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ORIGINAL PAPER

The Cost of Care: Exploring the Moral Side of Paradox Among Primary Medicine Doctors

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Abstract
Organizational paradoxes are traditionally viewed as problems that defy logic, yet they may also challenge individuals' moral beliefs and values. Drawing on interviews with primary medicine doctors in the United States (N = 24) and New Zealand (N = 26), our study focuses on the understudied moral side of paradox and how it relates to power relations. Specifically, we explore how power relations influence doctors' experiences of a "morally asymmetrical" paradox—namely, an underlying tension between cost and care imperatives—where one pole (care) is seen as morally important while the other (cost) holds largely instrumental value. We find the cost-care tension is generative for doctors when they can engage both poles on their own terms, but triggers moral distress when structural power imbalances prevent doctors from engaging morally important care imperatives. We also show how doctors respond to such distress using three "moral boundary management approaches"—*Moral self-differentiation, Moral dissociation*, and *Moral dissociation combined with extra-role moral engagement*—whereby doctors' (re)position their personal moral responsibilities in relation to their roles in the healthcare system. Altogether, our study advances understanding of the important yet understudied links among paradox, power, and morality.

Keywords Paradox · Power relations · Morality · Moral distress · Cost-care paradox · Paradox theory · Healthcare · General practitioners · Family physicians · Cost-containment · Profit-seeking

Introduction

> I felt just demoralized, like, you know, not that I failed them [my patients], but that our system has failed them, and I'm the current part of the system that's doing that. (Amy, family physician).

The doctor who shared this quote felt morally distressed by her powerlessness to engage both poles of a cost-care paradox. Moral distress is a psychological state that arises when individuals are forced to act in ways that conflict with their moral values and beliefs (Akerstrom et al., 2026; Stahlschmidt et al., 2022). Paradoxes are tensions between contradictory yet interdependent elements—known as paradox "poles"—which exist simultaneously and persist over time (Smith & Lewis, 2011). Examples of such tensions include social-commercial (Sharma & Bansal, 2017), cost-care (Pradies, 2023), and short-term—long-term (Slawinski & Bansal, 2015). Moral phenomena—defined as issues relating to "society's generally accepted standards for good/bad behavior" (Fairhurst & Putnam, 2023, p. 166)—have traditionally been overlooked in organizational paradox theory (Seidemann, 2024), which tends to focus on how individuals and organizations can navigate paradox to improve performance-related outcomes (Jarzabkowski et al., 2022; Miron-Spektor et al., 2018; Smith & Lewis, 2011). However, as we found in our study of doctors experiencing an underlying cost-care tension (Lewis & Smith, 2022), paradoxes may also be laden with moral elements that, if not engaged, can trigger debilitating moral distress.

Prior research already hints at paradox's potential to provoke morally charged reactions in individuals (Fairhurst & Putnam, 2023; Pradies, 2023). A key concept in this respect is what we label "moral asymmetry"—the notion that certain paradox poles hold greater "moral weight" than others. Existing studies implicitly acknowledge this

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concept by showing how individuals can experience competing demands as non-equivalent from an emotional or normative standpoint (Hahn et al., 2018; Pamphile, 2022; Pradies, 2023). For example, veterinarians may feel greater emotional attachment to care imperatives than to cost ones (Pradies, 2023), while individuals involved in corporate sustainability may normatively favor environmental and social missions over business goals (Albertsen, 2025; Hahn et al., 2018). However, although the concept of moral asymmetry is implicitly present in existing paradox scholarship, it has yet to be explicitly and fully developed.

Additionally, researchers have thus far paid scant (if any) attention to how moral asymmetries interact with *power relations* in the experience of paradox. Power relations refer to dynamic and perpetually negotiated configurations of social order that differentially shape actors' ability to behave—or influence others to behave—in accordance with their will (Fairhurst & Putnam, 2023). Researchers increasingly acknowledge that power relations shape and even constitute the lived experience of paradox (Amaral et al., 2026; Berti et al., 2026; Greenslade-Yeats, Mharapara, Ravenswood, Clemons, Staniland, 2026a). For example, imbalanced power relations can generate pathological manifestations of paradox (Berti & Cunha, 2023; Berti & Simpson, 2021a) and/or force individuals to experience underlying paradoxes as "presenting dilemmas"—proximate tensions that seemingly require distressing either/or choices (Lewis & Smith, 2022, p. 531). Despite these accumulating insights on the role of power in paradox, researchers have yet to explicitly examine the links among paradox, power relations, and *moral* phenomena (Fairhurst & Putnam, 2023). This lack of research leaves many important questions unanswered. For instance, how do individuals cope and respond when imbalanced power relations prevent them engaging morally important paradox poles? Moreover, are there certain configurations of power relations that could unleash the generative potential of moral asymmetries in paradox? Given that existing research provides only indirect and limited insights into such questions (e.g., Huq et al., 2017; Pradies, 2023), our study asks: *How do power relations influence the experience of paradox when it entails moral asymmetries, and how do individuals respond?*

We examine this question through a qualitative study of primary care doctors (N = 50) in the United States (US) and New Zealand (NZ). These doctors work in healthcare systems where care and cost imperatives represent the conflicting yet interdependent poles of an underlying paradox (Lewis & Smith, 2022). The purpose of healthcare systems is to provide care to patients, yet providing care comes as a cost in terms of human and material resources. Accordingly, costs must be kept in check to ensure healthcare systems remain financially viable, enabling the provision of ongoing care (Rijal, 2026). In this paradoxical context, doctors must constantly balance both care and cost concerns. However, as we found in our study, doctors find this balancing act morally challenging for two reasons. First, doctors do not view cost and care imperatives as normatively and emotionally equivalent. For them, care imperatives represent a *moral imperative*—a matter of right versus wrong —whereas cost imperatives are seen as the product of inevitable economic realities. Second, the ability to balance cost and care is often beyond doctors' individual control, shaped by organizational structures and systemic funding constraints (Rijal, 2026). Our findings illuminate how this combination of power relations and moral asymmetry often triggers *moral distress* in doctors, and how doctors respond using "moral boundary management approaches," whereby they (re)position their personal moral responsibilities in relation to their roles in the healthcare system. We also show how moral asymmetries embedded in the cost-care paradox can be generative when *balanced* power relations enable doctors to engage the paradox on their own terms.

As our overarching contribution, we advance understanding of the moral dimensions of organizational paradox. Researchers increasingly recognize the links between paradox and morality (Seidemann, 2024), and they have called for more research to examine these links (Fairhurst & Putnam, 2023). Yet, empirical studies on the moral side of paradox remain few and far between. Our work advances understanding of paradox as a moral phenomenon by explicitly examining the understudied links among paradox, power relations, and individuals' moral values (Fairhurst & Putnam, 2023). In doing so, we make three discrete contributions. First, we explicitly develop the concept of moral asymmetry and show how it can be a source of generative or debilitating tension in individuals experiencing paradox, depending on how power relations shape individuals' ability to balance distinct paradox poles. Second, we reveal moral distress as a novel outcome of experiencing paradox in a context of imbalanced power relations, and we develop a process model of individuals' responses to such distress, showing how these responses can amplify, flatten, or re-engage paradoxical tensions. Third, in describing the limits of doctors' individual responses to moral distress, we underscore the importance of combining both individual and systemic approaches to address pathological manifestations of paradox (Bednarek & Smith, 2024; Berti & Simpson, 2021b).

Theoretical Framing and Motivation

Management and organization scholars increasingly recognize the ubiquity and inevitability of paradoxes. Paradox theory, most notably encapsulated in the work of Marianne Lewis and Wendy Smith (Lewis, 2000; Lewis & Smith,

2022; Smith & Lewis, 2011, 2022), has become a prominent framework for understanding how to navigate and even leverage paradoxes for their generative potential. The theory's key premise is that because paradoxes cannot be "resolved", they are best navigated using a both/and approach. This approach entails addressing contradictory poles simultaneously without merging them (Seidemann, 2024). For example, competing demands such as social-commercial (Sharma & Bansal, 2017), short-term—long-term (Pradies et al., 2021a), and differentiation-integration (Tuckermann, 2019) are both engaged concurrently, yet recognized as requiring distinct strategies and actions. Actors accommodate each paradox pole in short-term cycles of oscillation, often supported by "guardrails"—structural boundaries that ensure neither pole is allowed to overwhelm the other (Smith & Besharov, 2019). Paradox theory contends that this both/and approach enables short-term peak performance *and* long-term sustainability through dynamic equilibrium (Jarzabkowski et al., 2022; Smith & Lewis, 2011).

Recent studies have drawn attention to two foci with the potential to expand paradox theory's reach and impact: power relations and normative concerns (Seidemann, 2024). First, power relations are increasingly recognized as shaping and even constituting the lived experience of paradox (Berti et al., 2026; Fairhurst & Putnam, 2023; Greenslade-Yeats et al., 2026a). A key distinction is between power relations characterized by "power-over" dynamics, where dominant actors and structures force subordinate actors to respond to paradox in certain ways, and "power-with" dynamics, where actors collaborate on a more equal footing to address paradoxical tensions together (Schrage et al., 2026). Research suggests power-over dynamics often produce "pathological" manifestations of paradox (Berti & Cunha, 2023, p. 875) such as pragmatic paradoxes (Berti & Simpson, 2021a) and double binds (Putnam & Ashcraft, 2017), leading to failed attempts to manage paradox (Amaral et al., 2026). There is also evidence that power-over dynamics can favor one paradox pole over the other (Huq et al., 2017), such as when organizational leaders prioritize business concerns over social missions (Pamphile, 2022). Guardrails may be established to protect both poles equally (Huq et al., 2017; Lewis & Smith, 2022), enabling responses characterized by generative power-with dynamics (Bednarek & Smith, 2024). However, the ability to establish guardrails is itself a product of power relations (Huq et al., 2017), implying it may not be feasible for low-power actors to establish and alter formal guardrails.

Another emerging stream of research draws attention to the understudied normative dimensions of paradox navigation. Seidemann (2024) argues that most paradox theory scholarship contains tacit assumptions about how paradoxes "should" be addressed. Specifically, this scholarship implicitly presents paradoxes not as intractable problems but as opportunities for creative action (e.g., Lê et al., 2017; Smith & Lewis, 2022). In turn, paradox theory implicitly assigns responsibility for navigating paradox to the individual actors—whether leaders or subordinates—who encounter them (e.g., Miron-Spektor et al., 2018; Smith, 2014). This implicit assignment of responsibility becomes problematic when one considers how power-over dynamics embedded in social structures and relationships often turn paradoxes into pathological phenomena (Berti & Simpson, 2021a; Greenslade-Yeats et al., 2026b) and/or constrain individuals actors' ability to address paradoxes through a generative both/and approach (Berti & Cunha, 2023; Berti et al., 2026). It also appears problematic when one considers that individual actors may *normatively* favor one paradox pole over the other, such as when vets identify more closely with care than cost imperatives (Pradies, 2023), or when individuals are ethically drawn to social or environmental missions (as compared to commercial objectives) in corporate sustainability paradoxes (Hahn et al., 2018).

Paradox scholars' growing interest in power relations and normative concerns comes together in Fairhurst and Putnam's (2023) call to explicitly examine the links among paradox, power, and morality. One way of exploring these links, they propose, is within the context of tensions between emotional and rational approaches to paradox. Emotions and morality are closely entwined because moral values and beliefs run deeper than instrumental concerns that can easily be expressed rationally (Pradies, 2023; Shadnam, 2015). Yet, power structures may favor instrumental concerns over emotional and moral ones because instrumental imperatives (such as financial or economic goals) are more easily justified in rational terms (Chow & Calvard, 2021; Timmermans & Almeling, 2009). Accordingly, the moral dimensions of paradox may surface in tensions between emotional and rational approaches to paradox and, in particular, how these approaches are influenced by prevailing power relations (Fairhurst & Putnam, 2023).

Some research already hints at how moral concerns can surface in emotional reactions to paradox. For example, Pradies (2023) studied veterinarians experiencing a business-care paradox. She found that vets were often forced to choose between business and care imperatives because clients could not afford expensive treatments for their pets. When this occurred, vets were worried their "action[s] may cause harm and distress" and felt "attached to care and upset at the organizational routine of prioritizing cost" (Pradies, 2023, p. 532). Meanwhile, Huq et al. (2017) examined a paradox of interprofessional collaboration in healthcare, which manifested as a tension between medical and psycho-social-behavioral (PSB) treatment approaches. The authors found that due to status differences in the interdisciplinary team, medical approaches consistently overrode PSB approaches in group discussions and decisions, leaving professionals

who identified with the PSB approach feeling "hurt", "anxious, discouraged, and even angry" (Huq et al., 2017, p. 514–515). Similarly, grantmakers in Pamphile's (2022, p. 1285) study felt "hurt" and "disheartened" that leaders in their organizations did not recognize or engage a business-society paradox, with leaders instead prioritizing instrumental, profit-driven imperatives at the expense of social impact.

Arguably, these studies suggest strong emotional reactions to paradox can stem from the differential moral weightings that individuals attribute to opposing paradox poles—that is, from moral asymmetries in the subjective experience of paradox. The studies also hint that power dynamics embedded in formal structures (Pradies, 2023) and hierarchical relationships (Huq et al., 2017; Pamphile, 2022) may trigger such reactions by "officially" favoring rationality/instrumentality over emotionality/morality. However, the studies do not explicitly or fully address how power relations interact with moral concerns to shape the lived experience of paradox, nor how individuals respond to paradox under such conditions. Therefore, our study is motivated by the question: *How do power relations influence the experience of paradox when it entails moral asymmetries, and how do individuals respond?*

As described below, we examine this question through a qualitative study of primary medicine doctors experiencing a cost-care paradox. Prior research suggests this paradox can entail moral asymmetries for individuals (Pradies, 2023) and that individuals' experiences of the paradox are shaped by systemic power structures that prioritize cost containment and profit-seeking over patient care (Dean et al., 2024; Molinaro et al., 2023). Accordingly, our empirical context is appropriate for addressing our theoretically motivated research question.

Research Design, Context, and Methods

We conducted a qualitative study to understand our participants' lived experiences of paradox (Gephart, 2004; Pradies et al., 2021b). As described below, our theoretical focus developed abductively as we iterated between data, existing literature, and suggestions from anonymous reviewers to develop novel theoretical insights (Folger & Stein, 2017; Locke et al., 2022).

Primary Care Medicine in New Zealand and the United States

We examined the links among paradox, power, and morality among primary care doctors working in two national healthcare systems: family physicians in the United States and general practitioners (GPs) in New Zealand. In both countries, primary care doctors are responsible for addressing patients' primary and ongoing health needs. As such, the scope of their practice tends to be broad compared to other medical specialties, and they rely on both relational and technical skills in their daily work. On the relational side, primary care doctors build ongoing, trust-based relationships with patients, developing interpersonal rapport and an in-depth understanding of patients' personal, family, and social circumstances. On the technical side, primary care doctors use medical skills and knowledge, prescribing pharmaceuticals, performing minor surgical procedures, and making referrals for diagnostic imaging and/or secondary treatment options (e.g., major surgery).

In New Zealand (NZ), GPs work in a universally funded national health system. They typically practice in privately-owned or corporate medical clinics that receive bulk funding from the government depending on how many patients are enrolled at the clinic. This funding arrangement is known as the "capitation" model. Medical clinics can be run as profit-making businesses or as cost-covering enterprises, either by owner-operator doctors, corporate entities, or charitable organizations. Clinics generally supplement government funding by charging their patients a co-payment for consultations; the maximum co-payment is regulated by the NZ health authorities and capped for patients with lower incomes.

In the United Sates, family physicians work in a market-based healthcare system funded predominantly by private insurance companies. Some insurance companies (e.g., MEDICAID and MEDICARE) receive partial funding from the government, yet are still run as private, profit-making entities. Family physicians generally work for themselves in independent private practice (often jointly with other owner-operators), for profit-making corporate healthcare organizations (hospital systems or groups), or for healthcare organizations with non-profit status (e.g., medical schools in universities).

Our study began as an exploration of meaningful and meaningless work among primary care doctors practicing in these two distinct health systems. We were interested in comparing how systemic factors such as funding models influenced experiences of meaningfulness and meaninglessness among doctors. However, as our study progressed, we came to two realizations that spurred us to shift our focus (as is common in paradox research; see, e.g., Pamphile, 2022). First, we realized that *meaningless* work was too "mild" a descriptor for many of the frustrations and downsides that doctors wanted to talk about. For instance, when asked what she found meaningless about her job, an early participant stated: "I mean, yes, I can describe some meaningless work, but I think even worse is like, work that feels harmful." Subsequently, we adjusted our interview prompts to focus on instances where doctors felt their work was harmful or demoralizing. Second, while conducting interviews with NZ

doctors (which followed those with US doctors), we realized that, despite differences in national funding systems, doctors' experiences of meaningless, demoralizing, and harmful work centered around the same tension between care and cost imperatives. Accordingly, doctors' experiences of this underlying paradoxical tension became the focus of analysis for the present manuscript.

Participants

After receiving study approval from our university's ethics committee, we recruited participants with the support of two professional bodies representing the interests of primary care doctors in our study locations. These bodies sent advertisements through newsletters and mailing lists. Potential participants made first contact with the team by completing an online consent form and demographic information survey, where they also left contact details. The first author then followed up to arrange an interview time. To be eligible for the study, participants had to be registered as a family physician in the US or as a GP in NZ. While most of our participants were actively working in these roles, some participants (N = 4) had recently moved into adjacent medical roles, one participant had retired from practice within the past 12 months, and one participant was between jobs. Eleven participants were owner-operators in their clinics (jointly or individually) and seven participants combined clinical work with paid administrative roles (other than owner-operator responsibilities). Tables 1 and 2 show demographic information for the doctors in our sample.

Data Collection

We collected data through participant interviews (N = 50). All interviews were conducted via Zoom between February 2024 and October 2024. Interviews followed a semi-structured guide that we adjusted as theoretically interesting themes developed (Charmaz, 2006). For example, whenever participants talked about situations where cost imperatives prevented them providing appropriate patient care, we asked: "What systemic factors are behind those situations, in your view?" and "How do you cope with those situations?" Interviews lasted 58 minutes on average (range = 35–86 minutes) and were digitally recorded. We transcribed interviews verbatim and, if requested, sent transcripts to participants for accuracy and confidentiality checks before commencing analysis.

Analysis

We analyzed data through an iterative process whereby we cycled between the data and related literature to develop theoretical insights (Locke et al., 2022; Miles et al., 2014).

Table 1 Demographic information of US family physician participants (N = 24)

Category	Statistic
Mean years of experience as a physician	17.3 years (*SD* = 11.5)
Mean hours worked per week	42.8 h (*SD* = 15.4)
Education/training	
US allopathic medical school	59% (*n* = 14)
US osteopathic medical school	28.5% (*n* = 5)
International medical school	12.5% (*n* = 3)
Mean age	47.2 years (*SD* = 12)
Gender	
Female	46% (*n* = 11)
Male	54% (*n* = 13)
Ethnicity	
White	70.8% (*n* = 17)
Black or african american	8.3% (*n* = 2)
Asian	8.3% (*n* = 2)
Middle eastern	8.3% (*n* = 2)
Mixed	4.2% (*n* = 1)
Relationship status	
Married, civil union	70.8% (*n* = 17)
Single	12.5% (*n* = *3*)
Separated or divorced	8.3% (*n* = 2)
De facto/common law relationship	4.2% (*n* = 1)
Widowed	4.2 (*n* = 1)

Table 2 Demographic information of NZ general practitioner (GP) participants (N = 26)

Category	Statistic
Mean years of experience as a general practitioner	17 years (*SD* = 11.2)
Mean hours worked per week	33.5 h (*SD* = 7.6)
Education/training	
NZ medical school	65.4% (*n* = 5)
International medical school	34.6% (*n* = 9)
Mean age	47.6 years (*SD* = 12.1)
Gender	
Female	81% (*n* = 21)
Male	19% (*n* = 5)
Ethnicity	
New zealand european	57.7% (*n* = 15)
European	23% (*n* = 6)
Asian	19.3% (*n* = 5)
Relationship status	
Married, civil union	57.7% (*n* = 15)
Single	15.4% (*n* = 4)
De Facto/Common law relationship	15.4.% (*n* = 4)
Widowed	7.7% (*n* = 2)
Separated or divorced	3.8% (*n* = 1)

As is common in qualitative paradox research (Jarzabkowski et al., 2022; Pamphile, 2022), the beginnings of our analysis occurred during data collection (Charmaz, 2006). Specifically, as interviews unfolded, we noted and discussed themes with the potential to generate theoretical insights. These themes included: "Meaningless work as harmful work," "cost/business-care tensions," "structural power imbalances," and "advocacy work to effect systemic change." We subsequently used these themes to guide interview prompts, ensuring we had adequate data richness to support our eventual theorization (Charmaz, 2006). Once we had completed data collection, we analyzed data in an iterative, three-step process (Miles et al., 2014). This process involved both emic and etic approaches to coding (Saldaña, 2013), as is common in paradox research (e.g., Jarzabkowski et al., 2022).

Descriptive Coding

Starting with an *emic* approach, we descriptively coded the data line-by-line to understand participants' experiences in their own words (Miles et al., 2014). Working with support from two research assistants, we developed an initial coding framework based on our collective reading of a subset of transcripts (King, 2012). We uploaded this framework to the analysis program NVivo, then coded the remaining transcripts in subsets, adding and refining codes as necessary. Descriptive coding served to break the data into fine-grained "meaning buckets," rendering it manageable for subsequent stages of analysis (Miles et al., 2014). Descriptive codes were organized thematically, allowing us to easily find relevant data as needed. For example, under the thematic category of "Time constraints," we had fine-grained codes including "Availability," "Length of appointments," and "Running late." The two paid research assistants performed most of the descriptive coding, with oversight from the first author and regular meetings involving all authors to ensure agreement. We used the same initial coding template for the two national datasets (UN and NZ), although each dataset was coded in a separate NVivo file. This approach enabled descriptive codes to be context-specific (in terms of detail) yet thematically coherent.

Pattern Coding

During pattern coding (Miles et al., 2014), the authors developed a reconfigured coding framework to combine and explore the most theoretically interesting themes from across the two national datasets. This coding aligned with an *etic* approach because it involved us (the researchers) adding our own theoretical interpretations to participants' descriptions of their experiences (Saldaña, 2013). To assist pattern coding, we reviewed notes about themes made during data collection and drew on ideas and concepts from relevant literature (Locke et al., 2022). For example, noting the theme of "cost/business-care tensions," we drew on concepts from the paradox literature (e.g., Fairhurst & Putnam, 2023; Lewis & Smith, 2022; Pradies, 2023) to develop codes such as "Interdependent view of cost and care imperatives," "Moral dichotomy view of cost and care," "Organizational structures restrict time with patients," "Cost constraints limit treatment options," "Care = morally important," and "Profit motives in healthcare seen as immoral." Pattern coding enabled us to move from descriptive patterns in the data to an understanding of theoretically relevant themes. Notably, during pattern coding, we assumed that all doctors experienced an *underlying* cost-care paradox—because this paradox is inherent to the organization of healthcare systems (Lewis & Smith, 2022)—even if our participants sometimes described cost and care imperatives in terms of a dichotomy (see Findings).

Abstraction and Theorization

In the final stage of analysis—which we undertook iteratively alongside pattern coding—we developed a high-level, theoretical understanding of our empirical findings, often by using visual aids (figures) to capture abstract ideas from the data (Pradies et al., 2023). To start, we clustered pattern codes into two aggregate categories (Locke et al., 2022), enabling us to address the two parts of our research question. The first aggregate category related to how power relations influenced doctors' experiences of the cost-care paradox. These codes revealed the importance of three key themes: *moral asymmetry between care and cost imperatives, generative elements of moral asymmetry,* and *moral distress as a reaction to powerlessness in engaging paradox.* Next, because doctors in our sample overwhelmingly experienced the association between power relations and moral asymmetry as a source of moral distress, we focused our subsequent analyses on their responses to such distress. Specifically, we clustered pattern codes relating to doctors' coping strategies while also returning to transcripts to read surrounding sections of interviews, which afforded a more holistic understanding of how doctors responded when they felt morally distressed in their clinical work. For instance, based on pattern codes, we identified that doctors sometimes viewed cost and care imperatives in terms of a "moral dichotomy," and that when they did so, they responded to moral distress by "morally differentiating" themselves from the healthcare system, typically by going above and beyond paid and medico-legal duties to care for patients. Drawing on retrospective accounts from interviews, we also analyzed how doctors maintained or shifted their responses to moral distress over the course of their careers and in response to changing circumstances. This analysis to differentiate doctors' responses yielded three distinct yet interconnected patterns, which we labeled "moral boundary management approaches" (see

Findings). We synthesized these approaches in a process model (Fig. 3) to theorize how individuals experience and respond to moral distress triggered by powerlessness in engaging paradox.

Findings

How Power Relations Influence the Experience of Moral Asymmetry in Paradox

> I think providers [doctors] feel the strain is, you know, administrative personnel are looking out from the lens of, "This is an industry and a business that we're trying to sustain." Providers, for the most part, will look at it from the lens of, "Here is my ideal way to practice medicine." … So there is a tension between that. (Adam,[1] family physician)

As this quote suggests, the cost-care paradox is omnipresent for primary care doctors, who must navigate a persistent tension between care and cost imperatives in their day-to-day work. On the one hand, primary care doctors have a legal duty and internalized commitment to provide appropriate care to patients. On the other hand, doctors work in systems governed by cost imperatives stemming from business interests and/or public funding constraints. Cost imperatives often conflict with care imperatives because they limit the care and treatment options doctors can offer to patients (see below). However, cost imperatives are also interdependent with care imperatives because healthcare systems must keep costs in check to remain financially viable; if they do not, systems may compromise their ability to retain the material and human resources needed to provide appropriate care.

Although the cost-care paradox is omnipresent in primary healthcare systems, doctors in our study did not view both poles as morally equivalent. Rather, doctors saw one pole (care) as morally important—a matter of right or wrong—and the other pole (cost) as holding largely instrumental value. Stated differently, doctors viewed providing appropriate care as being inherently "the right thing to do" (Catherine, family physician), whereas they viewed cost constraints as an inevitable facet of economic realities. Participants captured this notion of moral asymmetry in statements such as:

> I think that's the thing—a lot of family physicians aren't sort of capitalistic, you know, like we're in it to take care of patients, and we'd like to make a decent living and pay off our student loans in the process. But we're not trying to become millionaires, you know. We just want to feel good, feel like we're doing good a job and taking care of people and helping people. (Gabriela, family physician)

For doctors in our study, the moral elements of care imperatives went beyond medico-legal responsibilities toward patients. To illustrate, doctors could fulfil their legal duty of care toward patients—protecting themselves against litigation or disciplinary action—and yet still feel like they failed to do "the right thing" in terms of providing appropriate care. One family physician (Carmen) captured this notion when discussing how following the standard treatment procedures in her clinic "wasn't right." When asked why she thought the procedures were not "right," she responded: "Just day-to-day, it just felt horrible. Just the feeling was horrible." This response emphasizes the deep-felt, emotional nature of doctors' moral duties toward patient care, which contrast with the rational and instrumental character of cost imperatives. Carmen went on to explain that, often, she felt unable to provide appropriate care *because* she was following standard, cost-driven procedures:

> [In] outpatient, just seeing so many patients, having to review their record. You need double the time, but you only get, like, five minutes to review their record. The MA comes in, the medical assistant. She tells you the report, to which you're half listening because you're too busy doing something else, and then you see the patient. But you're typing the whole time, and you never really get to the core problem. I mean, you easily treat with a pharmaceutical. Anyone can do that. But you just never really get anywhere. And they just keep coming back, and then they go to the hospital because they're in acute or chronic heart failure, and you just—I feel that I was just doing things for the system, for insurance, for billing. (Carmen)

This quote illustrates not only the nuances of moral asymmetries but how they can combine with power relations to shape doctors' experiences of paradox. Specifically, the quote demonstrates that the structures of healthcare organizations and systems can prevent doctors engaging the morally important care pole, making it feel impossible for them to do "the right thing." As Carmen stated, she was often unable to "get anywhere" with patients because she was "doing things for the system, for insurance, for billing." In other words, organizational structures forced her to prioritize cost imperatives over care ones, even though her moral compass told her to prioritize the latter. Figure. 1 depicts how this structural-moral imbalance triggered morally laden tensions for doctors.

Figure. 2 depicts how doctors' experiences of this morally laden tension "hinged" on power relations. The scale on the left-hand side of the figure illustrates balanced power relations, which enabled doctors to experience moral asymmetry

[1] All names are pseudonymous.

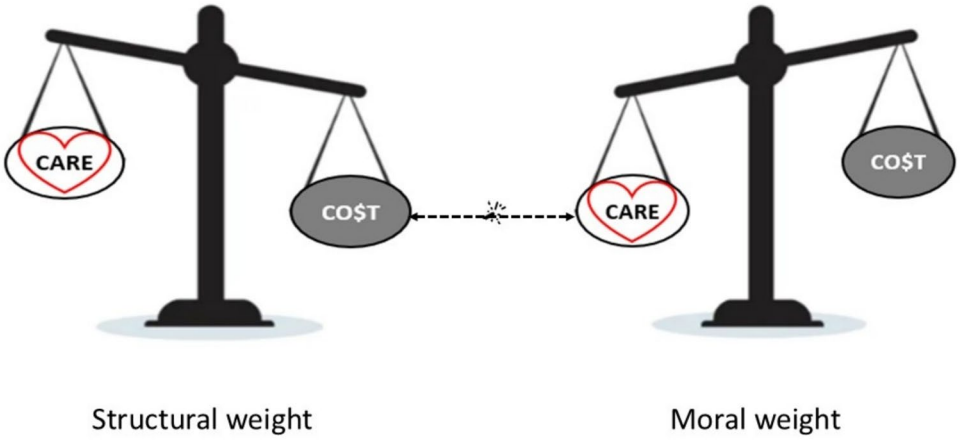

Fig. 1 How structural-moral imbalances engender morally laden paradoxical tensions

as a *generative tension;* the right-hand side shows imbalanced power relations, which transformed the same asymmetry into a *morally distressing tension.* In our study, the key "power balance" was between agency and structure—namely, individual doctors' agency to engage paradox on their own terms and the organization and systemic structures that shaped and constrained their actions.

Doctors in our sample experienced differing levels of agentic power to engage cost-care tensions. Some doctors were owner-operators of their clinics. As such, they could potentially reshape organizational structures to better accommodate both cost and care imperatives. For instance, one GP explained how she and her clinic's co-owners had decided to operate on lower profit margins to provide better care:

> So at our practice, we've actually decided to take less of a profit and offer 20-minute appointments to our patients instead of 15. So the government funds for 15-minute appointments, but we're finding in our demographic and with our patient needs, we can't fit that in. (Lara, GP)

Similarly, a family physician described how she had restructured her entire work life, starting a direct primary care practice, so she could help patients overcome financial barriers to care:

> So I have a direct primary care practice. I don't take any insurance, and people pay a monthly fee... and that pays for my time, whether that's calling me, texting me, seeing me in person, whatever is needed… I think a lot of decisions in medicine are made out of fear or lack of money. And I know my patients well enough that I can have conversations with them that are realistic…Because I think a lot of the fear in the medical system from patients is a lack of control and a lack of understanding. And I can help with both of those things. (Gabriela, family physician)

These examples illustrate how a relatively equal power balance between doctors' individual agency and structural constraints could transform moral asymmetry into a generative form of paradoxical tension (see Fig. 2). The moral imperative to engage care concerns (despite apparent cost constraints) motivated doctors to re-design organizational structures to better accommodate both paradox poles.

However, according to most doctors in our study, their experiences more commonly aligned with the right-hand side of Fig. 2, with imbalanced power relations preventing them from engaging care and cost imperatives equally. Sometimes, doctors' relative powerlessness to engage care imperatives was due to their position in organizations. For example, junior doctors typically lacked the power and financial resources to reshape formal structures such as appointment schedules. One junior family physician described how she was willing to sacrifice her earnings to provide higher quality care, but was not allowed to by her organization's management:

> So when I started out, they did like a ramp-up schedule of, like, starting with 12 [patients per day] and then with the goal in, like, six months to go to, like, 20 as my minimum, to meet the bare minimum salary pay that they guaranteed. I've actually asked not to be on the guaranteed salary, so I'm not beholden to those minimum requirements, because I'm okay with making less money. But they wouldn't let me. They were like, "You have to make this much, and you have to see this many [patients per day]." (Maria, family physician)

Another doctor described how she was admonished by her clinic's management for overshooting appointment times:

> I spent two hours a few weeks ago with a 17-year-old who was acutely suicidal, refusing to go to the ER [emergency room]. I was very worried about her safety. She had some self-harming behaviors recently.

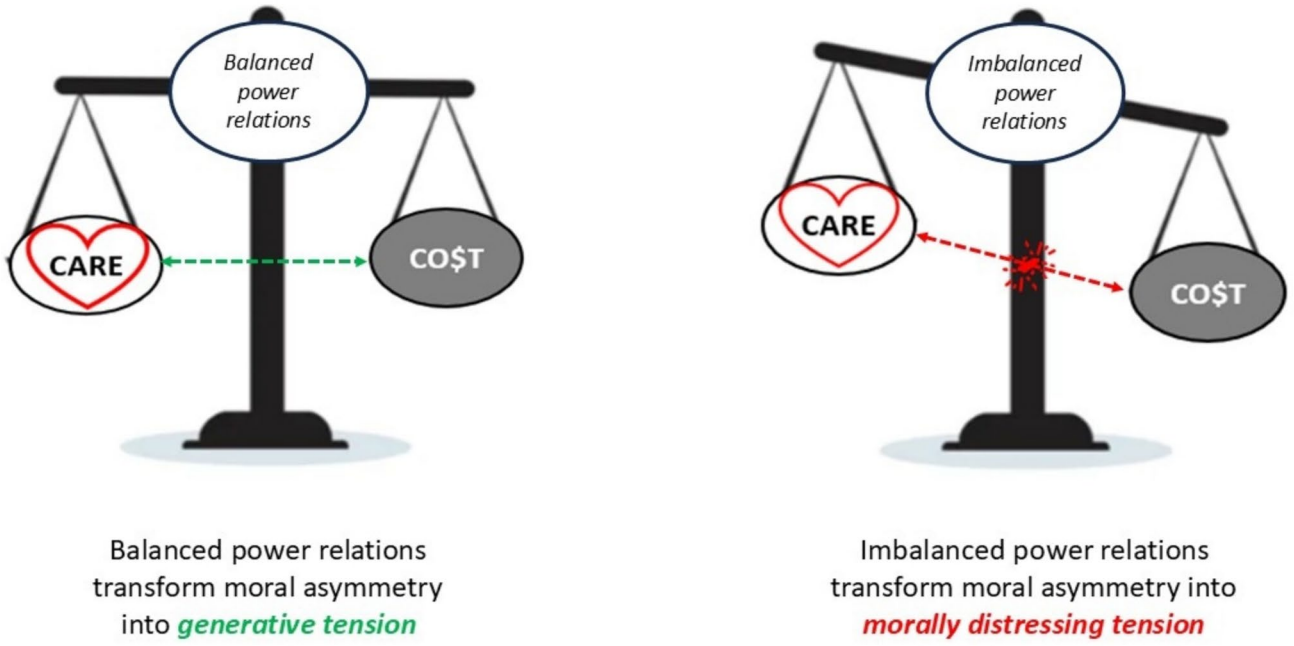

Fig. 2 How power relations influence the experience of moral asymmetry in paradox

> And I got yelled at for keeping the staff late because I spent that long with her. (Catherine, family physician)

We found that in such situations, doctors' powerlessness to engage care amplified the cost-care tension to the point that it became *morally distressing* (see right-hand side of Fig. 2). Participants captured moral distress in statements such as:

> [A] lot of my work felt harmful and in conflict with what I knew to be best for my patients. But I couldn't get it for them. It was inaccessible to them because of

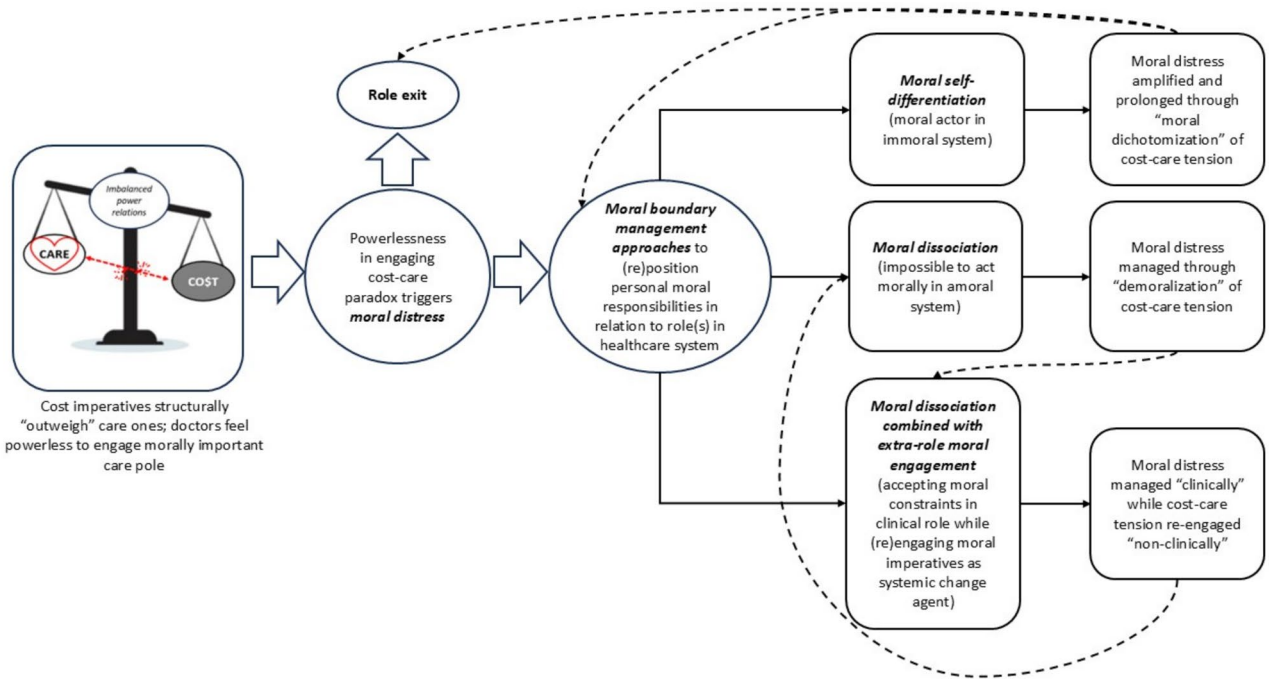

Fig. 3 How doctors respond to moral distress using moral boundary management approaches

> things totally outside of me and them. (Amy, family physician)
> I felt the guilt of not being able to meet their needs, and I struggled with that, knowing that I would do everything I could for them, and then knowing I was limited by [systemic constraints] … I don't know how to fix that. I think fee for service makes it bad... that guilt. (Brody, family physician)

Importantly, experiences of moral distress were not unique to more junior doctors. We found doctors at all levels were susceptible to moral distress because, as hinted in the quotes from Amy and Brody, many of the constraints impeding appropriate care were embedded in systemic funding structures over which individual doctors had practically no control, regardless of their position within organizations. For instance, in NZ, cost constraints stemming from inadequate funding of the public health system frequently blocked GPs' attempts to refer patients for secondary treatment in hospitals:

> I sent a referral off to a knee replacement, and this person had their X-ray done seven months ago, and it showed severe osteoarthritis. So I send a referral off, [and] I get a thing back saying the X-ray has to be within the last six months. I mean, that's just ridiculous. Severe arthritis isn't going to suddenly get magically better in the extra month… And [so] the whole referral system is driven by this desire to keep the wait list [for hospital-based treatments] low… You know, the pressure is on the hospitals *not* to put people on the wait list, and it definitely comes from the top. Like, I was talking to someone who decided which patients with knee and hip osteoarthritis got operated on, so what happens is that some manager comes in and says, "Of these 70 referrals, you can accept eight," and that's what happens. So, it is cost - it's totally cost driven. (Theresa, GP)

Despite such cost constraints coming "from the top," GPs were the ones who bore the moral burden of dealing with patients who had been declined appropriate treatment in hospitals:

> [We have] patients that are being cared for in general practice when that's not really the right place for them. And the example would be somebody that was on an orthopedic waitlist and who gets kicked off. So that is just going to be a really harmful relationship for both the patient and for us, because they are not receiving the care that they need. Their life is really difficult. Their pain level is not necessarily something we can control. People in the hospital have closed the door, and so every interaction we have with them will be really, really less than ideal. So, for them, it's frustration and often a bit of depression, and for us, it's just this complete inability to actually get the proper care for that patient. (Natalie, GP)

Doctors in the US reported similar constraints on care and treatment options stemming from the country's profit-driven, insurance-based funding system. For example:

> I've been on the drop zone with, like, one of my paratroopers that broke his ankle, and the thing's at a 90-degree angle, and I'm like, that needs an MRI [magnetic resonance imaging] and to go to surgery, like, tomorrow. And the MRI gets refused [by the insurance company] because they [the patient] have to fail PT [physical therapy] for six weeks before they can get an MRI. It's like, what algorithm are you guys looking at that fails to say, like, an ankle at a 90-degree angle from the leg is worthy of surgery? It's all just entirely set up to serve the profits of the shareholders of health insurance companies and large health organizations. I mean, they have a fiduciary responsibility to those people. It's not made to benefit anybody else. (Marvin, family physician, describing his experience as a primary care military doctor)

As happened to GPs when secondary referrals were declined, family physicians in the US bore the moral burden of telling patients when costly treatment options were denied or blocked by insurance companies: "[A] nother frustrating thing about [prior authorizations for expensive treatment options] is that the patient's impression is, like, I'm not doing something, or it's the doctor's fault, you know" (Gabriela, family physician). In turn, this burden became a source of ongoing moral distress[2]:

> These institutions, specifically the healthcare and insurance companies, create a scenario that, as a clinician, I can never be in an exam room and have it be a win-win situation. There's always going to be a loser in almost any scenario with a patient. So, if I choose the best medicine for diabetes, the cost is going to be so astronomical that the patient's pocketbook loses … but the pharmaceutical company wins…. Okay, I choose not to use the most expensive and best medicine. I choose an older medicine. Well, the patient's not getting the best care, but the insurance company is happy. It's scenarios like that that are always happening in exam rooms. And so when you're always picking winners and losers, it creates a moral injury, because

[2] Note that the participant instead uses the term "moral injury." It was beyond the scope of our research to assess whether our participants had actually experienced moral injury, as this is a serious condition that presents with symptoms similar to depression, burnout, and even post-traumatic stress disorder (Rabin et al., 2023).

> you're this referee, unbeknownst to the patient. The patient has no idea - they're just like, "I guess he's doing the right thing for me, the best thing for me." But I'm constantly having to do that. (Vikash, family physician)

In sum, doctors' experiences of the cost-care paradox hinged on interactions between moral asymmetry and structure-agency power relations. When these power relations were relatively balanced, moral asymmetry could become a source of generative tension, motivating action to engage morally important care imperatives. In contrast, when structural constraints systematically overrode doctors' individual agency to engage care, the same asymmetry triggered moral distress. As noted earlier (see Data Analysis), doctors in our study overwhelmingly experienced the latter of these scenarios, with imbalanced power relations consistently transforming moral asymmetry into a morally distressing tension. Accordingly, to address the second part of our research question (on doctors' responses), we focus the remainder of Findings on how doctors responded to moral distress.

Responding to Moral Distress: Doctors' Moral Boundary Management Approaches

Figure 3 summarizes our overall findings regarding how doctors responded to moral distress in the experience of paradox. Starting on the left, the figure shows how imbalanced power relations triggered such distress by rendering doctors powerless to engage morally important care imperatives. Moving to the right, it depicts three distinct "moral boundary management approaches" that doctors deployed in response: *Moral self-differentiation, Moral dissociation,* and *Moral dissociation combined with extra-role moral engagement*. As their names suggest, these approaches all involve efforts to (re)position doctors' personal moral responsibilities in relation to their roles in the healthcare system. We call them *boundary* management approaches because they entail efforts to *delimit* doctors' internal sense of moral responsibility toward cost constraints affecting patient care.

In most cases, individual doctors did not adopt a single approach consistently but rather shifted between the approaches over the course of their careers. Accordingly, the three approaches are interconnected via feedback loops, represented by dashed arrows in Fig. 3. For example, the feedback arrow linking the "outcomes" of *Moral self-differentiation* to the circle representing "Moral boundary management approaches" implies that a doctor who initially responded to moral distress through *self-differentiation* could later switch to a different approach (or exit their role) based on the outcomes of the initial approach. Similarly, the arrow linking the outcomes of *Moral dissociation* back to *Moral dissociation combined with extra-role moral engagement* suggests doctors who initially dissociated morally in clinical work could subsequently offset the negative outcomes of this approach with extra-role moral engagement (see below). The arrow linking the outcomes of *Moral dissociation combined with extra-role moral engagement* back to *Moral dissociation* represents the opposite shift. Finally, the figure shows that not all doctors responded to moral distress using these moral boundary management approaches; as depicted, some took more drastic action such as directly exiting a morally distressing role. We next explain and illustrate the three approaches with data from our study. Table 3 provides an overview of the key features of each approach and how it influenced doctors' experiences of the cost-care tension.

Moral Self-Differentiation

> I call patients and, like, I talked to someone for 30 minutes on the phone yesterday as I was driving home because my patient has Parkinson's. And her brother's really worried about her paranoid delusions and wanted to brainstorm that with me. So, I just spent a half an hour on the phone with him. Like, I didn't get paid for that phone call. But I do it because I care. And I think, you know, it's the right thing to do. (Catherine, family physician)

Catherine's actions epitomize the first moral boundary management approach that we identified—*Moral self-differentiation*. We found this approach was most common among early career doctors. Doctors adopting this approach tried to alleviate moral distress by *morally differentiating themselves* from the healthcare system in which they worked, viewing themselves as *moral actors* in an amoral or even immoral system. In turn, this approach entailed doctors fighting to prioritize morally important care imperatives despite the system's prioritization of cost constraints. Typically, doctors did so by going above and beyond their paid and legal duties to care for their patients (e.g., "I didn't get paid for that phone call. But I do it because I care").

Although *moral self-differentiation* alleviated moral distress in the short term (see below), our data suggest it often backfired over longer periods, producing the unintended consequence of amplifying and prolonging doctors' moral distress. There are two interrelated reasons for this. First, by morally differentiating themselves from the cost-driven healthcare system and morally aligning themselves with care imperatives, doctors came to see the cost-care paradox in terms of a "moral dichotomy." By this, we mean they stopped seeing cost and care imperatives as interdependent elements of functioning healthcare systems and instead viewed the poles in terms of a "right-wrong" or "good-bad" binary. Figure 4 depicts this morally dichotomous perspective in contrast to an interdependent, paradoxical view.

Table 3 Summary of moral boundary management approaches and associated outcomes

Moral boundary management approach	Description	Implicit view of cost-care paradox	Outcomes
Moral self-differentiation	Doctors go above and beyond for patients to *morally differentiate themselves* from the health system, viewing themselves as moral actors in an amoral or immoral system; by extension, they assume moral responsibility for system deficiencies	Moral dichotomy: Care imperatives viewed as inherently "good" or "right"; cost constraints viewed as inherently "wrong" or "bad"	Moral distress initially reduced by going above and beyond for patients ("sacrificial" work behaviors); work feels highly meaningful Over time, sacrificial work behaviors become unstainable, leading to lowered sense of self-efficacy (unable to help patients); work feels less meaningful and moral distress not only returns but increases
Moral dissociation	Doctors *morally dissociate* from their clinical roles in the health care system, viewing themselves as powerless to act morally in an amoral system; by extension, they abdicate moral responsibility for system deficiencies	Demoralization: Care imperatives lose their moral importance; moral asymmetry disappears and, in turn, reduces (potentially generative) moral tension between cost and care imperatives	Moral distress reduced (avoiding burnout and moral injury) Work becomes less meaningful; in extreme cases, relationships with patients may feel transactional or even burdensome Doctors seek meaning in other part of their lives (e.g., family commitments)
Moral dissociation combined with extra-role moral engagement	Doctors *morally dissociate* from their clinical roles while *morally engaging* cost-care tensions in non-clinical roles as systemic change agents; by extension, they both abdicate and assume moral responsibility for system deficiencies	Moral imbalance: Cost and care are viewed as inherently interdependent but out of balance (i.e., cost constraints "outweigh" care imperatives in the system); moral imperatives dictate restoring the "balance" between cost and care through systemic change efforts	Moral distress reduced (avoiding burnout and moral injury) Work remains meaningful on balance; meaningless clinical work offset by meaningful efforts toward systemic change and/or public health improvement Non-clinical roles absorb time and energy that would otherwise be dedicated to non-work and family activities; the costs of these efforts may ultimately lead to withdrawal from extra-role moral engagement

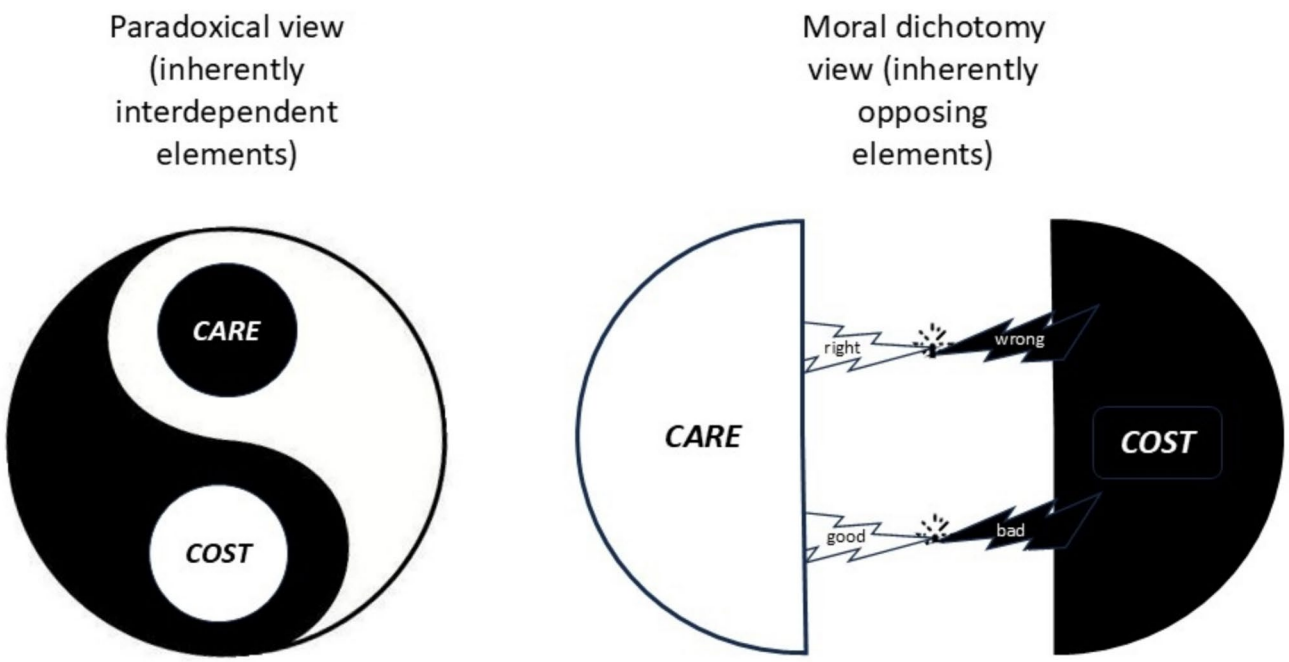

Fig. 4 Paradoxical versus morally dichotomous views of the cost-care tension

The moral dichotomy was evident in the language doctors used to describe cost versus care imperatives. For example, doctors adopting this approach often saw themselves as "fighting an uphill battle" (Melissa, GP) between "good" or "right" care concerns and "bad" or "harmful" cost imperatives. Some even viewed the recipients of care (patients) as victims of the entities imposing cost-related barriers: "We're not there to, like, take advantage of people in their time of weakness and need or sickness, which is the way the hospital system works right now, right? You get sick, and that's their opportunity to cash out, right? Like lions sitting in the tall grass" (Marvin, family physician). In turn, doctors who viewed cost and care as morally dichotomous elements experienced moral distress when they could not meet their patients' needs and, through a self-reinforcing cycle, that distress further entrenched the moral dichotomy. Indeed, we found that some doctors internalized the moral dichotomy to such an extent that even administrative tasks related to maximizing cost-efficiency were viewed as "harmful." For instance, here is how a doctor described her perceptions of "box-checking" testing requirements intended to lower the overall cost of patient care:

> I mean, it is like a box checking [exercise], but it frustrates me because it [is] just like a waste of resources, you know, a waste of tests that are unnecessary, a waste of the patient's time, and then a waste of my time to have to not only order these tests, but then I have to get the results back, and I have to sign off on the results. I think in a sense, it's like, all of that is a harm. It is harmful because it also makes us clinicians feel, you know, frustrated, annoyed, cynical, and jaded, and then we are not doing a good job for our patients, which is harmful. (Amy, family physician)

The other reason *Moral self-differentiation* amplified and prolonged moral distress is that it resulted in doctors' fighting a losing battle. As discussed earlier, doctors' moral distress was most often triggered by structural cost constraints over which they had practically no control. Therefore, when doctors morally differentiated themselves from the system—going above and beyond paid duties to care for patients—they (ironically) assumed moral responsibility for system deficiencies. In turn, this assumption of responsibility prolonged doctors' moral distress by perpetuating unresolved tension, often leading to burnout and/or symptoms of moral injury, either directly or by encouraging self-sacrificing behaviors. A family physician captured this notion as follows:

> You get stuck in this moral injury environment where you don't have the resources to do the right thing, but you feel that you must, and so you don't have what you need to do the right thing. And to me, that causes human suffering as a family physician, and the way that manifests is either you get burned out and depressed because you just can't possibly do it, or you sublimate that into a poor rationalization of sacrificing your health, your wellbeing, your marriage, and

> your family by spending more time taking care of the patients than you do of yourself and your loved ones. (Michael, family physician)

Our analysis suggests that when doctors made sacrificial efforts to do the "right thing" for patients, it initially made their work feel highly meaningful, alleviating moral distress. Because they were doing everything in their power to act morally in an amoral or immoral system, doctors felt like quasi-heroes in the "battle" between cost and care. Over time, however, such efforts took their toll on doctors, impacting their non-work lives and leading to exhaustion and burnout:

> Yeah, it's meaningful work. In fact, the need is so great that you never feel like you can quite manage it… And that was part of the burnout, was part of the community expectation to be everything to everyone at the same time. Am trying to be a mum, trying to deal with own family needs, trying to deal with own needs, thinking about how it might look long term… you know, all of that stuff. (Hayley, GP)

As these impacts accumulated, doctors experienced a reduced sense of self-efficacy: "So when you've got, like, 12 patients in four hours, and you're running 40 min late by the end of it, and people are talking about, like, suicide or cancer or childhood trauma, and you get to the end and you're, like, exhausted, you're like, I just can't, this is too stressful" (Tony, GP). In turn, the efforts to go above and beyond for patients that initially felt meaningful now felt "pointless," and moral distress not only returned but increased. As illustrated by the feedback arrows in Fig. 3, we found that this pattern of burnout and moral distress typically triggered a role exit or a change in how doctors managed moral boundaries.

Moral Dissociation

> And so that's how I've also managed…I've mentally told myself it's the system's fault; it's not my fault. So I've disconnected. You know, if someone's got to wait nine months or a year to get into the hospital, because that's their wait list, as sympathetic as I am, that's not me, you know, it's not my responsibility. It's not ultimately going to be my issue. It's the patient's issue. So, it sounds a bit brutal, but I think there's a lot of moral injury you see with the younger GPs because, again, you know, they're idealistic. They probably care more than I do, but I've learned it, and that's my way of coping. It's that, you know, if it's something that's outside of my control and I can't do anything about it, there's no point in me carrying that. (Richard, GP)

The second moral boundary management approach we identified was *Moral dissociation.* Like Richard, doctors adopting this approach made peace with their inability to always provide appropriate care by *morally dissociating* from their clinical roles in the healthcare system. In other words, when they felt powerless to do "the right thing" for patients, they told themselves: "it's the system's fault; it's not my fault" (Richard, GP). This is not to say these doctors no longer tried to provide appropriate care. Rather, they provided the best care they could within the limits of cost constraints: "There is a subtle difference between doing the best for the person in front of you and just trying to do the best that you can do in this situation, bearing in mind the limitations of what you have available now" (Richard, GP).

We found this approach was more prevalent among doctors with longer careers. Our data suggest this is because doctors who initially went above and beyond for their patients, taking responsibility for system deficiencies, often came to feel such efforts were futile (see Moral self-differentiation and feedback arrows in Fig. 3). For example, when asked what she did to push back against the system on behalf of patients denied secondary care in the hospital, a late-career GP stated:

> I have to say, less and less as time goes by, because we all get kind of, you just get burnt out by taking on the system after a while. But, you know, it's pretty rare now, but we might just all write a practice letter. We all kind of get together and debrief it and write a practice letter. But honestly, we did quite a lot of that at the beginning, when the health system started to go into free fall. But now you just - the energy to actually do that, you just can't find it. (Natalie, GP)

Contrast Natalie's statement with the following one from Tony, an early-career GP who was asked how he coped in situations where he did not have the power or resources to provide appropriate treatments to patients:

> Yeah, definitely had some good therapy over the past few years. That was really helpful, because I was, like, extremely burnt out. We kind of talked about that stuff. I am getting better at just being like, well, it's not actually my problem. It's their [the patients'] problem, and it's only my problem for the 15 minutes they're in the room. But our brains don't work like that, and when we see suffering, we want to, like, help people or fix the problem. Even if it doesn't fit inside the 15-minute appointment, it's still your problem to sort. So, yeah, I haven't fully figured that one out yet… Some doctors are [dismissive of the patient's problems], and can just completely be like, "Oh, well." I'm a little bit jealous of those doctors, but I also don't want to be those doctors, because they're the doctors that my patients

> or friends or family see. And then [the patients] are like, "I saw the [doctor] and nothing happened." And then it's me again, being like, "Why? Why am I always picking up the pieces?" (Tony, GP)

As this quote suggests, Tony recognized that morally dissociating from his role in the healthcare system would alleviate moral distress ("I am getting better at just being like, well, it's not actually my problem"). However, he resisted this approach because he viewed it as antithetical to his nature ("But our brains don't work like that") and to his professional identity ("I'm a little bit jealous of those doctors, but I also don't want to be those doctors"). In our interpretation, this resistance hints at an important unintended consequence of *Moral dissociation*. Specifically, it suggests that when doctors conceded to being powerless in the healthcare system, it may have alleviated their moral distress, but it also undermined the sense of meaning doctors derived from upholding the moral importance of patient care. In turn, *Moral dissociation* resulted in the "demoralization" of the cost-care paradox, flattening the (potentially generative) tension that arose from moral asymmetry between cost and care imperatives.

Statements from our participants suggested that, when taken to the extreme, this "demoralization" of paradox could encourage doctors to prioritize instrumental cost imperatives over care concerns. Because doctors were no longer morally invested in their patients' wellbeing, patient encounters could feel transactional or even burdensome:

> I would say, in the [insurance-funded] system, yeah, I think it helps to understand who the patient is. The patient's not the customer. The patient is just the courier carrying the money. You know, the customer is whoever's paying the bill, and that's the insurance company, so the patient's almost the enemy, like the patient is the person making your life harder [as a doctor]. Like, all I need to do is write these notes so that I can get paid. But now you're here sitting between me and my computer, where I could be writing the notes to get paid, right? (Marvin, family physician)

While this quote hints at an extreme outcome of *Moral dissociation*, we found that doctors more commonly offset the ensuing feelings of meaninglessness by finding purpose outside their clinical roles. As illustrated in the following quote, some doctors achieved this by focusing on meaningfulness in other parts of their life, such as non-work passions or family commitments:

> I can't imagine what it would be like, you know, if you didn't have something that can get your mind off, you know, some of these things. So yeah, even though it might not be intentional, the distraction, if I can use that word, of having something that gives your life purpose and meaning allows you to, you know, stay in a job where you might not always feel like you're getting meaning… Because, you know, right now, I have little ones and I mean, you don't want to disrupt their lives, so the meaning that you get from seeing them do well, you know, supersedes whatever frustrations you might be having at work. (Miles, family physician)

In contrast, other doctors offset *moral dissociation* in their clinical roles with *extra-role moral engagement*, as we explore next.

Moral Dissociation Combined With Extra-Role Moral Engagement

> I try to be more accepting of the system around me. Of this is the way it is, at least currently, and, you know, in the moment, it's not very helpful to get upset or mad or project it on other people. It is the system. Whereas I hope that by doing other things—I do work with our [state support body] and work for kind of change overall. That is why I get involved with these things. Like, we'll take on workforce issues, or, you know, labor issues, educational things, and even kind of, there's like an advocacy arm where we talk to legislators, we'll talk to insurance companies, to try to slowly bring about this change over time. It is a long game. (Daniel, family physician)

Daniel's quote captures the final moral boundary management approach we identified—*Moral dissociation combined with extra-role moral engagement*. In this approach, doctors coped with moral distress in their clinical positions by accepting their relative powerlessness and morally dissociating when they felt unable to provide appropriate care: "And so you think to yourself, there is no right and wrong in this. You know, you almost have to take away ethics and philosophy and … just think all of those things are too big" (Rachel, GP). However, doctors simultaneously compensated for ensuing feelings of meaninglessness by working toward systemic change in non-clinical, often voluntary roles: "So I go to our government agencies and, like, lobby to our Senators and Congressmen for the state saying, like, 'Hey, this is how this bill is going to affect us as physicians' and, like, educate them about the decisions they're making" (Dana, family physician). Accordingly, doctors adopting this approach created protective moral boundaries through *moral dissociation* in clinical roles while also positioning themselves as embedded moral actors through *moral engagement* in extra-role activities. In turn, this approach involved both abdicating and assuming moral responsibility for system deficiencies.

We found that this approach was more common among doctors with established careers and higher degrees of

control over their time due to a relative absence of financial pressures. These doctors typically adopted this approach when their feelings of powerlessness in the clinic coincided with a realization that, as active members of the healthcare system, they could potentially change it for the better:

> I really appreciate being able to function at multiple levels. So not only, you know, I found myself sometimes when I was just in clinical practice, finding some level of frustration, saying, "Oh, this system is not serving the patients, nor is it serving me." And I actually think of that as recognizing that I can't just point fingers, I actually have to go out there and try to make a difference and so change the system. (Grant, family physician)

This realization attracted doctors to administrative or voluntary roles where they could either circumvent systemic cost barriers to help patients or work toward loosening cost constraints from within the system. For example, some doctors became involved in population-level health initiatives where they could reach patients outside the exam room: "I'm involved in a large multi county initiative right now dealing with the opioid crisis in our community" (Bill, family physician). Others tried to reshape the funding structures underlying cost constraints through advocacy and lobbying efforts: "[W]e lobby politicians who can have some impact on the rules of engagement with insurance companies" (Vikash, family physician). Doctors described how involvement in such extra-role activities enriched their careers, enabling them to engage moral care imperatives beyond the constraints of clinical roles:

> [T]hrough the changes that I'm able to enact on a system, healthcare system level, now I can take care of millions of people across the state. I wouldn't be able to do that with just the direct clinical work that I do. So, to me, that's why I really, really enjoy fixing the problems that we have in healthcare, to make it so that it's more tangible and more accessible to people all across the state. (Aaron, family physician)

Our analysis suggests that, in contrast to the two previously described approaches, *Moral dissociation combined with extra-role moral engagement* not only alleviated moral distress but enabled doctors to re-engage the potentially generative tension between cost and care. Key to this re-engagement was the notion of "moral imbalance" between cost and care imperatives, which was implicit to this moral boundary management approach (see Table 3). As already noted, *moral self-differentiation* implied that doctors viewed cost and care imperatives as a "moral dichotomy," while *moral dissociation* entailed the "demoralization" of such imperatives. In contrast, doctors adopting the present moral boundary management approach continued to view cost and care imperatives as interdependent polarities that, in the contemporary system, were simply *out of balance*. As one doctor stated: "[W]e need adequate funding in all healthcare sectors… We're definitely underfunded for decades now, and it's probably since the 2000s where it started really hurting GPs" (Lara, GP). In turn, doctors adopting this approach were motivated by the moral imperative to restore balance between cost and care through efforts toward systemic change:

> [I]t takes a lot of effort and a lot of time, and it often isn't paid or recognized, and you're trying to fit it in with, you know, within your clinical work as well, which can be quite complicated. But I think if you don't have people that are prepared to do that, then you're not going to change the system. (Brenda, GP)

While this re-engagement of paradoxical tension may suggest a "superior" approach to moral boundary management (as compared to *Moral self-differentiation* and *Moral dissociation*), the actions involved were not without their costs for doctors. Brenda notes these costs above when discussing the unpaid and unrecognized work that she had to fit around clinical duties. Another doctor captured the same notion even more clearly:

> There's only so many hours in the day, and you know, these things [my advocacy work] are done outside of work. This is outside my normal job and my wife loves to point out the, you know, the jobs I have that I don't get paid for. So, it's another job that I have that I'll never get paid for, and it's existed in the afternoons and the nights and the weekends where I could be doing other things in my life and time. (Daniel, family physician)

We found that due to such costs, some doctors who initially combined *moral dissociation* with *extra-role moral engagement* could later revert to simple *moral dissociation* for self-protective reasons, as indicated by the feedback arrow in Fig. 3.

Discussion

We examined how power relations influence the experience of paradox when it entails moral asymmetries between poles. Focusing on doctors' experiences of an underlying cost-care paradox, we found that moral asymmetry could underpin generative tension when supported by balanced power relations, but that it provoked debilitating moral distress when combined with imbalanced power relations. We also illustrated how doctors responded to moral distress using three distinct moral boundary management approaches, each of which involved doctors' (re)positioning their personal moral

responsibilities in relation to their roles in the healthcare system. As such, our study illuminates the under-researched moral dimensions of paradox (Seidemann, 2024), providing theoretical insights into the particularly important links among paradox, power, and morality (Fairhurst & Putnam, 2023). Next, we discuss specific contributions and implications of our work.

Contributions and Implications

Our first contribution is to empirically develop the concept of moral asymmetry and provide a granular understanding of how it interacts with power relations in the experience of paradox. Prior research hints at the importance of underlying moral asymmetries in paradox, suggesting actors do not necessarily view opposing yet interconnected poles as normatively and emotionally equivalent (e.g., Albertsen, 2025; Hahn et al., 2018; Pamphile, 2022; Pradies, 2023). However, based on our empirical data and analysis, we provide a more explicit and sharper conceptualization of moral asymmetry as occurring *when one paradox pole is considered morally important—a matter of right or wrong—while the other pole holds largely instrumental value*. This conceptualization implies that from a normative standpoint, instrumental paradox poles mainly acquire value through their interdependent relationship with morally important ones. For example, business objectives might be considered pointless if they do not directly contribute to an organization's attainment of social or environmental goals, as in "strong sustainability" (Albertsen, 2025; Landrum, 2018).

This conceptualization of moral asymmetry is useful for explaining how ethical and emotional approaches to paradox can complement and even override instrumental and rational ones (Cunha & Putnam, 2019; Fairhurst & Putnam, 2023; Pradies, 2023). More specifically, it suggests moral beliefs and values can act as "internal guardrails" that prevent actors from prioritizing instrumental goals over ethical concerns (Hahn et al., 2018). Guardrails are typically comprised of formal structures that protect one paradox pole from being overwhelmed by its counterpart (Lewis & Smith, 2022; Smith & Besharov, 2019). However, formal structures may be shaped disproportionately by powerful groups and individuals (Berti & Simpson, 2021a) such that guardrails misalign with low power actors' internal beliefs about how to address paradox (Albertsen, 2025; Pamphile, 2022). For example, in primary medicine, cost and care imperatives are formally protected by funding constraints and medico-legal responsibilities, respectively. Yet, as we showed, doctors may feel that meeting their medico-legal responsibilities toward patients does not equate to fulfilling their moral duty to provide the best care possible. Accordingly, moral beliefs and values may protect certain paradox poles "internally" (within individuals) when external, formal structures fail to do so. Future research could examine what happens when morally important paradox poles can not only complement instrumental ones but are allowed to *override* them—for instance, when an organization's formal structure *subordinates* financial objectives to social and/or environmental goals (Albertsen, 2025).

Related to this topic, our study provides the first comprehensive examination of how power relations shape whether morally asymmetrical paradoxes are experienced as generative or debilitating (Putnam & Ashcraft, 2017). To start, we showed how moral asymmetry could be a source of generative tension when power-with dynamics enabled doctors to accommodate both moral and instrumental imperatives by re-shaping formal structures (Bednarek & Smith, 2024; Lewis & Smith, 2022; Schrage et al., 2026). For example, some doctors proactively reduced their clinics' profit margins to provide better care through longer appointment times. This finding resonates with prior research showing how individuals can draw on non-rational sources of motivation—such as emotions—to proactively address paradox, provided individuals have the autonomy to engage tensions on their own terms (Pradies, 2023). However, doctors in our study more commonly experienced the cost-care paradox in the context of restrictive power-over relations (Schrage et al., 2026), where they felt powerless to engage morally important care imperatives due to organizational structures and systemic funding constraints beyond their control. In turn, this powerlessness transformed the potentially generative tension between cost and care into a debilitating form of moral distress.

In future studies, researchers could build on our findings to explore how moral distress might motivate shifts from debilitating power-over dynamics toward more generative power-with dynamics (Schrage et al., 2026), especially when such distress is experienced collectively. A particularly intriguing angle for such research would be to examine how morally and emotionally informed approaches to paradox relate to the interplay between "discussable" and "undiscussable" issues in organizations (see Fairhurst & Putnam, 2023, Chapter 9). For example, are morally and emotionally informed approaches tacitly relegated to the realm of "undiscussable" issues in some organizations—and if so, how and why does this relegation occur? Moreover, what actions are required to bring morally and emotionally informed approaches to paradox into the realm of "discussable" organizational issues? Addressing such questions would provide valuable insights into how power shifts might favor moral over instrumental approaches to paradox, as well as how these shifts might occur—or get blocked—through communicative processes (Fairhurst & Putnam, 2023).

Our second contribution is to reveal moral distress as a novel reaction to paradox and show how individuals

respond to such distress using moral boundary management approaches. Prior research hints that paradox can elicit strong emotional reactions—which may have moral undertones—when individuals identify more closely with one paradox pole than its counterpart (Huq et al., 2017; Pradies, 2023). However, we went beyond prior studies by linking paradox to explicitly moral reactions, such as moral distress, which remain understudied in paradox scholarship (Fairhurst & Putnam, 2023; Seidemann, 2024). We also provided unique insights into how individuals cope with moral distress in the experience of paradox. The three "moral boundary management approaches" we developed represent responses to paradox not yet identified in the literature (Jarzabkowski & Lê, 2017) and contribute to understanding how individuals navigate paradoxes of structure and agency (Lewis & Smith, 2022). Specifically, these approaches all involved efforts to (re)position doctors' personal moral responsibilities (stemming from agency) in relation to their roles in the healthcare system (shaped by structure). *Moral self-differentiation* enabled doctors to view themselves as moral actors in an amoral or even immoral system. Yet, due to the structural nature of many cost constraints on care, this approach often resulted in the ironic outcome of doctors assuming responsibility for system deficiencies, perpetuating their moral distress. *Moral dissociation* enabled doctors to alleviate moral distress by ascribing responsibility for immoral outcomes to the system. However, this approach flattened the potentially generative cost-care tension through "demoralization" of paradox. *Moral dissociation combined with extra-role moral engagement* enabled doctors to both alleviate moral distress *and* re-engage the generative tension between cost and care. Doctors achieved this by both abdicating and assuming moral responsibility for system deficiencies (in clinical versus non-clinical roles).

From one perspective, these approaches provide valuable lessons on how to build "boundaries" that enable greater "comfort" in navigating structure-agency paradoxes involving moral responsibility (Lewis & Smith, 2022, p. 534–537). For example, by creating a boundary between personal and system responsibility, *moral dissociation* afforded doctors greater moral comfort in facing a paradox they could not control as individuals. *Moral dissociation combined with extra-role moral engagement* represented an even more sophisticated approach to structure-agency boundary management, allowing doctors to absolve themselves of moral responsibility in situations they could not control while embracing responsibility for system deficiencies in non-clinical roles as systemic change agents. In turn, the approaches we identified could contribute to a morally informed understanding of paradox mindset (Miron-Spektor et al., 2018) and, in particular, how it applies to the interdependent tension between individual agency and social structure (Giddens, 1984; Lewis & Smith, 2022).

However, from a more critical perspective, the strategies raise questions about who "should" be responsible for dealing with morally discomforting paradoxes (Berti & Simpson, 2021b; Seidemann, 2024). The doctors in our study adopted moral boundary management approaches in response to moral distress triggered by their inability to balance cost and care imperatives. In turn, that inability stemmed from organizational and structural power relations over which doctors had little or no control (Berti & Simpson, 2021b). Therefore, recommending that individuals reframe structure-agency boundaries to find comfort in navigating morally charged paradoxes could amount to what Berti and Simpson (2021a, 2021b, p. 256) call "victim blaming"—exculpating the system by putting the onus on the individual. From this perspective, doctors who find comfort by morally dissociating from their clinical roles are, in effect, being forced to compromise their values to cope with a paradox that "should" be addressed at a higher level (e.g., by health system leaders). Similarly, doctors who find moral comfort in *voluntary* non-clinical roles are sacrificing their personal time and energy—which may only be available to those in privileged positions—to fix systems that have been broken by decades of under-investment and profit-seeking (Dean et al., 2024).

Accordingly, our third contribution is to highlight the importance of combining both individual and systemic approaches to address paradox (Amaral et al., 2026; Bednarek & Smith, 2024). Scholars adopting a practice-based, processual view of paradox acknowledge how "the micro constructs the macro" (Bednarek & Smith, 2024, p. 587; Lê & Bednarek, 2017; Jarzabkowski et al., 2017), which is to say that individual actions shape social structures through a process akin to structuration (Giddens, 1984). Yet, social structures (such as healthcare systems) also shape and constrain individual behavior (Amaral et al., 2026; Berti & Simpson, 2021a), thus becoming self-reinforcing (Acker, 2006). When power imbalances favor the maintenance of a status quo, individual efforts aimed at systemic change become inherently limited (Berti & Simpson, 2021b).

From this perspective, our examination of doctors' responses to moral distress has important implications for understanding the limits of individual action to address pathological manifestations of paradox (Berti & Cunha, 2023; Cunha et al., 2023). For example, we illustrated how *Moral self-differentiation* and *Moral dissociation* both reproduce the power imbalance between rational and non-rational approaches to paradox that makes cost-care tensions morally distressing for doctors. *Moral self-differentiation* does so by burning doctors out as they fight a losing battle to pursue moral imperatives in a system that structurally prioritizes instrumental ones; *Moral dissociation* does so by encouraging individual doctors to repress their moral values and accept the system's prioritization of rational cost

imperatives. *Moral dissociation combined with extra-role moral engagement* is the response with the most potential to effect positive change at the system level because it acknowledges doctors' agency to re-shape healthcare funding structures as moral actors in non-clinical roles. However, enacting those roles requires that doctors attain administrative positions or have the time and energy to engage in voluntary work outside their clinical responsibilities—resources that may only be available to a privileged few. Therefore, our research underscores the limits of individual action to address morally distressing manifestations of paradox. By extension, it implies that such actions must be complemented by top-down, systemic approaches (Berti & Simpson, 2021b), enacted at the policy level.

Boundary Conditions, Limitations, and Conclusion

We encourage readers to consider the boundary conditions and limitations of our work. First, the combination of factors that triggered moral distress in doctors is most likely to occur in contexts where one paradox pole aligns with individuals' deeply held beliefs and values, and where the other pole has a largely instrumental pull (Albertsen, 2025; Hahn et al., 2018; Pradies, 2023). It is also likely to occur mostly in contexts characterized by imbalanced power relations that prevent individuals engaging the morally stronger pole (Berti & Simpson, 2021a; Pamphile, 2022). We suggest that aside from other healthcare contexts (e.g., Mharapara et al., 2023), this combination of factors may occur among humanitarian aid workers (Oelberger, 2024), environmentalists (Schmitt et al., 2019), and other values-based groups that are prevented from enacting their moral beliefs and values by organizational or systemic barriers.

We also acknowledge that the combination of moral asymmetry and powerlessness to engage the morally important paradox pole may not represent the only conditions that provoke moral distress in individuals experiencing paradox. For example, some paradoxes may involve tensions between goals and demands that are equally objectionable from a moral standpoint (Berti & Simpson, 2021a; Fairhurst & Putnam, 2023; Pérezts et al., 2011). In these cases, enacting a both/and approach to paradox may become a source of moral distress in itself, suggesting that the "normative superiority" accorded to both/and approaches in paradox theory may be *ethically* questionable in certain contexts (Krautzberger & Tuckermann, 2024; Seidemann, 2024). We encourage future research to examine situations where individuals perceive both sides of a paradox as morally unacceptable.

In terms of limitations, it was beyond the scope of our research to assess how individual differences influenced responses to moral distress. Relevant differences could include moral identity strength—the extent to which individuals view themselves as moral actors (Aquino & Reed, 2002)—and gender (Zhong, Chen, Ren, & Wang, 2025). Prior research suggests these factors can influence individuals' tendency to morally engage or disengage when they find themselves in morally challenging circumstances (Aquino & Reed, 2002; Zhong et al., 2025). To address this limitation of our study, future research could explore how individual differences in moral identity strength influence the specific moral boundary management approaches that individuals adopt in paradoxical contexts. For instance, stronger moral identities might manifest in a preference for *Moral self-differentiation*, whereas *Moral dissociation* might be associated with weaker moral identities. Similarly, men might be more likely to *morally dissociate*, while women may tend to *morally self-differentiate* (Zhong et al., 2025).

In conclusion, our research provides novel insights into how power relations influence the experience of paradox when it entails moral asymmetries. We highlight moral distress as a novel reaction to powerlessness in the experience of paradox, and we theorize the moral boundary management approaches that individuals use in response to such distress, revealing the role of self-constructed structure-agency boundaries (Lewis & Smith, 2022). Our work further highlights the importance of paradox's non-rational dimensions (Pamphile, 2022; Pradies, 2023), and shows what happens when prevailing power relations instead favor rational and instrumental approaches (Fairhurst & Putnam, 2023). As such, we hope our work inspires other scholars to consider why addressing pathological manifestations of paradox may require ethically informed approaches that combine both individual actions and systemic changes.

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Declarations

Conflicts of interest None to disclose.

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