

Prevalence of Moral Distress Among Physiotherapists in Anand District of Gujarat

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ABSTRACT

Background: Moral distress occurs when healthcare professionals recognise the ethically appropriate course of action but are unable to act because of institutional or external constraints. Persistent moral distress can negatively affect professional well-being, job satisfaction, and the quality of patient care.

Objective: To determine the prevalence, severity, and factors associated with moral distress among physiotherapists in Anand district, Gujarat.

Methods: A descriptive cross-sectional study was conducted among 68 GSCPT-registered physiotherapists practicing in clinical settings. Moral distress was assessed using the Measure of Moral Distress–Healthcare Professionals (MMD-HP) questionnaire. Descriptive statistics were used to summarize the data, and independent *t*-tests were performed to compare mean Moral distress scores according to gender and area of practice. Effect sizes (Cohen's *d*) and 95 % confidence intervals were calculated. Statistical analyses were performed using IBM SPSS version 22.0, with statistical significance set at $p < 0.05$.

Results: The mean moral distress score was 81.5 ± 57.8 . Moderate moral distress was observed in 16.2% of participants, while 83.8% reported low to mild distress. No statistically significant differences were

found according to gender ($p=0.700$) or area of practice ($p=0.397$). Domain-wise analysis showed that the Interpersonal Relations domain had the highest mean item score (3.38).

Conclusion: Although most physiotherapists experienced low to mild moral distress, approximately one in six reported moderate distress. Among the MMD-HP domains, Interpersonal relations, therapeutic obstinacy, and healthcare-related factors demonstrated relatively higher mean item scores, highlighting the need for institutional ethics support and strategies to reduce moral distress and promote professional well-being.

Keywords: Moral distress, Physiotherapist, Moral Distress–Healthcare Professionals, Cross-sectional study

INTRODUCTION

"Morals" refer to the values, principles, and personal and professional ideas that people hold about what is right and wrong. These beliefs and values influence people's judgements and decisions in certain situations. ^[1] Someone who can reason, think, decide, and act in conformity with moral standards and principles—both personal and professional—is considered a moral agent. ^[2] Moral principles constitute a normative framework that defines behaviours regarded as good, virtuous, just, right, and ethical, thereby guiding human

conduct within society. [3] These principles have been widely examined to explain the social behaviour of individuals living and interacting within groups. [4] Across diverse academic disciplines, morality is recognised as a fundamental component in maintaining social order by fostering cooperation, mutual trust, and social cohesion. [5] In particular, moral behaviour is commonly reflected through demonstrations of fairness, empathy, and altruism during face-to-face interactions, especially within close-knit groups where individuals are familiar with and mutually dependent on one another. [6]

Moral distress occurs when healthcare professionals believe they are unable to act according to what they consider ethically appropriate due to external constraints. [7] Research has shown that moral distress accumulates over time and becomes more intense with time [8], potentially resulting in burnout, compassion fatigue, disengagement, and a decline in the standard of care. [9,10,11] Sources of distress include continued life support not in the patient's best interest, inadequate communication, inadequate staff, and false hope given to families. It operates at three levels: patient-level (e.g., family demands), unit/team level (e.g., poor communication), and system-level (e.g., chronic poor staffing). [12]

As rehabilitation professionals, physiotherapists play a vital role in rehabilitation and must handle ethical dilemmas. They are guided by codes such as the Gujarat State Council for Physiotherapists (GSCPT) and the World Confederation for Physical Therapy (WCPT). Ethical issues in physiotherapy often involve setting treatment goals, deciding when to end treatment, and managing the close emotional and physical relationship between therapist and patient. [13] A research gap remains regarding the factors contributing to moral distress among physiotherapists and the mediating factors of moral distress across personal, professional, and organizational realms.

This study seeks to determine the prevalence of moral distress to help mitigate effects such as anxiety, depression, and hopelessness. [14]

Healthcare professionals should care not only for their patients but also for their own well-being. In a therapeutic relationship, healthcare professionals are expected to prioritise the well-being of others by remaining attentive to patients' needs, understanding their concerns, and adapting their care accordingly. [15] Such an approach reflects the ethical principles of beneficence and non-maleficence, ensuring that patient care promotes well-being while minimising the risk of harm. Accordingly, the responsibilities of physiotherapists extend beyond restoring physical function to include reducing pain and discomfort, particularly during demanding or potentially painful physiotherapeutic interventions. [16] In addition to providing patient-centred care, physiotherapists are responsible for maintaining their own physical and psychological well-being and ensuring a safe working environment. Adherence to healthy lifestyle practices and the promotion of workplace safety not only support their personal health but also enable the delivery of effective, safe, and high-quality care. Previous research has suggested that adherence to the principles of the ethics of care may vary according to sex, with women demonstrating greater alignment with care-oriented ethical values than men. [13] Furthermore, differences in moral attitudes among physiotherapists may also be influenced by their workplace settings, highlighting the potential impact of professional environments on ethical decision-making.

Therefore, the purpose of this study was to determine the prevalence of Moral distress among physiotherapists that might lead to disengagement, burnout and reduced satisfaction with the patient's rehabilitation program. So, it might help to intervene to reduce Prolonged moral distress, which may contribute to mental health problems such as anxiety, depression and a sense of

hopelessness. It also helps in Early identification and intervention that can help mitigate these effects, which will benefit patient care and rehabilitation as well as personal care.

MATERIALS & METHODS

Study Design: A descriptive, cross-sectional study was used to assess the prevalence of moral distress among physiotherapists.

Study Setting and Population: The study population consisted of practicing physiotherapists working in a clinical setting (including private clinics and physiotherapy colleges) within Anand District of Gujarat, India.

Study duration: Participants were recruited from January to June 2025.

Sampling and Sample size: Participants were selected using a convenience sampling technique.

The sampling frame consisted of approximately 75 practicing physiotherapists in Anand district. A total population (census) sampling approach was adopted to maximize sample size. With an observed response rate of approximately 90%, the final sample size was 68 participants (N=68)

Eligibility Criteria:

Inclusion Criteria:

- Physiotherapists registered with Gujarat State Council of Physiotherapy (GSCPT)
- Both male and female GSCPT-registered physiotherapists working in private clinics or physiotherapy colleges.

Exclusion Criteria:

- GSCPT-registered Physiotherapists currently pursuing a Master's in Physiotherapy (MPT) degree.
- Physiotherapists who are solely engaged in academic roles without any clinical responsibilities.

Ethical Considerations:

The research proposal was submitted to and approved by the “Institutional Ethics

Committee (IEC)” of Bhaikaka University, Karamsad. The approval number is IEC/BU/161/Faculty/20/28/2025.

Permission was also obtained from the HODs of the respective colleges involved in the study. Data were collected from private clinics and colleges. Participants were provided with an information sheet, and a written informed consent form was obtained prior to the study. Surveys were conducted in person, and anonymity was ensured by assigning unique codes to track responses.

Outcome Measure: The Measure of Moral Distress – Healthcare Professionals (MMD-HP) questionnaire scale was used. MMD-HP's reliability was $r=0.93$ across all participants (Epstein EG, 2019). This 27-item scale measures frequency (0-4) and level of distress (0-4) for each item, with a total possible score of 432. The scale covers five dimensions: Health Care (F1), Therapeutic Obstinacy (F2), Interpersonal Relations (F3), External Pressure (F4), and Covering up Medical Malpractice (F5).

Statistical Analysis

Statistical analysis was performed using IBM SPSS-22.0. Descriptive statistics were used to summarize the data. Continuous variables such as MMD-HP and all its domains were expressed as mean $\pm$ standard deviation (SD), whereas categorical variables such as gender and area of practice were presented as frequencies and percentages. Prior to inferential analysis, the assumptions of normality and homogeneity of variances were assessed using the Shapiro–Wilk test and Levene's test, respectively. Independent t-tests were conducted to compare mean moral distress scores according to gender and area of practice. Effect sizes were calculated using Cohen's d , and 95% confidence intervals (CIs) for the mean differences were reported. A two-tailed p -value of <0.05 was considered statistically significant.

RESULT

A total of 68 physiotherapists, aged 32.5 ± 5.4 years, participated in the study,

including 45 females (66.2%) and 23 males (33.8%). Of these, 26 (38.2%) were clinicians, and 42 (61.8%) were clinician-academics.

Table 1. Demographic Characteristics of the Participants (N = 68)

Variables	Category	N (%)
Gender	Male	23 (33.8)
	Female	45 (66.2)
Area of practice	Clinician	26 (38.2)
	Clinician-academician	42 (61.8)

Prevalence and severity of Moral distress

The overall mean MMD-HP score for the study population was 81.5 ± 57.8 . 16.2% (n=11) of the study population had moderate moral distress (score >144), whereas the remaining of 83.8% (n=57) experienced low to mild levels of moral distress.

The assumptions of normality and homogeneity of variances were assessed

before conducting independent-samples t-tests. The distribution of MMD-HP scores was approximately normal within groups, and Levene's test indicated homogeneity of variances ($p > 0.05$), supporting the use of parametric analyses.

Analysis of demographic variations:

Table 2: Comparison of Total MMD-HP Scores According to Gender and Area of Practice

Variable	Group	N	Mean $\pm$ SD	t-value	p-value	Cohen's d	95% CI of Mean Difference
Gender	Male	23	85.2 ± 60.4	0.387	0.700	0.10	-23.71 to 35.12
	Female	45	79.5 ± 58.8				
Area of practice	Clinician	26	73.9 ± 55.2	-0.853	0.397	0.21	-40.69 to 16.33
	Clinician-academician	42	86.1 ± 58.4				

Male physiotherapists had a slightly higher mean MMD-HP score than female physiotherapists (85.26 ± 54.66 vs. 79.56 ± 58.84). However, this difference was not statistically significant ($t(66) = 0.387$, $p = 0.700$; 95% CI: -23.71 to 35.12), with a trivial effect size (Cohen's $d = 0.10$).

Clinician-academics demonstrated a higher mean MMD-HP score than clinicians (86.14 ± 58.42 vs. 73.96 ± 55.22). However, the difference was not statistically significant ($t(66) = -0.853$, $p = 0.397$; 95% CI: -40.70 to 16.33), with a small effect size (Cohen's $d = 0.21$).

Table 3. Descriptive Statistics of MMD-HP Domain Scores:

	Mean	No. of items	Mean item Score
MMD-HP F1	32.6	10	3.26
MMD-HP F2	13.1	4	3.28
MMD-HP F3	13.5	4	3.38
MMD-HP F4	11.5	5	2.30
MMD-HP F5	10.6	4	2.66

The highest mean item score was observed for the Interpersonal Relations domain (3.38), followed by Therapeutic Obstinacy (3.28), Health Care (3.26), Covering up Medical Malpractice (2.66), and External Pressure (2.30).

DISCUSSION

The present study investigated the prevalence and severity of moral distress among practicing physiotherapists in the Anand district using the Measure of Moral Distress- Healthcare Professionals (MMD-HP) scale. The overall mean MMD-HP 81.5 ± 57.8 out of a maximum possible score of

432. Although the overall level of moral distress was relatively low, 16.2% (n=11). These findings suggest that while most physiotherapists reported low to mild levels of moral distress, a notable portion experienced clinically relevant ethical distress.

Male physiotherapists and clinician-academics demonstrated slightly higher mean MMD-HP scores than female physiotherapists and clinicians, respectively. However, these differences were not statistically significant ($p=0.397$ for area of practice; $p=0.700$ for gender), indicating that moral distress levels were comparable across these demographic groups.

These findings differ from those reported by Inbar et al. [14], who observed moderately high average moral distress that was significantly more pronounced in female practitioners. This divergence may stem from localised cultural or institutional factors in the Indian healthcare context, where professional burdens and clinical environments are more similar.

The Interpersonal Relations domain has the highest mean item score, closely followed by Therapeutic Obstinacy and Health Care, according to domain-wise analysis utilizing mean item scores. This result implies that moral discomfort among physiotherapists is significantly influenced by ethical issues pertaining to professional relationships, treatment continuation decisions, and healthcare delivery. Mean item scores were utilized to make cross-domain comparisons easier because the domains had varying amounts of items. Kulju et al. [13] similarly reported that physiotherapists frequently encounter ethical challenges related to lack of clinical resources, institutional prejudice, and team-based inefficiencies. Similar findings were reported by Taylor (2022) among emergency department nurses during the COVID-19 pandemic, where resource limitations and organizational pressures contributed largely to moral distress.

Nearly one in six physiotherapists in the Anand district is experiencing moderate moral distress, despite the fact that our sample reported a lower overall baseline mean than some international cohorts, such as the gerontic occupational therapy practitioners surveyed by Penny et al. (2016) [17], who noted high attrition rates linked to moral distress. Such untreated distress eventually undermines therapeutic

relationships, lowers job satisfaction, and jeopardises clinical decision-making.

These findings highlight the need for healthcare organizations to establish formal mechanisms such as ethics rounds, peer support programmes, and institutional ethics consultation services to help physiotherapists address ethically challenging situations. Such initiatives may reduce moral distress while promoting professional well-being and high-quality patient care.

The current study has several advantages. This study is one of the few that uses the validated MMD-HP questionnaire to assess moral distress among physiotherapists in practice in India. However, some limitations should be taken into consideration while interpreting the results. The small sample size from a single district restricts generalizability, the cross-sectional design excludes causal inferences, and self-reported responses may be biased. It is advised that future multicenter studies with bigger sample sizes look into more aspects of moral anguish in physiotherapists.

CONCLUSION

Although most physiotherapists experienced low to mild moral distress, approximately one in six reported moderate distress. Among the MMD-HP domains, Interpersonal relations, therapeutic obstinacy, and healthcare-related factors demonstrated relatively higher mean item scores, highlighting the need for institutional ethics support and strategies to reduce moral distress and promote professional well-being.

Declaration by Authors

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