Journal of Posthumanism
2024
Volume: 4, No: 2, pp. 231–238
ISSN: 2634-3576 (Print) | ISSN 2634-3584 (Online)
posthumanism.co.uk

DOI: https://doi.org/10.63332/joph.v4i2.3060

Ethical Conflicts Between Healthcare Providers and Institutional Policies

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Abstract

Recently, ethical conflicts between healthcare providers and institutional policies have been encountered in various healthcare settings. These conflicts occur at different levels in healthcare teams including nurses and physicians. Multiple previous studies have reported various themes of ethical conflicts experienced by nurses and physicians due to institutional policies such as workload that can impact safety and/or quality of patient care, constraints on healthcare funding, and lack of resources. Moral distress can be the result of these conflicts; moral distress is defined as the condition that occurs when a healthcare provider experiences a conflict between what they see as the right thing to do and external obstacles, most commonly institutional policies. Moral distress is prevalent among healthcare providers, leading to significant psychological, physical, and professional consequences. However, due to the busy schedules of healthcare providers and the chaotic realm of hospitals, identifying, assessing, and resolving moral distress and conflicts between healthcare providers and institutional policies remain challenging. Thus, this review aims to discuss the current evidence investigating ethical conflicts between healthcare providers and institutional policies. Physicians identified the insufficient resources and lack or preventive focus as a source of ethical conflict with the institution. While nurses spoke about how inadequate staff-to-patient ratios and workload are major sources for ethical conflicts. Future research should prioritize institution-level interventions over individual strategies, particularly those that empower early-career professionals and promote ethically aligned practice environments.

Keywords: *Ethical Conflicts, Healthcare Providers, Institutional Policies, Moral Distress, Physicians, Nurses.*

Introduction

Moral distress is the condition that occurs when a healthcare provider experiences a conflict between what they see as the right thing to do and external obstacles (1). Moral distress can also be described as a psychological conflict that arises when healthcare professionals recognize the ethically appropriate course of action but are unable to carry it out due to external barriers, such as institutional policies, power dynamics, legal restrictions, or resource limitations (2). Ethical conflict between healthcare providers and institutional policies is one of the most common

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causes of moral distress among healthcare providers.

Since healthcare providers have responsibilities for both the institution where they work and their professional association, they are exposed to ethical conflicts when their personal and professional values conflict with institutional policies (3). Various themes of ethical conflicts between both nurses and physicians and their institutional policies have been noted. Nurses spoke about workload that can impact safety and/or quality of patient care, ineffective or inappropriate actions taken by the institution, and lack of valuing human resources shown by management (4).

Physicians also experience ethical conflicts due to institutional policies such as constraints on healthcare funding and resource shortages (3). The constraints on healthcare funding put physicians in a conflict between patient advocacy and bedside rationing (5), where they have to make decisions, such as rationing intensive care unit resources, in spite of the wishes of patients or their families (6). Furthermore, physicians and nurses may experience moral distress due to end-of-life care and patient autonomy policies.

Moral distress can result in various side effects, such as the desire to leave a position, compassion fatigue, and burnout (7, 8). It also may lead to reduced self-esteem, work-related stress, physical adverse effects including fatigue, headaches, or loss of appetite (9, 10), and negative emotions, such as sadness, anxiety, fear, or frustration (2, 10-13). These adverse effects are the result of the often distressing and unpredictable work conditions in hospitals. On the other hand, moral distress might result in positive outcomes, including improved self-reflection, a stronger sense of responsibility for patients, and professional growth (14).

Ethical conflicts between healthcare providers and institutional policies, as well as moral distress, were first explored in critical care nurses (15), but recently multiple efforts have been exerted to identify moral distress across other healthcare professions and settings, including nurses, physicians, and care leaders (10, 16, 17). However, due to the busy schedules of healthcare providers and the chaotic realm of hospitals, identifying, assessing, and resolving moral distress and conflicts between healthcare providers and institutional policies remain challenging. The aim of this review is to discuss the ethical conflicts between healthcare providers and institutional policies, highlighting current gaps in research.

Methods

Medline (PubMed), Scopus, and Web of Science were used in systematic research until April 3, 2025. To retrieve the synonyms of search strategy, the MeSH database was used. Boolean operators, according to the Cochrane Handbook for Systematic Reviews of Interventions, were used to combine search terms by (“AND” and “OR”) as follows: “Ethical Conflicts” AND “Healthcare Providers” AND “Institutional Policies.” Summaries and duplicates of the found studies were exported and removed by EndNoteX8. Any study that discusses ethical conflicts between healthcare providers and institutional policies as well as moral distress among healthcare providers and is published in peer-reviewed journals was included. All languages are included. Full-text articles, case series, and abstracts with the related topics are included. Case reports, comments, animal studies, and letters were excluded.

Discussion

Ethical Conflicts between Physicians and Institutional Policies

Healthcare providers consistently spoke about various institutional policies that they did not

agree with but were expected to follow. Although they could occasionally ignore the policy, the presence of a policy that disagreed with their values remained a source of ethical conflict (3).

Physicians identified the insufficient resources as a source of ethical conflict with the institution. The scarcity of resources was considered as leading to negative impacts on the quality of work life and the quality and safety of patient care. Physicians reported that institutions focusing on hiring casual staff resulted in high turnover and made it harder to plan programs. They also mentioned that hospitals were operating as a business instead of providing the best required type of care for patients (3).

In addition, physicians reported an important ethical issue, which is lack of preventive focus associated with hospital practices, staff, and patients. For instance, a physician reported that a patient needed to be monitored for an anticipated deterioration; however, the physician was asked to transfer the patient to the ICU only if his condition did deteriorate. Another observed instance of a lack of preventive focus linked to hospital policies is that the institution valued curative care as opposed to preventive care (3).

Stulberg et al. explored ethical conflicts between physicians and institutions associated with religiously based patient care policies (18). They reported that half of primary care physicians had worked in religiously affiliated hospitals or practices. They also found that about one in five of these physicians experienced conflict with institutional religious policies (18). However, religious characteristics of physicians were not associated with whether they had worked in such institutions. Notably, physicians who never worked for religious institutions and younger physicians were more likely to report conflict (18). Furthermore, physicians may refer patients to other hospitals due to institutional religious policies, which may lead to delays in patient care, especially for time-sensitive interventions such as emergency contraception (19). These delays may be viewed differently depending on individual beliefs about the interventions themselves.

Recently, various solutions to mitigate these religious conflicts have been suggested, such as hospital administrators should involve physicians in policy-making, create systems for addressing physician concerns, and improve communication about institutional policies (20). On the other hand, physicians should inform patients about religious policies when non-urgent admissions permit.

Moral distress among Physicians

Physicians frequently experience moral distress during their work. However, it was suggested that physicians' concepts of moral distress may extend beyond Jameton's notion of psychological distress resulting from being in a situation in which one is constrained from acting on what one knows to be right (1). A recent systematic scoping review showed that moral distress in physicians also includes community and institutional factors, environmental factors, contextual factors, cultural factors, practice, quality of care, resource limitations and allocations, and ethical dilemmas (17). Furthermore, there are several personal factors that affect moral distress, most importantly existential beliefs (21), powerlessness and 'attacks' on integrity (22), professional codes (23), and personal values (24). Other factors, including gender, principles, specialty, beliefs and values, circumstances, experiences, and the availability of support strategies, may also affect perceptions and responses to moral distress (1, 17, 23-27). These personal and situational constructs may explain variations in the nature, intensity, duration, and onset of emotions such as anger, frustration, sadness, depression, and guilt (17, 21, 22, 27, 28). Some reports also indicate the presence of distress even when the right action is taken (22, 25,

29).

These insights suggest a more clinically relevant, evidence-based definition that defines moral distress among physicians, which is 'cognitive, existential, and/or emotional distress that arises with recognition that patient care may or has been compromised, and that sources of moral distress surpass institutional limitations and comprise conflict between a physician's principles, beliefs, and/or values and administrative, research, and clinical practices that threaten their identity and self-concepts of personhood' (17). Additionally, these insights demonstrate that moral distress among physicians is informed by emotional states, individual narratives, coping abilities, personal characteristics, and reflections, as well as psychosocial, relational, societal, financial, and contextual considerations and circumstances (17).

Ethical Conflicts between Nurses and Institutional Policies

Various themes of ethical conflicts between nurses and institutional policies have been reported by previous studies, such as lack of respect for professionals, insufficient resources that affect work life and patient care, disagreeing with institutional policies, administration turning a blind eye, and lack of transparency of the institution (3). Nurses have regularly mentioned that institutions do not show enough respect for their profession and for them as individuals. Their feeling of not being respected hinders them from feeling connected to the institution. Furthermore, nurses complained about how institutions do not act on requests for change from nurses, while administrators tend to act on requests from physicians (3).

Nurses also spoke about the institutions neglecting to invest in their development by providing education or career opportunities. The insufficiency in staff that can care for their patients hinders them from leaving to have time during their workday to attend in-services (3). Additionally, nurses think they should receive financial support to attend conferences outside their cities, to be able to attend all day workshops and university courses, and to get chances to grow within their profession by being promoted to other positions. The nurses see themselves as professionals deserving of ongoing opportunities for growth but feel the institution perceives them primarily as task-oriented workers, instrumental in maintaining the continuous flow of patients through the system, which is described as unethical by nurses (3).

"Workload" is one of the most frequent ethical conflicts experienced by nurses due to institutional policies (30). It is linked to staffing numbers that have been reported as a major concern for the institutional ethical climate (31). Furthermore, quantitative research showed that moral distress among nurses was most highly correlated to nurses' perceptions of unsafe staffing (2). It was also noted that staffing and workload problems affected nurses' intention to stay in their jobs, as these aspects of their work are linked to ethical climate (32).

Inadequate staff-to-patient ratios, along with high patient acuity and intensive technology use, have been linked to increased moral distress among healthcare providers (33). Nurses emphasized the importance of sufficient staffing, noting that it would enable them not only to deliver quality care but also to process the moral distress they experience (31). The availability of other essential resources such as time and hospital beds also plays a critical role. Ethical conflicts can emerge when institutional policies lean heavily toward efficiency, cost containment, and economic goals at the expense of addressing patient needs (2, 13, 34).

Moral Distress Among Nurses

Over the last four decades, moral distress has been considered a crucial topic in nursing studies.

Nurses frequently experience moral distress in different healthcare settings while delivering patient care (35). Recently, multiple studies have explored the frequency and severity of moral distress among nurses in different healthcare settings. According to these studies, moral distress levels can be classified into various categories depending on scoring scales (2, 36). Notably, studies found that moral distress remains at a moderate level (37, 38). In some situations, nurses may realize the ethical course of action; however, it conflicts with the institutional policies or with colleagues' personal values, leading to moral distress and psychological imbalance (39, 40). Furthermore, moral distress can result in nurses' professional independence challenges (41), reduced job satisfaction (42), and job burnout (43). It was observed that nurses who experience moral distress are more prone to quit their jobs compared to those who do not (44).

In order to mitigate moral distress among nurses, they should be ethically oriented through balancing personal ethical values with institutional ethics (45). Further preventive factors can be implemented, such as clearly defined job roles, professional independence, and managerial support (38). In addition, to addressing moral distress, nurses should find their voice in safe spaces, such as ethics committees and consultations with trained ethicists (46).

Various interventions were introduced at the institutional level to improve moral distress in nurses. The American Association of Critical Care Nurses (AACN) created the 4 A's approach—ASK (identify distress), AFFIRM (recognize moral integrity concerns), ASSESS (determine the right action), and ACT (develop and implement an action plan) (46). Institutional policies should encourage transparent hospital administration, shift management, and continuous ethical education to support nurses' well-being and ethical decision-making. Additionally, interventions including professional ethics training, structured rest periods, and hospital ethics consultations are recommended for improving nursing satisfaction and community health (38, 46).

Future Research and Current Gaps

For years, ethical conflicts in healthcare institutions have been addressed through individual approaches, putting the burden of resolving ethical conflicts and moral distress on the individual provider (47). However, it has been noted that moral distress is significantly related to the ethical climate of institutions, leading to a more focus on systemic and institutional factors (48). Although individual factors remain critical, it is equally critical to evaluate institutional policies that either hinder or enable ethical practice, especially in settings where economic concerns take priority over well-being (49).

A positive ethical climate can mitigate moral distress and ethical conflicts among healthcare providers and support ethical behavior (49). Thus, assessing institutional policies and structures is essential to comprehend and reduce moral distress (30, 47, 48). Approaches on the institutional level can detect systemic problems and result in meaningful improvements (50). Institutional-level research is still lacking, especially in investigating experiences among various healthcare professionals, understanding the role of policies, and evaluating interventions (51).

Additionally, ethical leaders should implement mechanisms such as debriefings and protocols, acknowledge moral distress, support professional practice, and encourage dialogue (34, 52). The ethics committees at hospitals also can play a role in encouraging institutional change by addressing values and ensuring they are implemented in daily decision-making (50, 52). Building an ethically supportive institution is challenging but achievable with consistent leadership and resource commitment (31, 52).

Conclusion

Ethical conflicts between healthcare providers and institutional policies are a prevalent source of moral distress, affecting both physicians and nurses across various clinical settings. These conflicts occur due to discrepancies between professional and/or personal values and institutional requirements, which can be exacerbated by a lack of resources and administrative priorities. While moral distress can have negative effects on the well-being and job satisfaction of healthcare providers, it also offers opportunities for professional growth and ethical reflection. In order to mitigate these conflicts, a shift from individual-level strategies to institutional and systemic approaches that foster supportive ethical climates should be done. Future research should prioritize institution-level interventions, particularly those that empower early-career professionals and promote ethically aligned practice environments.

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