ACADEMIC MEDICINE
Journal of the Association of American Medical Colleges

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DOI: 10.1097/ACM.0000000000005817

Academic Medicine
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A Phenomenological Exploration of Physicians' Moral Distress: Situating Emotion Within Lived Experiences

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Funding/Support: None reported.

Other disclosures: None reported.

Ethical approval: The study protocol was approved by the University of British Columbia's Behavioral Research Ethics Board (July 22, 2022, #H22-01334).

Previous presentations: This research was presented at the Centre for Health Education Scholarship's annual Celebration of Scholarship; October 3, 2023; Vancouver, British Columbia, Canada.

Abstract

Purpose

Physicians often experience moral distress from being prevented from taking what they believe to be the right course of action. Although causes and consequences of moral distress have been studied, little research offers insight into the significance of feeling morally challenged, especially in medicine. This study was undertaken to advance understanding of what physicians experience when encountering morally challenging situations and to examine how those experiences influence their interactions with the world of health care.

Method

Guided by hermeneutic phenomenology, the authors conducted semistructured interviews with purposefully sampled Canadian physicians from September 2022 to January 2023. Analysis used Van Manen's 6 activities of hermeneutic research and included "story crafting" to sharpen insights. Late in that process, Van Manen's "lived existentials" was determined to provide a strong framework for physicians' experiences of moral distress.

Results

Of the 12 physicians interviewed, all experienced varied and long-lasting emotional reactions to morally challenging experiences. The emotions associated with moral distress, reported as inevitable, were experienced in ways that aligned with the lived existentials of body, space, time, and relations.

Conclusions

A richer understanding of physicians' lived experiences with moral distress can help mentors and educators more thoughtfully engage in conversations about it with colleagues and learners. This study highlights the core dimensions of moral distress through body, space, time, and relations, thereby providing a means to enrich discussion about emotions and their transformational power. Through such nuanced consideration, calls for emotional candor may be strengthened to enhance practice by acknowledging the scope of impact that efforts to deliver care are likely to provoke.

Medicine is reputed for having a culture of professional alexithymia, one that "address[es] the emotional realm through ignoring, detaching from, and distancing from emotions."[1(p 326)] We use the word *culture* because this tradition gets passed, deliberately or otherwise, from generation to generation, both explicitly and implicitly, to the point that learners have reported feeling compelled to actively suppress emotions provoked by clinical encounters.[2] This culture has begun to change, with authors in recent years advocating for emotional candor as a means of helping learners and practitioners navigate highly challenging situations that can be damaging.[3] Negative consequences of not acknowledging emotions include both psychological (e.g., depression, anxiety) and physical (e.g., fatigue, insomnia) issues,[4] which can lead students and physicians to question their career choice, experience reduced job satisfaction, or quit the profession altogether.[5,6] During this time of heightened burnout and workforce attrition, we can ill-afford to continue losing practitioners because they care in a way they perceive to be disavowed by the profession.

As medical educators have begun to seek deeper understanding of the effect of emotions, whether positive or negative,[7-9] emphasis within the field has tended to be placed on 3 distinct discourses. According to McNaughton,[10] emotion is usually spoken of physiologically, as a competence, or sociopolitically. How a field talks about a concept such as emotions both represents and influences the lived reality of individuals, making it noteworthy that research into emotion across all 3 discourses tends to focus on cause and effect, generating theory about how to define emotion or how to solve emotional reactions, with considerably less emphasis on the personal meaning and social significance of the provoking experience. It is critical that we

fill that gap if we are to optimize the benefits of emotional reactions rather than simply seeking ways to minimize or overcome their hurt. Consider, for example, the concept and study of moral distress.

Coined by Jameton,[11] the term *moral distress* is the emotional reaction that occurs when an individual is challenged by knowing the right thing to do without being able to act in that way. Various explanations have been offered for moral distress,[6] but the research in medicine again tends to focus on cause and effect.[12] For example, the literature review by Kherbache et al[5] summarizes causes (e.g., system-related factors, professional disagreements), consequences (e.g., psychological, physical, and professional impacts), and ethical principles that physicians use to navigate morally challenging situations. Such research has led to the development of various models that outline processes of moral distress from cause to finish,[13,14] but little has been done to understand the significance of feeling morally challenged, especially in medicine.[15] That is a substantial oversight because, as Sartre[16] has noted, becoming emotional transforms one's relationship with, and awareness of, the world around them, fundamentally changing responses to it.

To understand how to help physicians and learners navigate their emotional reactions, enabling psychological well-being and an adequate workforce, we need stronger first-person accounts of lived experiences in which emotion reflects more than fleeting mental states. Frustration, for example, can be lasting, but it also ebbs and flows and affects individuals' interactions with their world in ways that do not always yield negative outcomes, such as resignation. Such

accounts would provide a better understanding of individuals' lived experiences, which could enable better knowledge of when and why emotions have their impact, thus providing better guidance for educators and peers regarding how to effectively engage in emotional candor to support colleagues and, in turn, their patients. The purposes of this study, therefore, were to advance understanding of what physicians experience when encountering morally challenging situations and to examine how those experiences influence their interactions with the world of health care.

Method

Design

Semistructured interviews were completed with practicing physicians. In designing and focusing the study, we drew on hermeneutic phenomenology and its core concepts, such as treating the lived experience as an interpretive process.[17,18] Phenomenology has a rich history within studies of the nature and function of emotions, dating back at least 80 years.[16,19] Phenomenologists prioritize first-person perspectives to understand lived experiences of phenomena such as emotions, including how they are felt, while considering one's position within social groups and the world more generally.[20,21] The University of British Columbia's Behavioral Research Ethics Board approved this study.

Study setting and participant recruitment

The study was conducted in British Columbia, Canada. Using snowball and purposeful sampling, we identified prospective participants through professional contacts and advertised the study

through local medical association newsletters. We sought physicians from various career stages, disciplines, and practice settings to capture the abstractness, richness, relatedness, and depth of our phenomenon of interest (Table 1).[18]

Data collection

An interview guide was generated iteratively, and data were collected from September 2022 to January 2023 using Zoom (Zoom Video Communications Inc.). D.C.C. conducted the interviews, each of which lasted 45 to 60 minutes. Participants were asked to share a morally challenging experience they had had during clinical practice while providing as much descriptive detail as possible. Throughout the conversation, we probed for additional information, including anonymized patient details, where and when the experience took place, who was involved, and, most extensively, what the participant felt in response to the experience. Audio recordings were transcribed and anonymized.

Data analysis

Data were collected and analyzed concurrently with these efforts in a manner informed by Van Manen's[22] 6 research activities for hermeneutic phenomenology (Table 2). To help us move between the parts (codes) and the whole (stories), we also incorporated story crafting.[23] That is, extraneous details were removed from transcripts so they could be re-read with a sharpened focus. Doing so facilitated insights into what lies in, between, and beyond the words offered by participants, extracting a richer understanding of what physicians experience when

encountering morally challenging situations (Box 1). By removing verbal tics and tangential statements from the interviews, we were better able to focus attention more clearly on the core of the stories our participants told, making their tales resonate more powerfully.

All team members met regularly, and an audit trail was maintained throughout the study. Late in our analysis, Van Manen's[22] notion of "lived existentials"—core dimensions of human experience, including body, space, time, and relations (as defined below)—became a particularly useful organizing framework.

Reflexivity

In hermeneutic phenomenology, the researcher's subjectivity is integral to the interpretative process.[24] Therefore, our research team paid particular attention to our own lived experiences. To help with that, D.C.C. and M.K., the clinician authors, reflected on their preconceived notions by crafting stories about a morally distressing experience of their own before interview development. Furthermore, memoing after each interview ensured that live-time thoughts enriched our later reflection, discussion, and writing. Recognizing that the experiences shared by participants were very personal, we did not want to reflect individuals simply with participant numbers. Therefore, when they are quoted, we use pseudonyms to honor the humanity in their stories while preserving their anonymity.

Results

Overview

Twelve physicians were interviewed before the investigators agreed that theoretical sufficiency had been achieved. Our findings demonstrate that morally challenging experiences elicited varied and long-lasting emotional reactions in physicians regardless of their career stage, discipline, or practice setting. The resulting moral distress generated much doubt and was often accompanied by physical reactions that were amplified when physicians felt blamed for their decisions by those around them. In any case, experiences of moral distress lived in participants in ways that influenced their sense-making and well-being for years or decades. Memories were often intrusive, leading physicians to relive the experience and its associated emotions while prompting them to seek consolation and meaning in numerous ways, including talking, reflecting, and counseling others. Van Manen's "lived existentials" (i.e., lived body, lived space, lived time, and lived relations) provided a valuable organizational framework,[22] as detailed below.

Experiencing moral distress: Lived body

Van Manen's existential notion of "lived body" refers to how experiences are felt, revealed, and concealed through our visceral reactions.[22] Box 1 contains an excerpt from the "story crafting" performed on Deborah's transcript that illustrates the applicability of the concept to the lived experiences our participants described. While worried about a patient's worsening symptoms, Deborah knew which investigation she needed, but she could not get it despite her best efforts. The distress evoked a highly emotional reaction that was lived through physical response. That

was common among participants, including Kathleen, who became tearful during the interview as she shared her difficulties admitting a patient due to bed shortages, resulting in an adverse clinical outcome: “I had this like emotional response, like a physical emotional response; you can see me, I get teary just thinking about it, about what I could have done differently for this patient.”

Daniel also recounted a challenging experience in which he had a visceral response of anger and distress when an elderly patient was severely ill and unconscious, likely due to COVID-19. Despite health risk to the patient and the health care workers, the patient’s family refused to wear a mask, denied the existence of the pandemic, and insisted on full intervention: “You can feel the tension, you can feel that your autonomic nervous system is in a particular way that isn’t exactly conducive at work.”

Experiencing moral distress: Lived space

“Lived space” refers to the way we feel and experience things through our physical environment, including divisions between public and private space and invasion of personal boundaries.[22] In this instance, the notion most strongly appeared in relation to participants’ descriptions of the health care system in which they were working. The “system” was rarely, if ever, defined yet it appeared to be omnipresent as a suppressing factor that led to much of the tension inherent in moral challenge. In fact, experiences of moral distress were starkly different when participants recounted a challenge brought about by a patient’s (or their family’s) desires relative to when they spoke about systemic barriers. The contrast is evident in the following

quotations. First, Rebecca illustrates sadness when she wanted to intervene to reduce a patient's suffering but faced opposing wishes from the patient's family: "Pretty terrible to watch and then feel so helpless as his physician and not being allowed to do something that I think would actually help him and that he was suffering unnecessarily. That was pretty hard." Second, Linda's comment, relating how the health system has deteriorated, brings to light feelings of loss and defeat:

> Our system is so broken, that those of us who are trying to deliver the kind of care that I delivered for the past 30 years is impossible.... And I think that we are in a crisis that no matter who you are … you're feeling demoralized, stressed, anxious and just not good about your chosen career anymore.

Deborah, alone, highlighted these contrasting reactions as she reflected on her experiences:

> So, when I see a person suffer, I feel pain and empathy for that person and sadness, but when I'm faced with a system failure, I feel more frustration and demoralization. I don't feel demoralized about an individual person, I feel pain or sadness.

Experiencing moral distress: Lived time

Most descriptions of distress contained a mixture of emotions, suggesting individualized responses that were dynamic. "Lived time" is subjective and describes how we experience the world temporally. In our data, lived time was presented both as changes in perspective and in

the long-lasting and recurring nature of many emotional experiences.[22] For example, with respect to the former, as Evelyn's perspective shifted, her emotions toward a patient evolved from heightened anxiety toward curiosity:

> It's kind of changed over time … before, anytime I needed to go talk with either parent, you would go in really anxious and kind of preparing yourself … often not really wanting to go, because you never knew what was going to happen…. And now I think I go in more with kind of curiosity … overall, kind of the anxiety and all of that has subsided somewhat … now I know what I can do and what I'm not in control of, so it's better.

With respect to lasting impact, the metaphor of "dwelling" came up repeatedly in our efforts to understand participants' stories as their descriptions suggested that morally challenging experiences lived inside them for a long time. That is, emotionally evocative experiences continued to influence their sense-making and well-being, as reminders often re-created emotional responses years or decades later. As Deborah said, "That case was years ago, and I still think about it. It was probably three or four years ago. So, it doesn't leave, eh; it still hurts to think about it." Steven said,

> I think just reliving those things it's—it brings back it's sort of emotion too, right? That you kind of feel that, what it felt like in those times, and now you kind of, you know, as a 25-year-old physician at the time, like, how did I actually get through it?

Highlighting the complexity of these experiences, the relationship between lived time and emotionality was not always clear-cut. Susan, in fact, reported continuing to feel emotional weight, evidenced by her becoming tearful, despite having adjusted her expectations over time:

> It's just same emotions, they're still there. I don't think emotions and feelings go away. I don't think it's something that you can, yeah make just leave. But I do think it's something that you recognize. Sometimes there are no answers in life. And sometimes you can only do your best.

Whatever one's experience or response, the feeling of inevitability expressed by our participants, treating morally challenging experiences as integral to what one must grapple with, fundamentally defined what it is to practice as a physician. Brian spoke to this sentiment: "It's not going to be an if, it'll be a when, as to when you're going to face moral dilemmas or issues."

Experiencing moral distress: Lived relations

Finally, although the focus of our study was on the lived experience of individual physicians, their descriptions of the distress arising from moral challenges illustrated these moments to be highly social. "Lived relations" refer to our interactions with others, and in this regard emotional experiences could be both prompted or modified by those around physicians.[22] Consider, for example, Nancy's feelings of resentment directed toward her colleague for changing the care plan she had spent a long time establishing with a patient:

> So, there's a certain amount of resentment that I'm doing the best I can and yet, I still have to trust the next person. And frustration that I know that [the colleague is] going to make their best choice and I need to trust that, right?

Steven also described empathy being directed toward a patient: "And part of that was being empathetic towards them. You know, having that little bit of physical contact, hand on the shoulder, and just saying, you know, I'm really, really sorry."

Emotional reactions could similarly be amplified by physicians feeling their colleagues' and patients' reactions to them. For example, when describing being questioned by others about a decision that required balancing what the patient wanted and what the system allowed, Brian felt blame and expressed indignation: "No matter how in the right you end up being found, it's still – you never want to have your care questioned. Especially when it's something you struggle with in the first place."

Kathleen similarly recounted a jarring reaction that amplified her distress and rumination when a patient complained following an adverse clinical outcome despite Kathleen believing she had done her best within the system's constraints: "I think because there's been subsequent review of this case, and I've had to think about it a lot, my moral feeling about it has amplified and my distress has amplified over time."

At the same time, lived relations were also a dominant means through which participants expressed attempting to find consolation and meaning from their experiences with morally challenging situations. That is, they talked with others, reflected on their roles, reactions, and capabilities, and used their experiences to teach and support others (Table 3).

Discussion

Berger[25] described moral distress as "a silent epidemic in medicine." In doing so, he argued that "medical educators have an enormous opportunity to impact training and life-long practice experiences by recognizing the ubiquity and impact of moral distress on medical students and residents."[25] That sense of inevitability was supported by our participants' descriptions of morally challenging encounters and the fundamental influence such experiences have had on their lives as physicians. By collecting first-person accounts, while adopting a phenomenological lens, our study moved beyond efforts to describe the causes and consequences of episodic emotional reactions toward acknowledging the significance and all-encompassing nature of feeling morally distressed. In doing so, these data reflect how emotionally evocative experiences are internalized while also highlighting how physicians' sense-making reflects the entangled nature of human existence.

Van Manen's[22] concept of lived existentials, core dimensions of human experience, helped us to see how moral distress was experienced through body, space, time, and relations. Emotions were embodied (e.g., through tears or feeling punched in the stomach) in a way that was intertwined with space (e.g., fundamentally influenced by perspectives on the health care

system); furthermore, the phenomenological perspective rendered visible how such embodied experiences evolved and dwelled in participants over time and how emotions were amplified (e.g., when questioned or seemingly blamed) or consoled (e.g., through collegial debriefing) dependent on one's social relations. By seeing how these core dimensions entangle with one another, it becomes possible to recognize how emotional experiences become deeply embodied in practitioners, fundamentally becoming part of their expectations for, and contributions to, health care.

By situating emotion as a lived experience, health professional educators can more carefully reason through the benefits and risks of engaging in, or encouraging a break from, the culture of professional alexithymia. Despite all our participants reinforcing long-reported perceptions that moral challenges are inevitable, it remains true that medical learners and professionals are not generally trained or supported to manage moral distress.[4,26,27] In describing their experiences, our participants put considerable emphasis on their lived relations in a way that highlights the value of debriefing with trusted colleagues. However, such interactions were not presented as a means to resolve (i.e., move on from) emotional experiences; rather, participants reflected a way of making sense of how they were changed by emotions that were expected to continue to dwell within them for long periods as well as what that meant for their evolving practice as a physician.

As a result, encouraging candor, "improvisational expression of doubts, thoughts, and problems with the dual purpose of learning and promoting others' learning,"[28] in relation to emotions

should not be considered a simple matter of recognizing the ubiquity of moral distress that is borne by those who provide health care. Instead, achieving the benefits that Berger[25] alluded to requires careful consideration of how emotions are fundamental to human experience, not just as "I" experiences but as "we" experiences in which body, space, and time interact with various relations. In other words, the lived experience of moral distress appears not simply to be felt by the physician in the way implied by most models of emotion, which are individualistic, but also as part of how the physician is embedded in the world, affecting "us" in the way "we" form a profession, in the way "we" interact with colleagues, and in the way "we" care for patients. Taking fuller account of one's existence as "lived" through multiple dimensions requires that calls for emotional candor recognize and treat emotional provocation as more than a reaction to a particular moment in time but also as an experience that has the potential to alter time, body, space, and relations.

Limitations

We did not purposefully sample demographic subgroups, which might experience moral distress differently, but our findings reinforce the value of considering the intersectionality that influences individuals in idiosyncratic ways. In addition, although we improved on much of the past work on emotions by drawing participants from a wide range of backgrounds, some of whom had practiced elsewhere, all participants currently worked within a single health care system. Given how perspectives on the system appeared to interact with lived experience, influential contextual factors warrant further study.

Conclusions

Moral distress is widely experienced in medicine. Our study highlighted the core dimensions of this experience through body, space, time, and relations. This more fulsome understanding of physicians' lived experiences can, when adequately supported, position mentors and educators to enrich conversations about moral distress and their transformational power with trusted colleagues and learners. By doing so, we hope emotional candor can be strengthened to enhance practice by acknowledging the scope of impact that efforts to deliver care are likely to provoke.

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Table 1
Characteristics of the Study Participants

Characteristic	No. of participants
Career stage	
Early (< 10 years)	3
Mid (10-20 years)	4
Late (> 20 years)	5
Discipline	
Medicine	3
Surgery	2
Family medicine	4
Other	3
Practice setting	
Urban	9
Rural	3

Table 2
Methodologic Examples of Van Manen's 6 Research Activities[22]

Activity	Example
Turning to a phenomenon that seriously interests us and commits us to the world	To begin interview guide creation, D.C.C. and M.K. reflected on and wrote stories about their own lived experiences of moral distress as physicians. These stories were then discussed, with further reflection taking place within the research team. The effort reinforced our deep interest in the topic and our belief in its importance.
Investigating experience as we live it rather than as we conceptualize it	During the interviews, D.C.C. explicitly asked participants to use as much descriptive detail as possible and used follow-up questions to refocus the conversation when needed. In our research team discussions, we paid attention to how we conceptualized participants' experiences by differentiating descriptions from explanations.
Reflecting on the essential themes that characterize the phenomenon	D.C.C. iteratively shared the interview transcripts with the research team. All team members reviewed the transcripts by focusing on how each participant described their lived experience. D.C.C. and K.W.E. coded each transcript iteratively, and D.C.C. synthesized all the codes and gathered them into overarching themes. Throughout the process, M.K. similarly offered her observations on each transcript and used her expertise in phenomenology to guide the research team. In doing so, we collectively achieved a consensus regarding aspects of the data that stood out as particularly powerful and informative. Later in our analysis, Van Manen's "lived existentials" provided a valuable organizational framework.
Describing the phenomenon through the art of writing and rewriting	D.C.C. drafted the initial findings and continued to rewrite it based on input from K.W.E. and M.K. The process helped the team distill and refine our understanding of the phenomenon.
Maintaining a strong relation to the phenomenon	D.C.C. analyzed the data based on the research purpose. Regular team discussions also ensured that the phenomenon of interest remained in focus.
Balancing the research context by considering parts and the whole.	D.C.C. incorporated story crafting (described below) and shared each story with the team for further discussion.

Table 3
Ways for Physicians to Find Consolation and Meaning When Dealing With Moral Distress[a]

Action	Example
Talk with others	Donald: "That will really decrease your risk of moral distress because you know when something difficult comes along you could just knock on your colleague's door and say have you got a minute, right?"
	Evelyn: "And we would make sure that we would then have a debrief session afterwards too, so we can support each other."
Reflect on their roles, reactions, and capabilities	Rebecca: "When my emotions are high, I know there's something—like that's a good time for me to take a step back and just think what's going on, why am I upset, why am I—you know, there are moments for reflection."
	Brian: "Probably just the time to reflect on it and the depth … actively digging into the emotions and the feelings associated with it as opposed to just the medical teaching aspects of it … it's more focusing my thoughts on the emotions and the feelings as opposed to the system issues."
Teach and support others	Deborah: "I use it for teaching. But I do use it to say, hey, here's a case that really impacted me, and I want to tell you the story, because I think that stories help with learning.
	Steven: If they're—you know, year 3, 4 as a clinical clerk, making sure that there is—they get exposed to that kind of experience. Not that they're going to be on their own with it, but just, you know, I'm going to send you in to see this patient and this may be an uncomfortable conversation, or we can do it together, or I can shadow you or—those are things that I think are, you know, will help shape those physicians in how they respond."

[a]Names are pseudonyms.

Box 1

Deborah's Experience of Moral Distress[a]

Because it was an unusual diagnosis, I spent a great deal of time taking a careful history and doing a very detailed physical examination, explaining my concerns to the family. I was worried about it, and I wanted them to be reassured that I was working on it very hard. That I kept failing, not getting attention [from consultants] for my concerns, was very distressing to me. I kept questioning my own judgement—everyone around me kept telling me I was wrong, not taking me seriously, not taking my concerns seriously as a professional. I wasn't able to advocate well for my patient.

Am I crazy? Why can't I get any traction with my concerns here? Am I wrong? Maybe I'm wrong. I must be wrong. I keep being told that I must be wrong over and over. But then, I went back and reassessed the patient multiple times. Her symptoms were progressing right in front of my eyes over four or five hours. I am powerless to stop this train that's heading in the wrong direction.

When I first heard the news, I felt gutted, just ugh, like somebody had punched me in the stomach sad. I found out the patient had the bad outcome. I was exceptionally distressed. I blamed myself for not trying harder. I spent a lot of time questioning myself afterwards. I was sad. But also mad. I told you so, I asked for your help, and you wouldn't help me and you wouldn't help my patient, and now look what happened.

These feelings come in stages. Frustration and then self-doubt and then more frustration and then sadness and then anger in the end. And maybe back to sadness. After my shift, I had time to reflect and process it, I was angry again. I came full circle. If anyone had listened to me, maybe this wouldn't have happened.

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[a]Deborah is a pseudonym. Extraneous details were removed from transcripts so they could be re-read with a sharpened focus.