefully it will be on the next shift, hopefully it will be on the night shift so I don't have to face that situation, and that happens very frequently, so I think we should try to be a little more, as doctors, open towards death'. (ICU-S-M-001).

This leads to constant reflection on their previous work experiences, constantly evaluating whether their actions could have caused harm in any way. 'If I feel that I did something wrong or failed in any way, I wouldn't be able to cope with the guilt'. (G-R-F-001). It is a feeling they want to avoid and which, in one way or another, shapes their daily lives. 'It even conditions the way I act, the way I do things, the way I prepare things, always thinking about not feeling guilty'. (G-R-F-001). There is also a complex scenario that occurs when the family judges medical action: 'One of the daughters turns to me and, between tears and a raised voice, tells me that she doesn't want to see anyone from the geriatrics team and that her mom died because of us'. (Field journal G-R). The potential to cause harm through action, omission, or communication is a constant concern. "Sometimes you don't consider the state of the person you're throwing a grenade at. And sometimes you have to say, give the information to your family because we only give information once a day'. So sometimes that seems like crap to me". (G-R-M-002).

The participants expressed emotions such as pain, sadness, and fear when addressing difficult clinical cases related to end-of-life decisions or extreme situations of illness. These emotions were associated with bodily expressions and sensations such as paralysis to act. At times, the emotional expression was not intentionally directed towards a specific event or situation but was linked to a mood characterized by being more diffuse, hardly attributable to a single event: 'I think I also failed at that moment because I didn't know what to do; instead of saying something, I just watched him for 10 damn hours there, how he suffered, and all I could say was: God, please let the gentleman die, because it was the only way I saw at that moment to end that process' (G-R-F-001). Another participant indicates: 'They were coming in like grenades, and I didn't know what to do; I was paralyzed; I didn't know what to

use; I didn't know how to help her; and finally, the patient dies'. (ICU-Fw -M-001).

The intensity of distress varied depending on the closeness of the patient. If the patient was known or a relative, whether it was a real experience or an imaginary situation, distress increased. '(. . .) seeing myself from that family perspective is very difficult because I obviously see myself from the other side of the doctor and the nurse providing that care. I see myself from the other side, and it's difficult. All the nurses are different. Some are stricter than others, some are a little tougher than others, and that shouldn't change in terms of the humanity and humanization that we should have with patients' (E-Nur-F-003).

Discomfort and unease also arose when personal values and those of patients differed regarding the end of life: 'I felt frustration in understanding that fine line between the patient's will and what one would like them to choose, knowing that, for example, symptom control could provide a better quality of life; however, understanding that she wants something else and it's part of her autonomy'. (Field journal G-R). Loyalty to the patient's wishes is a central principle, which is not necessarily fulfilled because there are logics associated with the fear of death that lead healthcare personnel down a different path: 'You never touch on that topic [death] until you're in the mud, and then you say, "do you want?" [referring to treatments] You dress it up and say, "If you want, I'll remove the choking and intubate you", as if intubation would remove the choking, but it's not true. You sell what you want them to buy' (ICU-S-M-001). Here, distress is related to the recognition of the inconsistencies that emerge in the clinical relationship: 'Doctors always try to implant our ideas (. . .) well, I've often found myself telling someone, even unintentionally, what I want them to do' (FG-HO-001).

The care of older patients with dependency and functional limitations can further hinder communication and generate discomfort: 'I feel that in this case it would have been better to have been able to explain things directly to the patient, but her severe hearing loss made communication very difficult. . .' (Field journal G-R). For specialties other than geriatrics, the death of an older person caused less distress than that of a young person: 'Every death has its own characteristics. But when it's an older person with many comorbidities, it's much simpler because, well, they have already lived, they have already experienced, whereas with younger patients, it's more complex because one expects them to live longer, they have more to live for, they have more opportunities'. (ICU-S-M-001)

Specifically, MD is expressed in interviews and focus groups through the frequent use of expressions such as 'I had to' as an obligatory act that transcends personal position and implies an inability to act autonomously. Where and how MD appears depends, among other things, on the specialty and role of the healthcare personnel interviewed, and on power relationships

and positioning within those relationships. For example, for geriatrics residents, MD occurs more frequently in intensive care units: 'During this time I was in the ICU, I had many experiences of this kind which left me emotionally exhausted' (Field journal G-R). The style referred to is the constant appearance of contradictions between objectives and therapeutic pathways between their specialty (geriatrics) and those of intensive care, combined with their subordinate position in a unit other than their own.

On the other hand, for a physician in training in intensive care, MD is associated with chronic illnesses and the barriers that patients and families will have to face in the long term with chronic illnesses: 'So, in the acute setting, there is not much family resistance or anything like that because well, the scenario doesn't exist. In the chronic setting or in cases with a more prolonged dying process, it's more complex, there are barriers with families, sometimes with the healthcare system, with the hospital you're in, for example, there are patients who request euthanasia, and it's not done in our hospital by the hospital's own decision. So, there are barriers in the long and chronic scenario'. (ICU-Fw-M-001).

In interviews, MD also emerges associated with medical meetings and ethics committees, not necessarily as spaces for discussion among equals, but as spaces for the exercise of power, social pressure, and resolution of MD that some team members may be feeling. An oncology specialist recounts a medical meeting where there was consensus among the attending physicians regarding a decision made by a younger oncologist: 'It's a meeting where there are 100 specialists . . . How did I interpret it? As a mechanism of pressure to change the decision we had made . . . for me, it was very clear that it was a matter of distress for the attending physicians, of being able to offer something more. . . there were 50 colleagues supporting him [referring to the attending physician] and not the young oncologist that who knows if he just graduated'. (O-S-M-001).

One of the residents express, in relation to a case she experienced, whether or not to continue dialysis in a patient 'She [a experienced nephrologist] tells me that we should put in the note that we [geriatricians] are going to continue dialysis. She said that I am the resident and she is the nephrologist and I should pay attention. I tried to discuss with her other alternatives, and tell her that I don't understand the purpose of dialysis [referring to the patient's poor condition], but she tells me that the only thing I should do is to write that "dialysis will be continued"' (Field journal G-R). This accounts illustrate the pressure and exercise of power that occurs regarding a decision, and how roles and power are made by a specialist in relation to the proposals or arguments of someone younger, which for the interviewed individual might be more appropriate from the perspective of their specialty.

MD is particularly expressed in the nursing team, which often questions procedures that must be performed by medical order but—from their

perspective—without any justification: 'Sometimes I wonder if the patient has a do-not-resuscitate order, if the patient, let's say, doesn't want any further interventions, why are we doing so much? Why do we have to take laboratory tests every day? hemoculture every 72 hours, every 48 hours, take glucose measurements every 6 hours, and take vital signs more frequently? And I said, "Let's say, how can I determine if the patient can have a prognosis? Can I say it as a nurse? But his medical history says that there will be no improvement and that the patient is in poor overall condition. Why are they doing this?"' (E-Nur-F-003).

In the same scenario, a resident expresses the same conflict: 'Additionally, for me, it was very clear that we were already in an end-of-life context due to the characteristics of the patient, from what I knew and experienced at the time with end-of-life processes, and not being able to establish a care plan in time led to interventions being continued that should not have been continued, such as taking vital signs and glucose measurements, which cause pain and are futile at the end of life'. (Field journal G-R).

One of the main barriers causing MD in healthcare professionals is framed in limited communication skills, reduced time, and spaces poorly adapted for delivering transcendental information. Also, in delivering bad news, MD can be generated, particularly in relation to infrastructure and available resources: 'The scene made me think of a class I had in undergraduate studies on how to deliver bad news, where it proposed an appropriate environment, quiet, without interruptions, where theoretically those receiving the bad news accept the information better. All this happened in a hospital hallway, where there was patient traffic, people, nursing cars, family members from other rooms peeking in, and I believe that in this type of situation, it would not have been possible to take the family to an isolated and silent place to tell them that their family member had passed away'. (Field journal G-R).

When recording scenes associated with MD in field journals, a resident points out that, as a physician, recognizing the socioeconomic barriers that the patient will face once discharged is a source of MD: "She remains silent for a few seconds and tells us that she definitely doesn't believe chemotherapy is for her, that many doctors have told her throughout her life that it's useless, that it only worsens the quality of life, and that it's better for cancer to take her soon because she doesn't want to deal with the healthcare system, pharmaceutical companies, and doctors' lies". (Field journal G-R).

Another source would be institutional logics and power relationships that seek performance and bed turnover, which prevent slower processes, with all the necessary information to make decisions or, as in this case, declare death: 'The head nurse interrupts me impatiently saying "Doctor, you can't feel the pulse anymore", [referring to the pulse], "are you going to declare death now?" I look at her, I tell her no because you can still hear a very weak heartbeat, and I tell her to

wait. During my conversations with the head nurse, I felt frustrated. It seems to me that the way she asked me things was part of a procedure that she had to do in her morning . . .' (Field journal G-R). In the homogenous focus group, a resident express: 'The patient is already defined before the rounds. That happens a lot (. . .) Dr. X already put in the orders even before seeing the patient. Before talking to us, before rounding, because he already has his plan defined, and many times there is academic discussion but there is no other role in which we intervene in this part'. (FG-HO-001).

Very specifically in this study, MD can be related to the threat of violence from external actors. In this case, the external threat forces actions to be taken or not taken to keep someone alive, putting one's own life at risk. Referring to his previous work experience, an interviewee points out that in his rural practice: "(. . .) sometimes dead patients would arrive, and we had to intubate them, they would arrive, and the doctor would get out of the ambulance acting as if they were resuscitating. So, you would ask him 'come on, what happened?' and they would tell you something like 'this is X person's grandmother', who was like the town thug, so instead of saying that they died on the way in the ambulance, that nothing could be done, they had been resuscitating him for about an hour. You feel the discomfort and all you can say is 'Let's do it'. . ." (G-R-M-002).

Finally, and in line with the previous results, non-beneficial treatments (NBT) or futile treatments are a source of MD, to the extent that they are proposed in contexts with hierarchies that often impose treatments that, when thought about for oneself, make no sense, while when thought on an 'another', they become justified: 'We intubate, we put in catheters, we sedate, a series of things that, with the resources we have, the dispositions, when well used, serve a purpose, but sometimes we abuse that, and honestly, because of all this pandemic stuff, we ourselves wonder, come on, if it's necessary, do we stop? And I never had a clear decision about that' (ICU-S-M-001).

Strategies for coping

As mentioned above, paralysis is one possible way to respond to distressing situations. This leads healthcare personnel to state that it's good to 'not feel', seeking ways to reduce the patient to an object to thus modify intersubjective dynamics, allowing them to take action (Ramírez et al., 2023): 'If you let yourself be affected daily by this and don't establish a limit on it, it's very difficult to work, or at least that's what happened to me; it was like a kind of transferring the pain, or I don't know. So, I had to start defining the process in a simpler way, to think physio-pathologically about the situation, so that it wouldn't cause me so much pain, wouldn't affect my judgment, and in the way, I communicated with the family'. (G-R-F-001).

Within the coping strategies for distress, there are also forms of resistance that involve confronting the source of fear, mobilizing resources, or challenging opinions, depending on what is perceived as the source of the barrier. Some quotes show how acting in favor of what is considered right brings tranquility: 'Finally, the gentleman died about 3 hours after they were taken to a room, and when I saw that palliative care was able to see him and start end-of-life care, it gave me peace of mind because at least he could have adjustments made to his medications and interventions that could cause more suffering'. (Field journal G-R).

It is the action most coherent with the patient's well-being that brings tranquility, especially when it involves deciding to stop treatments and accept death as part of professional practice: 'When I'm sure that there's nothing else to do, I say: there comes a point where there's nothing else to do, and we're going to remove things and let the situation follow its course and he's going to die. And I do this because I believe it's not right, when one has things very clear, to put stress on the family'. (ICU-S-M-001).

This capacity to act, participants say, especially medical personnel, is developed by analyzing all available scientific information, which would allow the specialist to decide. Fear, they indicate, becomes a driving force for action: 'That fear of making mistakes leads me to try to get information, finally, it's not going to give me a solution, but I'm going to approach it. As much as possible to a point where I will be able to make the decision. The best-informed decision, despite the fear'. (FG-HO-001).

Education on dying and death and decision-making

Upon investigating tools or prior education on the approach to death or distressing situations, participants agreed that training on the subject was scarce in their undergraduate and postgraduate processes. Most reported having their first experience with death with family or friends and then in the hospital without any preparation or support. Some reported participating in workshops on delivering bad news without considering that these resolved the emotional, conflicting, or relational aspects of the topic.

'In no way [responding if they had training on the subject], and on many other topics as well, but how to face a death process, how to process information, it was not something purely academic; everything went to the patient's assessment, but never an approach on how one should handle the patient's death, the family, how you feel about the patient's death, and well, at that moment it was seeing a person die; I mean, when in life had I seen someone die? I came in very young, and no, that was horrible; they didn't prepare me'. (G-R-F-001)

In most participants, knowledge and study were highlighted as a strategy that alleviates distress: 'Because for that, I said well, this won't happen to me

again, I have to train myself so that these things don't happen to me again, because the fear of the unknown is quite difficult to face, because you don't know what to do'. (ICU-Fw-M-001).

However, in the mixed focus group, difficulties in communication between healthcare and non-medical personnel were highlighted. Especially due to the use of various logics, expert language, and medical knowledge versus the emotional experience of family members and caregivers. Explaining an end-of-life situation, explaining the consequences of starting or ending a treatment, as well as projecting the quality of life in an imaginary situation was challenging for healthcare personnel and was resolved by redirecting attention and seeking support and validation from the participant with higher rank. However, the difficulty was not in the expert use of terms, but in the ability to connect with the experiences of family members and patients and delve into the necessary information to understand the situation.

None of the participants reported formal learning for addressing their affective world, their emotions, or DM, except for the containment of emotions and the negative judgment of any emotional expression.

Discussion

DM, as a category, has mainly developed in the 20th and 21st centuries, gaining relevance globally during the COVID-19 pandemic. Discussions around the term in health contexts have revolved around the lack of a solid theoretical understanding, its transdisciplinary nature that complicates the precise definition of the object of analysis, translation problems into different languages, and particularly its empirical basis, which some consider limited. It emerged as a necessity to describe and understand the experiences of nursing students in clinical contexts, with Jameton being the first to use it. Despite its relevance, there are conceptual and methodological challenges that require critical attention in future research (McCarthy, 2020).

After analyzing and coding the information, MD is revealed as a diffuse object of research and difficult to code. This characteristic is related to the multiple disciplinary approaches, the difficulty of participants to name their experiences, and the complexity in naming the relational, power-related, as well as emotional, bodily, cultural and spiritual dimensions of them.

Another source of discussion in the field has to do with the very definition of MD proposed by Jameton (1984) in which the presence of external factors or barriers that go against the individual's values is indicated as essential for its appearance, in a causality model (Morley et al., 2019). From the presented results, external factors affect individuals, whose response is linked to individual conditions and capabilities, as well as their place and role in the organization or healthcare system. Previous literature indicates that experienced and qualified physicians

experience less MD than nursing staff (Dodek et al., 2016). In this study, MD is particularly linked to medical specialty residents and nursing staff. When MD arises, it is related to uncertainty and discomfort, responses to potential errors, difficulty in making decisions, or not achieving specific goals, such as curing or resolving the patient's illness. This possibility of error is associated with lack of experience in situations where the future is uncertain and when there is no information to address or control the situation.

The debate around MD as a concept revolves around whether individual, structural, or institutional conditions generate it. Interpretative critical theory suggests the convergence of these levels (Scheper-Hughes & Lock, 1987). MD is the result of their personal experiences, which are in turn relational with their family, society, university education, place of origin, gender, generation, specialty pursued, the institution where they work, and all of this framed within healthcare systems. In the literature, the use of the term tends to consider it an individual psychological matter rather than a complex, social phenomenon specific to contexts, a perspective that this work aims to address.

This study identified that different specialties shape distressing experiences differently, and it is the difference in treatment goals, principles, the lack of dialogic scenarios, as well as the lack of adequate infrastructure and resources that generate them. As noted by the participants, communication between health care professionals and patients can be further complicated not only by the quality of the news, but by physical variables such as lack of private scenarios, lack of hearing devices, complex power relations, all of which should be addressed to avoid making communication even more difficult.

It is noteworthy that, even though the hospital has social workers, the participants did not mention them as central figures in patient care or family support at the end of life. A review is needed regarding the necessary and ideal team for this moment (Daly & Matzel, 2013).

Recommendations of specific training programs that prepare healthcare personnel to handle these complex situations with greater empathy and ethics will depend on the tools and capacities available at the training scenarios. There is a range of specific training programs identified, that go from creative work with art and humanities (Song et al., 2023) through more reflective ways to raise awareness such as simulation (Lippe et al., 2020), empathy programs (Charon, 2017) to elective courses (Park, 2020) or more behavioral proposals that suggest following steps to change behavior such as Spyke model (Baile et al., 1999; Herrera et al., 2014). However, training programs must be based on contextual and a relational analysis, recognizing MD as a structural problem, especially in medical education, and not only an individual deficiency.

While medical education has emphasized communication in difficult situations and bioethical dilemmas, literature begins to point out 'moral

courage' (SaldíSaldíAs-Fernández, 2022) as a capacity to be taught and developed by healthcare personnel as a strategy to face MD. Undoubtedly, this raises a critical and reflexive view on power relations within a highly hierarchical institution such as the hospital, and on the development of agency as a desirable competence within the healthcare team. Health institutions must develop multi-level organizational interventions, and efforts aimed at alleviating MD ought to focus on interventions at the team and systemic levels, aiming to enhance interprofessional collaboration and uphold the ethical principles and moral obligations of healthcare professionals (Vincent et al., 2020). Further research should address this implementation.

Although having common references for a good death can help in the continuity and coherence in end-of-life care plans, healthcare personnel can learn and develop strategies to handle uncertainty and identify different perspectives in these scenarios. The literature describes questioning of one's own ideals, both in favor of patient autonomy, as well as critically and positionally towards one's own work team, institutions, and the healthcare system, as well as the depersonalization or disengagement of the medical 'self' to transform communication (Castro-Frenzel, 2022; Kay et al., 2008).

It is important to recognize the link between the cultural milieu in which health care professionals are embedded and the experience of MD. In this research we found that it is necessary to understand particular ways in which different actors interact, considering different meanings, roles and power relations between them.

It is also important to understand Colombia´s long standing relationship with violence, which has permeated its social dynamics, and needs to be addressed to understand why health personal act as they do. A social complex perspective has to be incorporated to the MD studies in order to design interventions that address this issue in a culturally appropriate way, unmasking stereotyped views not only about older persons, but also medical specialties and roles within high complexity hospitals. MD seems to be one of the blind spots (Berlinger & Berlinger, 2017) that needs to be addressed not only in terms of spaces for reflection and emotional support, but also in terms of inequities between disciplines, and forces beyond the realm of individual action.

Conclusions

Both the previous theoretical framework and the results regarding MD show us a phenomenon addressed from different disciplines, focusing on specific aspects of the problem, without there being a consolidation of the theoretical model. A transdisciplinary and comprehensive approach to the phenomenon is necessary, addressing lived reality rather than segments of it.

In this case, emphasis is placed on how participants organize and conceive their own world, and future qualitative research is invited to collect experiences within highly hierarchical hospital institutions, determined by logics specific to healthcare systems, that lead to situations in where conflicting perspectives, if not recognized and addressed, directly impact patient goals of care and wellbeing.

The world of emotions, feelings, and interpretations of medical personnel must be considered as complex, interconnected with their social, family life, as well as previous experiences and institutional dynamics and healthcare systems. From previous approaches and articles, it is emphasized that, in general, definitions of MD do not consider structural forces such as violence directed at healthcare personnel and that, for the Colombian case, it modulates the actions of healthcare personnel in specific scenarios, not necessarily related to the institution where this work was carried out.

MD, from its critical perspective, gives attention to external and structural forces of healthcare systems and institutions rather than individualistic perspective, and this would broaden the possibility of a comprehensive understanding of a complex phenomenon that needs to consider certain cultural and social variables to address it and would better facilitate the implementation of feasible frameworks to engage it, avoiding the pitfall of using a 'one-size-fit-all' strategy or training programs.

Delving deeper into it also calls on institutions to consider alternatives for the mental health of their medical team that go beyond individual interventions and have the potential to improve relationships among all actors, including the design and management of suitable spaces for intimacy and communication, available time for deepening relationships both with patients and colleagues, spaces for the elaboration of the healthcare personnel's affective world as a group, and review of power relations between specialties, ranks, and roles.

Methodologically, addressing MD presents challenges, as qualitative tools such as interviews and focus groups only offer a retrospective approach to participants' experiences and interpretations of events lived. Given the qualitative nature and small sampling, the results are limited to specific scenarios and groups studied. Future research exploring gender, ageism, processes of racialization, ethnicity, and socioeconomic status is encouraged to deepen power relations and hierarchies that generate MD. Since the study was conducted in Spanish, the results are confined to the understanding that this language has of these category. The inquiry into MD among healthcare personnel in managerial roles and other actors such as social workers and the potential inter- or transdisciplinary discussion with professionals in philosophy or psychoanalysis, disciplines with greater theoretical development, remained pending.

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Disclosure statement

Within the team, there were a nephrologist and two geriatric residents who were affiliated with the hospital where this study was conducted. This may constitute a conflict of interest. As the qualitative research underwent rigorous tracking, information triangulation, and reflexional processes, this position is acknowledged within the article and is assumed as the starting point for understanding the realities experienced by healthcare personnel within the hospital.

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Data availability statement

The data that support the findings of this study are available on request from the corresponding author, Ana María Medina. The data are not publicly available due to their containing information that could compromise the privacy of research participants.

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Appendix 1. Script used in the semi-structured interviews

Protocol: Non-beneficial treatments (NBT), moral distress (MD), and a good dying (GD): Qualitative approaches to the care of older adults in critical condition or with a chronic illness in the final stage in a hospital in the city of Bogotá.

Script for semi-structured health personnel interview

Date: _____

Interviewee: _____

Interviewers: _____

Contact information to be provided (phone or email): _____

Profile: (Specify role, function, or position) _____

Gender: _____

Education: _____

Interview context: (How it was arranged, where it takes place, who is present, etc.)

_____

Interview duration: _____

Recorded YES___ NO___ Audio available at: _____

Instructions specifically underlined for exclusive reading by the interviewer. In black, the suggested text for the conversation.

Initial greetings: Politely greet the person, introduce the two interviewers, ask how they are, inquire about recent events, (develop customary questions or polite inquiries to lighten the mood).

Project presentation: Explain the project to the interviewee and inform them (if applicable) of the reason for conducting the interview.

Informed consent (Read the document, have it on hand, and request permission to record):

Consent: Habeas Data Authorization: In compliance with the provisions of Law 1581 of 2012 and Regulatory Decree 1377 of 2013, which develop the right to habeas data, we request your authorization for the organizing professor (xxxxxx) and the student researchers acting as Data Processing Controllers to collect, store, use, and consult your contact information in order to present results of this project or delve into certain aspects of the interview.

Topic	Macro Questions	Subsequent Questions
1	If I mention the word death, what comes to your mind, what image comes to your head?	How has this idea changed over time? How was your thinking before your career, during undergraduate studies, and now in postgraduate studies? How has your relationship with death changed over time?
	How do you imagine a good or appropriate end of life? How do you imagine a good death?	Is this imagination different from what you had in undergraduate studies? What has influenced this change? Could you tell me a bit about these influences?

(*Continued*)

Topic	Macro Questions	Subsequent Questions
3	What significant experiences or important cases have you had related to death in your personal life, undergraduate studies, or postgraduate studies?	Go deeper into those related to Non-Beneficial Treatments (NBT), Good Death (GD), Moral Distress (MD), or Ethical Dilemmas (ED) in older adults, or by contrast: You mentioned X case. If the patient were an older person, would it be different?
4	If not mentioned in 3: Have you had any significant experiences that made you question a good death, therapeutic futility, or that caused distress?	What did you know about a good death at those times? What would you have liked to know? You mentioned X case. If the patient were an older person, would it be different?
5	In medical work, it happens that one is not always in agreement with the decisions or actions taken, have you ever had a negative experience related to the treatment of an old/older patient with which you disagreed or thought it should have been different? Could you tell me about the situation?	How would you have liked it to be? How did you feel? What thoughts, emotions, or feelings did that situation generate? How did you deal with that experience? What would you have liked to do? What prevented or hindered you?
6	Returning to end-of-life processes, what is the most challenging aspect of these scenarios in your work?	What feels impossible to do in end-of-life scenarios? What do you think hinders the process? What do you think could be done differently in these cases? If the patient is old or an older person, does this vary?
7	We are approaching the end of the interview; I would like to hear your general opinions about the interview, your successful approaches to the topic, things that make you consider the results as failures, aspects to improve for future interviews, and any other matters that concern you.	
8	Would it be possible for us to contact you again to delve into some aspect of the interview, invite you to participate in a focus group, or in workshops on narratives and writing on the topic? Are you interested?	

Appendix 2. Coding Categories

Category of Interest	Primary Category	Secondary Category
Knowledge	Knowledge of death	Relational/communication knowledge
		Biomedical knowledge
		Beliefs Sociocultural knowledge
	Training experiences with death	Training trajectory
		Hidden curriculum
		Life trajectory (pre-university, undergraduate, postgraduate, professional)
		Individual barriers
		Paralysis
Attitudes	Moral distress	Values/principles
		Inability to act
		Pain/suffering
		Attitudes towards a good death
	Attitudes towards death	Denial/acceptance
		Emotion/feeling
		Good dying
		Communication
		Barriers/structural barriers/social barriers/ institutional barriers
		Patient autonomy
		Family
Practices	Dying process	Illness
		Dignity
		Symptoms
		Non-beneficial treatments
		Non-beneficial care
		Moral distress in the care of patients
	Treatments and care	Medicalization of death/hospitalization/discharge/ death at home
		Practices/family practices/healthcare personal practices
	Death practices	

Taken from: Mejía-Grueso A, Medina Ch A, Giraldo CI. Social representations of good dying in the context of hospital care for older adults in critical condition or with a chronic illness in the final stage at a hospital in the city of Bogotá [Internet]. Pontifical Universidad Javeriana; 2023. Available from: http://hdl.handle.net/10554/65951

Appendix 3. Focus group guide

(1) Protocol presentation and consent form signing.
(2) Mention/write 3/5 words you associate with the words: death/dying/mourning.
(3) Each participant receives a printed case.
(4) A time for individual reading and reflection is allowed on the following questions:
    (a) Regarding these cases, do you consider the management was appropriate?
    (b) What knowledge about end-of-life or the dying process would be required for good care?
    (c) Where and how is or was this information obtained?
    (d) What emotions do these cases evoke for you? If known, how did you feel about them?
    (e) What is the most difficult or impossible to handle in these cases? (Where you in agreement with the management?)
    (f) How would you envision a good ending for this case?
(5) Group discussion.
(6) Thanks to participants and closure.