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Moral dilemmas in healthcare during the COVID-19 pandemic: an organizational perspective

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Introduction: The COVID-19 pandemic exposed healthcare professionals to unprecedented ethical challenges, forcing them to confront moral dilemmas under conditions of uncertainty, scarcity, and institutional pressure. This study examines these experiences through an organizational lens, emphasizing the interplay between structural constraints, moral distress, and sensemaking.
Methods: Using a qualitative design, 13 physicians and nurses from hospitals in Lombardy (Italy) were interviewed through semi-structured protocols exploring their emotional, ethical, and organizational experiences during the pandemic. Data were analyzed through a hybrid coding framework combining the Moral Distress Model with concepts of organizational sensemaking and ethical suffering.
Results: The analysis confirmed all categories of moral events identified in the Moral Distress Model and revealed additional cross-cutting themes such as emotional overload, institutional betrayal, and peer solidarity. Participants described a collapse of ethical frameworks and the emergence of "warfare triage," reshaping professional identity and moral reasoning.
Discussion: The findings reveal how organizational breakdowns transformed moral agency into ethical suffering. Strengthening institutional ethics infrastructures and collective sensemaking processes is essential to support healthcare professionals' moral resilience in future crises.

KEYWORDS

moral dilemmas, healthcare, COVID-19 pandemic, ethical suffering, organizational sensemaking

1 Introduction

A moral dilemma is typically defined as a situation in which an individual must choose between two and more conflicting moral principles, where each option carries significant ethical consequences. Such dilemmas demand the balancing of competing duties, rights, or values and often provoke moral uncertainty and psychological tension (Thomson, 1985; Alexander and Moore, 2016).

In philosophical and psychological literature, moral dilemmas are frequently employed to explore the intricacies of ethical decision-making, particularly in contexts where no course of action appears morally optimal. Iconic examples such as the trolley problem, or real-world organizational conflicts, are often used to illustrate these tensions (Foot, 1967; Greene et al., 2001).

When considering the specific contexts of healthcare organizations, moral dilemmas arise when healthcare professionals must balance competing ethical principles such as autonomy, beneficence, and justice (Beauchamp and Childress, 2013; Jonsen et al., 2022). Situations involving end-of-life decisions, informed consent, or the allocation of scarce resources exemplify these challenges. Frequently, such dilemmas lead to moral distress: a condition in which professionals recognize the ethically appropriate action but are constrained from executing it (Jameton, 1984; Epstein and Hamric, 2009).

The COVID-19 pandemic significantly intensified these ethical challenges. Physicians and nurses in hospitals and ICUs were repeatedly confronted with urgent decisions under resource scarcity, high mortality, and institutional pressures. In this context, organizational factors—including structure, hierarchy, policy clarity, and leadership—played a critical role in shaping ethical responses (Schein, 2010; Treviño et al., 2006). Moral dilemmas emerge not merely as individual cognitive or emotional experiences, but as processes deeply embedded within complex social networks and institutional structures of healthcare organizations. This embeddedness highlights how decisions and ethical tensions are shaped by relational and organizational contexts, influencing worker wellbeing and moral agency (Granovetter, 1985).

A strong organizational ethical culture can facilitate open communication and mitigate ambiguity, while leadership sensitivity to ethical concerns can reduce the intensity of moral distress (Schminke et al., 2005). Conversely, organizations that prioritize efficiency or bureaucratic compliance over ethical reflection may foster environments where moral disengagement becomes normalized (Bandura, 1999; Schwepker, 2001). Hierarchical systems, in particular, often centralize decision-making, potentially silencing dissent and restricting the agency of frontline workers. This is especially burdensome for lower-ranked professionals—such as nurses—who frequently face ethical constraints without the power to influence decisions (Sperling, 2021).

Healthcare ethics thus involve not only personal values but also institutional logics and shared moral frameworks that guide practice. The pandemic provides a rare opportunity to investigate how moral dilemmas emerge and are collectively addressed within healthcare organizations. This study focuses on physicians' and nurses' lived experiences of moral distress during the pandemic, employing the conceptual lenses of organizational sensemaking (Weick, 1995) and ethical suffering (Dejours, 1998, 2024) to illuminate the organizational dimension of moral complexity.

The paper is structured as follows: first, it outlines the contextual factors that gave rise to moral dilemmas during the pandemic, particularly in emergency and critical care settings. It then presents the conceptual assumptions guiding the analysis. Subsequently, the research design and method are described, followed by an in-depth discussion of findings. The paper concludes by reflecting on the implications for healthcare ethics and organizational practices in crisis contexts.

2 COVID-19 and healthcare ethics

On March 11, 2020, the World Health Organization declared COVID-19 a global pandemic. Italy, among the first European countries to be severely affected, experienced a rapid saturation of its healthcare system. Hospitals, particularly ICUs, faced unprecedented pressure, forcing healthcare professionals to make ethically fraught decisions under extreme conditions (Lamiani et al., 2021).

Although decisions were nominally guided by classical ethical principles—autonomy, beneficence, non-maleficence, and justice—these principles often came into conflict, leaving healthcare workers exposed to moral distress. Over time, continuous exposure to ethically troubling situations contributed to burnout, compassion fatigue, and increased professional attrition (Varcoe et al., 2012; Lamiani et al., 2017).

As Jameton (1984) classically noted, moral distress arises when individuals know the right course of action but are constrained—by institutional, legal, or structural forces—from acting accordingly. Research suggests that nurses often experience higher levels of moral distress than physicians, due to their subordinated position within medical hierarchies (Hamric et al., 2012; Lamiani et al., 2021). However, during the pandemic physicians, too, were severely impacted by resource shortages, suffering, and the emotional toll of repeated life-or-death decisions (Kherbache et al., 2022).

In particular, three ethically charged areas stood out during COVID-19 crisis: triage and resource allocation, healthcare worker safety, and visitation policies.

2.1 Triage and resource allocation

Perhaps the most visible ethical challenge was how to prioritize patients and allocate scarce life-saving resources—such as ventilators and ICU beds—under triage protocols. These decisions were grounded in competing ethical frameworks:

- *Utilitarianism*, which aims to maximize overall benefits by prioritizing patients with the highest chance of survival, was widely adopted during the crisis (Persad et al., 2009; Emanuel et al., 2020). However, this approach risked systemic bias, as it could inadvertently disadvantage elderly individuals and marginalized groups raising concerns of justice (Emanuel and Persad, 2023).
- *Egalitarian models*, such as "first come, first served" or random allocation, emphasized equality of treatment (Daniels and Sabin, 2002). Though ethically compelling in terms of justice, these models were often criticized for failing to maximize survival outcomes.

Persad et al. (2009) proposed four primary criteria for ethical allocation: equal treatment, priority to the worst-off, maximization of total benefits, and promotion of social utility (e.g., giving precedence to healthcare workers). The principle of social utility, which justifies prioritizing scarce medical resources or care for individuals deemed most beneficial to society, is a well-established ethical framework in bioethics (Persad et al., 2009; Daniels and Sabin, 2002). Understanding how this principle was perceived and applied during the COVID-19 pandemic enriches interpretations of the moral dilemmas healthcare workers faced.

2.2 Healthcare worker safety

A profound ethical dilemma concerned the protection of healthcare workers themselves. Severe shortages of personal protective equipment (PPE) meant that doctors and nurses were often forced to choose between their duty of care and their own safety. Many experienced moral injury, a form of

trauma that occurs when one's actions violate core moral beliefs (Williamson et al., 2020). These conditions led to widespread anxiety, depression, and PTSD symptoms (Greenberg et al., 2020).

2.3 Visitation restrictions

To curb virus transmission, hospitals imposed strict visitation bans, especially in critical and end-of-life cases. These measures, though grounded in a utilitarian rationale, clashed with deontological ethics that emphasize the dignity, autonomy, and emotional needs of patients (Hugelius et al., 2021). Healthcare workers often found themselves caught between institutional protocols and empathic responses to patients and families, especially in cases where final goodbyes were not permitted.

These scenarios illustrate the profound ethical complexities faced by healthcare professionals during the pandemic, and highlight the importance of understanding how such dilemmas were navigated within specific organizational contexts.

3 Organizational sensemaking and ethical suffering

This study adopts an organizational lens to explore healthcare professionals' experience of moral distress during the COVID-19 pandemic, focusing on two key conceptual tools: sensemaking and ethical suffering.

Sensemaking is often defined as the process by which people give meaning to their collective experiences particularly, when faced with new challenges, crises, or opportunities (Weick, 1995). Central to this idea is the notion that sensemaking is inherently social and context-dependent. In organizations, sensemaking typically emerges when individuals or groups confront unexpected events or ambiguities, requiring them to interpret new information, question assumptions, and reframe their understanding of a situation (Weick et al., 2005).

Understanding the dynamics of sensemaking can provide insight into how organizations deal with moral dilemmas. Healthcare workers can rely on sensemaking to interpret and navigate moral dilemmas (Weick, 1995).

While the process of sensemaking is intrinsic to organizational action even under normal conditions, it becomes more explicit precisely when the current state deviates from what was expected and there is no obvious way to address the situation (Weick et al., 2005). It is especially in such circumstances that this construct reveals its heuristic power, allowing us to "reframe the organization as the experience of being thrown into a continuous, unknowable, unpredictable flow of experience in search of answers to the question "what's the story?" (ibid., p. 410). Sensemaking—became crucial for healthcare professionals trying to make sense of the rapidly evolving situation. it allowed healthcare workers to navigate the complex ethical terrain of the pandemic, reinterpreting shared ethical frameworks to align with the urgency and scarcity of resources they were facing.

The ethical dilemmas and psychological strain experienced by healthcare professionals during the pandemic are particularly aligned with Dejours' concept of ethical suffering (Dejours, 1998, 2006, 2015, 2024). as they grappled with the ethical tension between utilitarianism and maintaining the individual dignity and autonomy of patients.

Christophe Dejours' theory of ethical suffering provides a unique lens through which the psychological distress experienced by healthcare workers can be understood during the crisis of the COVID-19 pandemic. He conceptualizes work as a source of both suffering and meaning, highlighting the ethical dimensions of labor and its profound impact on workers' mental and emotional wellbeing. Unlike traditional economic or functionalist views of work, which emphasize productivity, efficiency, and the division of labor, Dejours focuses on the subjective experience of work and its deep connections to identity, psychological health, and ethical challenges. Central to his perspective is the idea that work is not just a means to achieve material ends, but an integral part of human existence, with profound psychological and ethical implications (Dejours, 1998, 2024). One of his major contributions is the concept of ethical suffering, which he argues emerges when workers are forced to confront moral conflicts or situations where their personal values are in tension with organizational demands. According to Dejours, these experiences of suffering are not only psychological but also have ethical dimensions, as they force individuals to make decisions that affect their moral integrity and sense of self (Dejours, 2006).

Ethical suffering, as defined by Dejours, is a form of psychological distress that occurs when individuals are forced to violate their personal moral values due to external factors, particularly within the organizational structure of the workplace. The moral conflicts inherent in the healthcare crisis due to COVID-19 pandemic—from resource allocation to life-and-death decisions—have placed immense emotional and psychological strain on healthcare professionals. As healthcare systems became overwhelmed, many workers experienced a loss of autonomy and agency. Dejours (1998, 2024) argues that, in these situations, workers can experience alienation, emotional burnout, and a disconnection from their personal values. This sense of disconnection is compounded in healthcare environments where workers are tasked with managing high levels of emotional labor while simultaneously making difficult ethical decisions. The moral dilemmas of the pandemic—such as resource allocation and patient prioritization—led to extreme ethical conflicts, reinforcing Dejours' argument that work-related suffering has both psychological and ethical dimensions (Dejours, 1998, 2015).

The COVID-19 pandemic thus represents a crucible in which both sensemaking and ethical suffering were activated to a profound degree. Healthcare professionals were required to make difficult decisions about resource allocation, patient prioritization, and family communication, often in the absence of adequate support, guidelines, or autonomy. These challenges forced a reconfiguration of professional ethics and organizational logic in real time.

By combining these two analytical frameworks, this study seeks to uncover not only the content of moral dilemmas experienced by healthcare workers, but also the processes through which these dilemmas were collectively interpreted, emotionally metabolized, and ethically navigated within healthcare institutions.

4 Method

4.1 Research design

The primary aim of this research is to examine the moral dilemmas faced by physicians and nurses during the COVID-19 pandemic from an organizational perspective, with particular attention to the processes of collective sensemaking and the emergence of ethical suffering.

To this end, a two-phase analytical approach was employed:

Phase 1: focused on identifying the types of moral events that led to distress. We applied the moral distress model developed by Morley et al. (2022) and refined by Lemmo et al. (2022), which classifies moral events into five categories: moral constraint, moral tension, moral conflict, moral dilemma, and moral uncertainty.

Phase 2: concentrated on the sensemaking processes by which these events were interpreted and managed within the organizational context.

This dual framework enabled an in-depth exploration of how organizational features shaped the moral experiences of healthcare professionals.

4.2 Participants

The study involved 13 participants: 9 physicians (7 female, 2 male) and 4 nurses, all of whom had worked in hospitals across the Lombardy region (Italy's first and hardest-hit area during the pandemic). Inclusion criteria required participants to have:

worked in a COVID-19 ward,

operated within Lombardy,

been active during at least the first two pandemic waves (that occurred in Spring and Autumn, 2020).

Participants were recruited through snowball sampling from 6 hospitals and participated on a voluntary basis. Initial contact was established via email, and informed consent was obtained for participation and data processing.

4.3 Tools and procedure

Data collection was carried out through a purpose-designed semi-structured interview protocol. The interview aimed to elicit the emotional, ethical, and organizational experiences of healthcare workers during the pandemic, with a specific focus on: (i) changes in emotional states before and after the vaccine rollout; (ii) organizational factors that either exacerbated or alleviated emotional strain; (iii) coping strategies at individual, group, and institutional levels.

Importantly, no explicit questions about "moral dilemmas" were included in the interview guide. This decision was grounded in the research objective to capture spontaneously emerging ethical concerns, allowing the narratives to reflect participants‘ lived experiences without presupposition. Although visitation restrictions were noted in the first part of the paper, they were not asked about directly in the interview protocol. Instead, they emerged spontaneously in participants' narratives, highlighting their ethical salience in lived experience.

The interview was structured in four parts:

- Biographical and professional background (approx. 15 min): professional history, current roles, and organizational responsibilities.
- Emotional experience (approx. 25 min): personal and emotional reactions to the evolving situation.
- Critical events and coping mechanisms (approx. 25 min): analysis of difficult scenarios and individual or collective responses.
- Reflexive closure: a reflective conclusion aimed at emotional closure and integration.

All interviews were recorded (audio and video) with prior consent, fully transcribed, and anonymized. Identifiable information such as names and institutional affiliations was removed to protect participants' privacy.

4.4 Analysis

The analysis of the interview material was conducted using a hybrid coding framework, combining deductive and inductive strategies. Deductive coding was informed by the typology of moral events proposed by Morley et al. (2021) and Lemmo et al. (2022), which distinguishes between five categories: moral constraint, moral tension, moral conflict, moral dilemma, and moral uncertainty. Alongside this, an inductive coding process allowed for the emergence of unanticipated themes, particularly those related to emotional responses and processes of meaning-making in the face of extreme clinical and ethical adversity.

The analytical process followed three steps:

- Shared Reading: all interviews were read collaboratively to identify narratives representative of moral distress, following the theoretical definitions.
- Coding: selected narratives were coded according to the five moral event categories.
- Thematic Interpretation: significant excerpts were interpreted through the lenses of organizational sensemaking and ethical suffering.

The coding was conducted independently by two researchers and yielded 99% interrater agreement, demonstrating high reliability in identifying and classifying moral experiences.

Emotional reactions—such as fear of contagion, grief for patients, institutional frustration, and ethical disorientation—were also recorded and analyzed. These responses were found to intensify ethical suffering, reduce resilience, and lead, in some cases, to decreased job satisfaction and intentions to leave the profession (Rushton, 2016; Lamiani et al., 2017).

5 Results

5.1 Experiences of moral distress and emotional suffering

The interviews overall reveal a very strong core of shared experiential realities. The five categories of moral events outlined in the moral distress model all emerged from the analysis of the interviewes‘ experience, confirming other studies’ results (see Lemmo et al., 2022).

Across the dataset, moral constraint emerged frequently in narratives describing situations where healthcare workers were prevented from acting in accordance with what they believed to be ethically right, due to institutional limitations such as lack of beds, protective equipment, medication, or qualified staff. One participant recalled,

> “*I knew what had to be done, but there were no beds or medications… I couldn't manage alone*” (nurse).

Another described the impossibility of offering critical care support due to shortages, reflecting:

> “*We had to choose who to save… you accompany someone to death, but wonder if in another situation you could have saved them*” (physician).

These experiences illustrate the internalization of systemic failure as personal guilt and the erosion of professional agency under constraint.

Moral tension appeared in moments of ethical unease, where no clear violation or wrongdoing was present, yet participants described a persistent discomfort. This was especially evident in cases where nurses had to give patients false reassurances to preserve hope. One participant recounted,

> “*I told the patient she'd get the helmet to breathe… but I knew we didn't have one. Lying was extremely hard*” (nurse).

These experiences demonstrate the psychological toll of having to reconcile empathy and professional composure in the absence of viable options.

Moral conflict was present in situations involving clashing ethical imperatives, particularly between patient autonomy and clinical judgment. For example, a nurse reported:

> “*The patient refused intubation, seeing it as a death sentence… but it was the only way to save him*” (nurse).

These experiences underline the challenge of making ethical decisions in the absence of shared understanding or clear protocols.

Although less frequent, moral dilemmas were observed in retrospective reflections, where participants questioned the basis of their choices in emergency contexts. One nurse reflected:

> ““*I kept wondering: did I choose based on empathy or fairness? Who really deserved that intervention?”* (nurse).

These moments highlight the lingering effects of unresolved ethical uncertainty, often long after the event itself.

Moral uncertainty was a pervasive thread throughout the corpus, especially during the early stages of the pandemic. Healthcare workers repeatedly described feeling lost, unsupported, and unsure about how to act, especially in communicating with families and in the face of rapid clinical deterioration. One participant shared:

> “*A pregnant girl… we didn't know what to tell her, how to prepare her… should we lie? Protect her? We had no guidance*” (nurse).

Complementing this deductive structure, inductive coding uncovered rich, cross-cutting themes related to emotional and psychological experiences.

A central theme was emotional overload, often expressed through words such as anguish, impotence, guilt, nightmares, and despair. The recurring exposure to traumatic deaths, the inability to provide basic human contact, and the experience of helplessness in front of systemic collapse contributed to deep emotional injuries. As one nurse put it:

> “*I had nightmares. I felt guilty. I had to see a therapist*” (nurse).

Many participants described an overwhelming volume of death, leading to emotional exhaustion and detachment.

> “*Death, for me, was extremely difficult because up until that point, yes, in my work I had seen people pass away, but not in such large numbers. We were losing between 6 and 10 people a day, and that was a number I couldn't even process: it was just too much. I ended up not talking about it anymore because, in the end, I felt like more of a burden than anything else*” (nurse).

A perceived lack of dignity in the management of deceased patients deeply troubled many healthcare professionals.

> “*When a patient passed away, we had to decide what was important. I saw some of my colleagues just take the personal belongings and throw them away without even looking at them, and I couldn't do that... Fortunately, I wasn't the only one struggling with this; it didn't seem right to just take everything and throw it away. But having to sit there and make decisions, choosing what to keep or discard, felt like it was also something important for them. There was very little respect when patients passed away, there was no respect even in death*” (nurse).

A second emergent theme was institutional betrayal, with many participants reporting disillusionment toward the healthcare system and leadership figures. One remarked: “*We were heroes… then we were plague-spreaders… then we were*

forgotten" (physician). Feelings of having been used and discarded were compounded by the perception that no real structural improvements followed the crisis. Moreover, some professionals were forced to give patients or families false hope, reporting emotional conflict and institutional deception.

A third major axis was the role of peer solidarity in enabling a sense of resilience and meaning. Despite the overwhelming pressure, several healthcare workers emphasized that support from colleagues was vital in helping them endure. As one participant described: "*We helped each other, we supported each other... it was the only way to survive*" (nurse). These experiences were not only crucial for emotional containment but also fostered a sense of professional and personal transformation, allowing participants to reframe their roles and reaffirm their identities.

By the second wave, a sense of fatigue and resignation had replaced the initial motivation to overcome the crisis.

> "*By the second wave, we were exhausted. We knew what we were up against, but we still didn't have the resources to deal with it a second time. I also noticed much less attention from my colleagues, a lot more resignation. In the first wave, we were more motivated, still trying to find solutions to deal with the different situations. But by the second wave, we were much more resigned, and there was much less focus*" (nurse).

5.2 Sensemaking and ethical suffering

A prominent theme that emerged from the narratives was the collapse of established ethical paradigms and their replacement with new moral logics.

In the absence of institutional guidance, healthcare workers were forced to construct *ad hoc* systems of meaning, largely through peer interaction and informal consensus. Weick conceptualizes sensemaking as a fundamentally social and retrospective process in which individuals organize their experiences to render ambiguous or chaotic situations meaningful. In the interviews, participants recount a persistent collapse of organizational coherence, especially in the early phases of the pandemic. Decision-making lacked structure, communication was inconsistent, and responsibilities were often redistributed arbitrarily. One nurse from an intensive care unit recalled:

> "*There were no guidelines. No protocols. You had to improvise every hour. I would ask for help or direction, but nobody knew more than I did. It felt like we were flying blind*" (nurse).

Another nurse described how these impromptu shared meanings were formed:

> "*The only thing that kept us going was each other. We would talk between shifts, try to make sense of what happened. Sometimes it was just to cry or laugh at the absurdity. That was all we had*" (nurse).

These moments of shared reflection served as what Weick terms "interpersonal plausibility structures": social spaces where fractured meaning could be temporarily restored. However, these micro-collectives were fragile, unevenly distributed, and insufficient to compensate for the broader vacuum of institutional sensegiving.

One of the most profound transformations reported by participants was the abrupt shift from care-based to warfare-based triage, in which the ethics of individualized patient care were replaced by survival-oriented decision logics. In fact, one striking feature of many interviews was the use of warlike language. Metaphors of combat, sacrifice, and endurance were pervasive, reflecting the intensity of the collective experience.

This transition marked a critical rupture in the interpretive frameworks traditionally used by healthcare workers to make sense of their work. From the perspective of Karl Weick's sensemaking theory, this constitutes a paradigmatic case of frame collapse, in which the foundational structures that guide perception and action—what Weick calls "recipes for action"—are no longer applicable under emergent conditions.

In pre-pandemic practice, triage decisions were often guided by clinical guidelines, individual patient trajectories, and multidisciplinary deliberation. During the height of the pandemic, however, these procedures were subsumed by protocols of scarcity, with nurses and physicians forced to prioritize treatment based on utilitarian logics rather than patient-centered ethics. This shift in ethical orientation involved a reconfiguration of values. Under extreme conditions, ethical decision-making aligned increasingly with utilitarian and militarized principles: prioritizing survival over autonomy, collective wellbeing over individual dignity, and efficiency over deliberation (Vinay et al., 2021).

> "*On the other hand, it was not just the fear of getting sick, but also the fear of the possible consequences, because, of course, we always saw, and I use the word 'massacre', but unfortunately, it really was a massacre, especially during the first wave*" (nurse).
>
> "*What happened, which is understandable given the circumstances, is that when you don't have resources, you end up doing a 'wartime triage', essentially, you lower the minimum level of care. Once you reduce what is considered normal care, that becomes the new standard*" (physician).

These metaphors served as cognitive anchors for collective sensemaking, helping professionals understand and justify actions that, under normal conditions, would have been morally indefensible. The recurring use of terms such as "war triage," "massacre," and "selection" reflect how deeply this new ethical framework was internalized.

The metaphor of war also shaped emotional and relational dynamics:

- Fatigue and Resistance: long, uninterrupted shifts evoked the endurance of soldiers under siege.
- Emotional Detachment: professionals reported learning to suppress emotions as a psychological survival strategy.
- Isolation and Abandonment: participants described feeling unsupported by institutional leadership, akin to frontline troops left without reinforcements.

- Moral Injury: guilt over unavoidable patient deaths mirrored the trauma of combatants who survive while others perish.

One participant captured this shift starkly:

> "*We were told to use helmets for patients under 60. We didn't discuss it. We just did it. It felt like war, like someone gave an order and you obeyed. That wasn't medicine anymore. That was survival*" (physician).

This quotation reflects what Weick (1995) describes as a shift from sensemaking to sensebreaking. In contexts of high uncertainty and time pressure, the organizational need for swift coordination may override normative deliberation. Rules are accepted without reflection because interpretive capacity is saturated, and action takes precedence. In such contexts, sense is made through doing, not through understanding.

Several participants described the experience of depersonalization as a consequence of this shift. One nurse stated:

> "*At a certain point, they weren't people anymore. They were bodies. You learned not to look at names or faces. You had to shut off everything just to function*" (nurse).

This dehumanization was not the result of apathy, but a functional necessity within a radically altered system of care. For Weick, sensemaking under threat often involves bracketing out emotional and ethical information that could paralyze decision-making. However, this psychological distancing is not without cost: once the crisis abates, previously suppressed moral frameworks return with force, leading to retrospective dissonance and emotional collapse.

Indeed, some participants only later began to articulate the moral implications of the choices they had made during the triage phase. One reflected:

> "*I only realized afterward what I had done. That I had let someone die. I didn't think about it at the time. I couldn't afford to*" (physician).

This *post-hoc* awareness aligns with Weick's view of sensemaking as retrospective: it is often only after action has taken place that meaning is constructed and ethical contours become visible. The temporal lag between action and reflection creates a space where moral suffering can take root, particularly if no collective framework exists to process and integrate these experiences.

Importantly, the shift to warfare triage also reconfigured professional identity. Nurses were no longer healers or caregivers, but actors in a command chain, executing resource-based decisions often communicated as top-down imperatives. One nurse remarked:

> "*I stopped being a nurse. I became a soldier. I didn't feel like I was helping anymore. I was just following orders*" (nurse).

This statement reflects a disidentification with the professional self, a phenomenon Weick identifies as a crisis in the identity anchor of sensemaking. When one's role no longer aligns with one's values or practices, the ability to generate coherent interpretations of action deteriorates. What remains is role performance without meaning, a condition ripe for the emergence of ethical suffering.

Weick emphasizes the centrality of identity in sensemaking. The pandemic disrupted the nurses' professional identities by rendering core practices—like touch, communication, and accompaniment—either impossible or ethically fraught. One participant expressed this rupture as follows:

> "*We were supposed to be there to comfort, to explain, to hold hands. But all we could do was cover them in plastic and write names on their gowns. I started asking myself: is this still nursing?*" (nurse).

This quotation points to a deep ontological destabilization. When organizational reality no longer supports the conditions for meaningful role performance, the sense of professional self begins to unravel. The transition to warfare triage represents not just a change in practice, but a collapse of the normative and symbolic structures through which healthcare workers interpret their role. Viewed through Weick's lens, this shift produced a disruption of collective sensemaking, where habitual scripts and ethical reasoning were suspended in favor of survival-based action.

From Dejours' perspective, this interruption of ethical continuity—combined with the absence of organizational mechanisms to process distress—laid the foundation for long-term psychological and moral injury.

The incoherence of public narratives added to this confusion. Multiple interviewees mentioned the transition from being celebrated as heroes to being accused of spreading the virus, then ultimately being forgotten. One commented:

> "*First we were clapped for in the streets. Then people yelled at us for going to the supermarket. Then it was like we never existed. That broke something in me*" (physician).

This evolving symbolic framing undermined the workers' ability to maintain a coherent narrative of purpose, exacerbating the fragmentation of both individual and collective identity.

While Weick allows us to trace the contours of cognitive and identity disintegration, Dejours' theory of work-related suffering helps explain how moral injury becomes embedded in organizational life when ethical violations are normalized or silenced.

According to Dejours, ethical suffering arises when workers are forced to act in contradiction to their values, without recognition, discussion, or symbolic repair. The document is rich with examples of what Dejours calls "the betrayal of work" (Dejours, 1998, 2015). One of the clearest illustrations comes from an intensive care nurse who was required to withhold ventilation from a patient due to resource scarcity:

> "*I had to tell a patient he would get the helmet to breathe, but I knew he wouldn't. I knew he would die. I smiled and lied. That's what was asked of me. That wasn't care. That wasn't human*" (nurse).

This narrative captures the crux of ethical suffering: not only the injustice of the situation, but the internal collapse it provokes when one is made complicit in that injustice. The nurse is not merely upset by the outcome; she is morally injured by having to perform a lie under institutional pressure, without space for ethical deliberation or personal refusal.

Similarly, another nurse described the impossible choices made during triage:

> "*A woman my mother's age begged me for help. But there was only one helmet left. I gave it to a younger man. I walked away without saying anything. That moment stayed with me. It split me in two*" (nurse).

This statement exemplifies the psychic cost of morally coerced silence. For Dejours, the inability to speak, to be heard, or to resist constitutes a form of institutional violence, one that turns organizational constraints into intimate suffering.

The lack of organizational response or support further deepened this pain. Many participants described how institutional leadership failed to acknowledge or process what had occurred. One nurse stated bitterly:

> "*They clapped their hands, put up posters, sent emails. But nobody ever asked: how are you really? What did you go through? What did it cost you?*" (nurse).

Dejours would interpret this as the failure of symbolic reparation, which is essential to reintegrate traumatic work experiences into a shared ethical and social framework. Without such reparative gestures, suffering remains private, illegible, and corrosive.

Taken together, the interviews describe a process of organizational disintegration in which frontline healthcare workers were left to improvise meaning under crisis, negotiate impossible moral demands, and carry unresolved ethical injuries. What emerges is a landscape in which institutions abdicated their role as moral interlocutors, leaving workers to bear structural contradictions in solitude.

While micro-communities of peers sometimes offered relief, these informal collectives could not substitute for systemic ethical infrastructures. The result was a pervasive sense of betrayal, moral loneliness, and identity fracture; a condition that persists well beyond the acute phase of the pandemic.

This analysis highlights the urgent need for institutional frameworks that enable collective ethical reflection, even under crisis conditions. Without these, healthcare systems risk transforming frontline workers into silent carriers of unresolved trauma, caught between action without meaning and suffering without voice.

6 Discussion

The findings from this study reveal the profound ethical and emotional challenges faced by healthcare professionals during the COVID-19 pandemic. Across the five categories of moral events—constraint, tension, conflict, dilemma, and uncertainty—participants described ethically complex situations marked by frustration, guilt, and powerlessness. These individual experiences were not isolated; they were shaped and often exacerbated by organizational dynamics that limited professional autonomy, obstructed communication, and prioritized efficiency over deliberation.

At the individual level, the inability to act in accordance with one's moral judgement gave rise to persistent moral distress. This was particularly evident in the narratives concerning triage decisions, restrictions on family visits, and the silencing of dissenting ethical views. The emotional residue of these experiences—what some scholars call "moral residue" (Epstein and Hamric, 2009)—was manifest in accounts of enduring sadness, regret, and disillusionment.

At the organizational level, the crisis revealed some weaknesses in institutional ethics. The re-centralization of decision-making and the breakdown of participatory processes alienated frontline professionals, especially nurses. These findings align with previous literature highlighting how top-down governance can silence ethical reflection and diminish professionals' sense of agency (Brown et al., 2005; Kish-Gephart et al., 2010).

One of the most compelling findings concerns the shift in ethical paradigms. In the face of systemic collapse, healthcare workers redefined their ethical frameworks through collective sensemaking. Drawing on metaphors of war and scarcity, they adopted a utilitarian rationale that prioritized outcomes over process, and survival over dignity. Within this utilitarian framework, scholars have long debated the role of social utility—particularly the prioritization of essential workers and those who contribute to the functioning of society—as a criterion for resource allocation (Persad et al., 2009; Daniels and Sabin, 2002; Emanuel et al., 2020).

While this utilitarian shift was necessary for operational functioning under emergency conditions, its incorporation of social utility principles also raised unresolved ethical tensions, producing lasting psychological strain.

The pervasive use of war metaphors—"massacre," "selection," "triage"—reveals a symbolic reordering of moral language that legitimized choices otherwise unthinkable in peacetime. This resonates with Dejours' theory of ethical suffering, wherein professionals experience distress not only because of traumatic events, but because their capacity to act ethically has been compromised by the organizational context (Dejours, 1998, 2006). The accounts of guilt, emotional detachment, and disillusionment suggest that many participants underwent a crisis of moral identity, which may have long-term implications for professional retention and mental health.

Finally, this study demonstrates the relevance of sensemaking as a theoretical lens to understand ethical dynamics in healthcare. In crisis situations, sensemaking enables collective meaning construction that sustains action under ambiguity. However, as

shown here, this process is not neutral: it can produce ethical trade-offs and normalize exceptional decisions that carry long-term consequences.

These insights underscore the need for healthcare organizations to invest in structures that promote ethical deliberation—not only through formal ethics committees, but through participatory leadership, inclusive communication, and emotional support mechanisms. Ethical resilience must be cultivated not only at the individual level, but as a core feature of organizational culture.

7 Conclusion

This study examined the moral dilemmas encountered by healthcare professionals during the COVID-19 pandemic through the dual lenses of organizational sensemaking and ethical suffering. Drawing on qualitative interviews with physicians and nurses working in COVID-19 wards in Lombardy, it revealed how extreme conditions led to the reconfiguration of ethical norms and the emergence of deep moral distress. Although the results cannot be generalized to all healthcare organizations involved in managing the pandemic, the phenomena observed appear particularly interesting in illustrating what happens in highly pervasive crisis situations.

Rather than viewing moral dilemmas solely as internal conflicts, the findings highlight their organizational embeddedness. Moral suffering did not stem only from individual indecision, but from systemic constraints, breakdowns in communication, and the erosion of professional autonomy. Under such conditions, sensemaking processes enabled the construction of new moral logics—rooted in triage ethics and crisis management—but these also introduced ethical contradictions and emotional burdens.

The concept of ethical suffering was particularly useful in interpreting how healthcare workers experienced a fracture between their ethical identity and the institutional demands placed upon them. These fractures led to forms of psychological and moral alienation that persisted beyond the acute phase of the pandemic.

The study underscores the importance of building organizational infrastructures of ethics, environments in which professionals are empowered to reflect, deliberate, and act in line with their values. In preparation for future crises, healthcare systems must prioritize not only logistical readiness but also ethical preparedness: fostering cultures of care, responsibility, and participatory governance that can withstand the moral pressures of emergency.

Data availability statement

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author.

Ethics statement

The studies involving humans were approved by Research Evaluation Committee, Department of Psychology, University of Milano-Bicocca. The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study. Written informed consent was obtained from the individual(s) for the publication of any potentially identifiable images or data included in this article.

Author contributions

LPV: Conceptualization, Validation, Investigation, Methodology, Funding acquisition, Supervision, Writing – original draft, Writing – review & editing. MC: Conceptualization, Validation, Investigation, Methodology, Formal analysis, Project administration, Data curation, Writing – original draft, Writing – review & editing.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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