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Review

# Characteristics of moral distress from nurses' perspectives: An integrative review

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ABSTRACT

*Objective:* This integrative review aimed to identify the common characteristics of moral distress in nursing and distinguish it from other types of distress by examining nurses' perspectives in the literature. These insights will help update existing tools and create new ones to capture moral distress better, guiding the development and implementation of strategies to support nurses in addressing this challenge.

*Methods:* Whittemore and Knafl's integrative review method was employed to guide a systematic search for literature in three databases (EBSCO Medline, CINAHL, and PubMed). Additionally, two journals, *Bioethics* and *Nursing Ethics*, were manually searched to reduce search bias. The included studies were primary resources published in English between 2018 and 2023, utilizing quantitative, qualitative, or mixed methods to examine moral distress's characteristics, components, and definitions. All of identified studies were screened, extracted, and analyzed independently by two researchers.

*Results:* Nineteen studies were included. The results were grouped into five themes shaping the main characteristics of moral distress: 1) experiencing a moral situation, with five ethically conflicted situations identified, including treatment plans, professional and personal moral values, team dynamics, complex contexts, clinical practices, and patient-centered care; 2) making a moral judgment, where nurses experience moral distress when they cannot act consistently with their values, ethical principles, and moral duties; 3) the presence of constraints, categorized at three levels: individual factors related to the nurse, patient, and patient's family; team factors related to the team or unit involved; and system factors, including institutional and policy elements; 4) moral wrongdoing, which occurs when nurses are unable to perform the right moral action; and 5) moral suffering, with studies showing that moral distress impacts physical, emotional, and psychological well-being.

*Conclusion:* The findings enhance the understanding of moral distress characteristics among nursing staff, highlighting the concept of the crescendo effect, which underscores the cumulative and escalating nature of unresolved moral distress, emphasizing the need to address moral conflicts proactively to prevent the erosion of moral integrity and professional satisfaction.



## What is known?

- Moral distress arises when nurses know the right action to take but are prevented from doing so by constraints, leading to negative self-worth, self-doubt, and physical and emotional suffering.
- Moral distress disrupts team dynamics, weakens the ethical climate, and contributes to higher turnover rates, staff shortages, and compromised patient safety.

## What is new?

- Understanding the contributing factors to mitigate the effects of moral distress, promote professional satisfaction, and maintain the integrity of healthcare workers.

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- Moral distress encompasses five key themes: experiencing a moral situation, making a moral judgment, facing constraints, moral wrongdoing, and moral suffering. Constraints are analyzed at individual, team, and system levels.

## 1. Introduction

In the late 1970s, ethical principles that guided healthcare delivery were still evolving. Much attention was given to implementing ethical principles in the healthcare system then. The importance of ethics inspired Andrew Jameton (1984) to write about moral distress in his book *Nursing Practice: the ethical issues* for the first time [1]. Jameton (1984) first defined *moral distress* as arising "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action."[P 6]. Jameton's work inspired other philosophers who explored this phenomenon and contributed to practical and conceptual changes. Most recently, Kim et al. [2] redefined "moral distress as an experience of the moral emotion agent-regret, as it fittingly arises in response to one's participation in a tragic or potentially unjust care-related circumstance in which one is unable to act otherwise due to factors beyond one's immediate control."

Moral distress is a complex blend of ethical challenges that can affect the well-being of healthcare professionals [3]. As the healthcare industry continues to evolve, practitioners often find themselves in situations where their moral values conflict with their obligations. This conflict between what is considered ethically correct and the realities of practice leads to distress [4].

Moral distress may affect healthcare systems at different levels, starting at the individual level, affecting the unit, and extending to the entire institution [5,6]. At the personal level, nurses who experience moral distress may develop negative self-worth, self-criticism, self-doubt, and self-blame [7]. These experiences may increase the distance between nurses and patients, causing nurses to feel as if they are disappointing patients and questioning their duties toward patients' rights [6,8].

Moral distress influences team dynamics, compromising the ethical climate. Nurses may lose their moral judgment capacity within this nonconducive environment and feel powerless. In response, critical care nurses (CCNs) may ask to be changed to another unit to protect their integrity and self-respect [9]. At the organizational level, moral distress is associated with an increased turnover rate, affecting the organization's ability to retain healthcare expertise, leading to staff shortages, increasing the stress on remaining staff, and disrupting the organization's overall image. Consequently, the scarcity of skilled nurses can affect the achievement of safety goals and may place the organization under legal and financial burdens [6,10].

The prevalence of moral distress and its consequences encouraged researchers to expand the definition of moral distress as an umbrella term that covers different morally distressing events and proposes leading causes [11–13]. Efforts to expand the definition of moral distress have led to ambiguous and contradictory views [12–15]. Therefore, identifying the characteristics that differentiate between moral distress and other forms of distress is essential. Different moral situations may lead to feelings of distress, but not all of these situations may classify as moral distress [16]. The characteristics of a phenomenon include its distinguishable components, features, elements, attributes, or properties that describe a particular concept. These characteristics could help to differentiate between related phenomena.

Recent researches on moral distress among nurses has focused on several key areas: its prevalence, the development and use of measurement tools, the identification of underlying causes and constraints, the consequences of moral distress on healthcare professionals, its relationship with related ethical concepts, and the effectiveness of interventions aimed at mitigating its impact [3–5,8–11]. Accordingly, This integrative review aimed to identify the common characteristics of moral distress from nurses' perspectives in the literature.

## 2. Methods

### 2.1. Design

Following Whittemore and Knafl's updated methodology [17], the integrative review was conducted in five steps: identification of the phenomenon (defining characteristics of moral distress among nurses), comprehensive literature search across electronic databases, quality evaluation of selected studies, data extraction and analysis through coding and thematic grouping and presentation of findings, including implications and limitations.

### 2.2. Problem identification

The identification of the problem in this integrative review focused on understanding the characteristics of moral distress from nurses' perspectives. The primary goal was to distinguish moral distress from other types of distress by examining relevant literature and synthesizing findings. This section addressed two main questions: What are the defining characteristics of moral distress among nurses? How do these characteristics differentiate moral distress from other forms of distress?

### 2.3. Literature search

The literature search was conducted based on Whittemore and Knafl's methodology (2005) [17], which emphasizes using multiple databases to ensure a comprehensive review. We utilized EBSCO Medline, CINAHL, and PubMed for electronic searches. Additionally, to minimize potential search bias and ensure depth in our findings, we manually searched two key journals, *Bioethics* and *Nursing Ethics*, due to their specific relevance to the topic under study. To further enhance the rigor of the review, an ancestry search was performed to identify and include seminal articles referenced within selected studies.

The PICOT framework guided the search strategy. For Problem (P), we focused on terms such as moral distress, moral conflict, and ethical conflict, as well as their definitions, characteristics, and components. The Population (P) was restricted to the nursing profession, encompassing all available specialties and using keywords like "nurse," "nurses," and "nursing." Intervention (I) involved examining moral distress's characteristics, components, and definitions. The Time (T) parameter included primary resources published in English over the past five years, incorporating quantitative, qualitative, and mixed-methods research.

The inclusion criteria for the review consisted of primary studies published in English that conceptually or empirically examined moral distress among nurses within the specified time frame. Studies that did not directly explore moral distress, unpublished doctoral theses or dissertations, systematic reviews, integrative reviews, meta-analyses, gray literature, or commentaries were excluded. Content experts were consulted during the evaluation process to validate the reliability of the findings.

The initial search yielded 540 articles from the selected databases, with an additional eight studies manually sourced from *Bioethics* and *Nursing Ethics*. RefWorks (http://www.refworks.com/) managed references and streamlined the process, removing 254 duplicates. After applying the inclusion and exclusion criteria to the

remaining titles, 72 articles were selected for abstract screening, further narrowing the selection to 25 studies for full-text evaluation. Following this detailed evaluation, 19 studies were included in the final review (Fig. 1). The PRISMA guidelines effectively structured the integrative review report [18].

### 2.4. Quality appraisal

In this review, we utilized the Johns Hopkins Evidence-Based Practice Model [19] to evaluate the quality of studies rather than employing different instruments for various types of research, as originally suggested by Whittemore and Knafl (2005) [17]. The Johns Hopkins model was chosen because it provides a comprehensive scoring system that includes quality and strength assessments. Each study was evaluated based on a quality score, ranging from A (high quality) to C (low quality), and a strength score, from 1 (highest) to 5 (lowest). This dual evaluation allows for a robust integration of evidence quality and strength, offering a clear indication of the reliability of each study.

The evaluation considered different types of research, including qualitative studies, quantitative studies, and mixed-methods research. The quality assessment involved evaluating study design, data collection integrity, confounding factors, and interpretation of findings. Scores for the selected studies were then discussed with a content expert to ensure an objective evaluation. Two authors conducted the quality assessment independently (M. Aljabery and N. Al-Hmaimat). In instances where discrepancies occurred, discussions were held with the third author (I. Coetzee-Prinsloo) to reach a consensus.

### 2.5. Data analysis

Considering the studies' diversity, thematic analysis was employed for this integrative review. The data analysis process involved sequential steps of data reduction, display, comparison, conclusion drawing, and verification. All articles were analyzed to extract elements such as definitions of moral distress and the shared characteristics or components that define it. The findings were organized into a data matrix that categorized information based on research location, study aims, methods, sample, key findings, and quality score. Theoretical sources were compared to understand different moral distress frameworks and their significant arguments. After the initial data extraction, sources were coded according to frameworks of ethical sensitivity and clustered into groups using this coding scheme. Data were then sorted and assembled into subgroups aligned with the research questions to effectively integrate the results from all included studies. Two authors (M. Aljabery and N. Al-Hmaimat) conducted the data analysis independently, ensuring objectivity and consistency throughout the process. Any discrepancies were discussed with the third author (I. Coetzee-Prinsloo) to reach a consensus. Similar data were compared and categorized until final themes emerged and were refined.

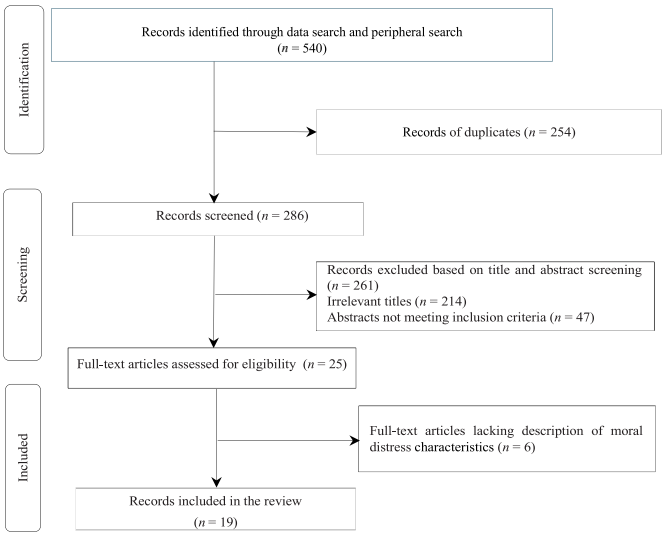


**Fig. 1.** PRISMA Flowchart of study selection in this review.

## 3. Results

### 3.1. Study characteristics

The review included 19 studies conducted worldwide, including 11 qualitative studies [13,20,21–23,24–28,29], three quantitative studies [30,31,32], one mixed method study [33], three studies focused on the concept analysis or definitions of moral distress [2,7,34], and one study described the development and testing of a revised version of the Moral Distress Scale-Revised (MDS-R), a tool frequently used to measure moral distress [35] (Appendix A).

The quality of the included studies was variable. In three studies, there was a lack of in-depth analysis, with minor limitations in methodological rigor. The qualitative studies provided high (A) to good (B) quality evidence regarding transparency, diligence, verification, self-reflection, and participant-driven inquiry. All quantitative studies were non-experimental and rated as good (B) quality. The correlation between quantitative and qualitative results was clearly explained regarding the mixed-method study, reflecting high (A) quality evidence (Appendix B).

### 3.2. Identified themes

From the included studies, five themes were identified to represent the main characteristics of moral distress: 1) experiencing a moral situation, 2) making a moral judgment or knowing the right course of action, 3) the presence of constraints, 4) taking the wrong ethical action (moral wrongdoing), and 5) moral suffering or associated feelings (Appendix C).

#### 3.2.1. Experiencing a moral situation

Morally distressing situations may vary according to the type of conflict. From the literature, we identified different sources of ethically conflicted situations, including treatment plans [20,30,33,35], professional and personal moral values [22,23], team dynamics [20,23,31], complex contexts [33,24–26], clinical practices [24–26], and patient-centered care [13,35,22,24,26,27]. Thorne et al. [24] concluded that moral situations arose from the complex nature of clinical contexts. The complexity of care and variety of ethical challenges make these contexts a warzone where nurses' emotional, physical, and psychological states are charged and tense [33].

Clinical practice is a frequent source of moral conflict. A mixed-method study with a large sample size ($n = 462$) conducted by Prompahakul et al. [33] reported that end-of-life-related clinical practices constituted 80% of the moral situations experienced by nurses. Several studies have reported that clinical practices such as providing futile care [33,23,25,28], giving false hope [33,20], inappropriate treatment plans [30,20,25,28], and palliative care [20,25,28] are the most common practices that contribute to morally distressing situations. Ko et al. [22] emphasized that morally distressing situations occur when nurses witness patients not receiving adequate information about the progression of their

sickness, medical decisions failing to optimize patient benefit, and terminally ill patients being denied a dignified death. Regarding treatment plans, Kim et al. [2] described morally distressing situations as "a tragic or potentially unjust care-related circumstance." They claimed that the individual's experience in a given moral situation is evaluative and circumstantial, where moral distress arises according to the individual's perceived role in that situation. In some moral events, the perception of moral conflicts might be individualized based on personal experiences and perspectives. Variations in moral values, beliefs, and duties between nurses and other healthcare providers (HCPs) can lead to morally contradictory situations, leading to moral anguish when nurses clash and require prioritizing one over another. In contrast, the conflict in moral values might be false if not constructed based on moral knowledge and skills [2,35,21]. Morley et al. [13] defined a moral situation as "… any combination of the following: moral tension, moral conflict, moral dilemma, moral uncertainty or moral constraint." They presented moral events contributing to moral distress in such a way that broadens the concept of moral distress. Including moral dilemmas and uncertainty as events that lead to moral distress is debatable. For example, Dorman and Bouchal [34] conducted a concept analysis to differentiate moral distress from moral uncertainty. They used a matrix to compare the differences and similarities between moral uncertainty and moral distress. The main difference was related to the outcomes, where in moral distress, the desired and known outcomes are not achieved due to constraints. In contrast, in moral uncertainty, the outcomes lack probability or preferability. The validity matrix showed that both concepts may lead to poor patient care, resulting in moral residue and sharing some internal, external, and institutional constraints. Moral distress occurs when the right action cannot be performed, and conflict is related to self-judgment. In contrast, uncertainty occurs when the agent cannot decide and is unsure of the course of action, and conflict is related to self-questioning. We need to be careful to confuse moral dilemmas and moral uncertainty with moral distress. Moral dilemmas are not related to the conflict between right or wrong action, as in moral distress. Dilemmas are associated with choosing between two options equally supported by ethical principles but may have varying degrees of desirability. In contrast, moral uncertainty occurs when the right course of action is unclear. McCarthy and Monteverde [14] emphasized differentiating moral distress from other moral events and acknowledging the epistemological and normative variances between these moral situations.

### *3.2.2. Making a moral judgment or knowing the right course of action*

Knowing the right course of action is an integral part of moral distress. Nurses need to be able to determine the best action for a particular moral situation while considering both the right and wrong sides. Nurses experience moral distress when they cannot act consistently with their values, ethical principles, and moral duties [14]. Thorne et al. [24] associated moral distress with HCPs' inability to translate their professional and personal knowledge when providing appropriate moral care. As an independent profession, nurses have moral values derived from their education, clinical experience, culture, and personal beliefs. Ko et al. [27] suggested that moral values guide nurses in making the right decisions in managing morally distressing situations. They highlighted two core values, "accountability" and "patient-centered care." In a qualitative study, onco-hematological nurses experienced moral distress when required to treat a patient in a way that contradicted their moral knowledge and judgment [13]. Nurses may struggle to follow decisions that conflict with their moral values and ignore their moral sensitivity when directly involved in implementing these decisions and witnessing the patient's suffering [23]. In a qualitative study, Arends et al. [23] provided an example from one of the participants who stated, "Sometimes the symptoms and side effects can be very serious, and eventually we [nurses] are the ones that are cleaning up the mess." Moral distress arises when HCPs are compelled to follow a plan that is not in the best interest of patients and implement futile care [20,23]. Wachholz et al. [32] stated that nurses attributed moral distress to impediments in the moral deliberation process, their inability to act according to their professional judgment, their denial to practice as patient advocates, and their lack of consideration of moral competency in the decision-making process. Dorman and Bouchal [34] considered knowing the right moral action as an antecedent to moral distress and the inability to perform the right moral action as an attribute of moral distress. Much debate surrounds nurses' abilities to recognize the right moral action. Knowing the right ethical action is not easy. We do not know all the choices available to us, let alone the implications of each one. As a result, we do not always know the right course of action. For example, Morley et al. [13] suggested avoiding referring to knowing the right course of action or using moral judgment as a necessary condition because it excludes uncertainty. Ko et al. [27] self-doubt reflects a lack of confidence and may be labeled an internal constraint; nurses may become reluctant or uncertain about participating and sharing their opinions even if they know the right action. In contrast, confident and competent nurses are more specific and willing to share, participate, and act according to the correct moral judgment. The moral judgment process has also been widely debated. Moral conflict may occur when professional and personal moral values are clashed. Epstein et al. [35] emphasized that the right course of action should not be related to personal beliefs but to professional ones. In contrast, should nurses' personal experiences and feelings be ignored? Isolating nurses' emotions, feelings, experiences, personal values, and beliefs is challenging. Ko et al. [22] argue that moral distress should not only be related to judgments based on professional beliefs, as moral distress also occurs when one cannot act according to personal moral goodness.

Moral judgment is constructed from moral character, sympathy, kindness, compassion, honesty, altruistic actions, and internal standards of right and wrong. These moral traits help nurses deal with conflicting situations, build trustful and respectful relationships with patients and team members, and increase acceptance from colleagues and patients. Similarly, Burton et al. [21] identified personal values and beliefs as a source of moral judgment, where nurses experience moral distress if they are prevented from working according to their values and beliefs. Moral judgment is also linked to nurses' autonomy in making decisions or participating in decision-making. Abdolmaleki et al. [31] explored the relationship between moral distress and professional autonomy in the emergency department. They revealed that less professional autonomy was associated with greater intensity and frequency of moral distress. Restricting nurses' professional autonomy may impair their moral reasoning and decision-making skills. Similarly, oncology nurses also experienced moral distress due to a lack of professional autonomy. Özbaş et al. [25] Further, it was reported that nurses not involved in decision-making due to institutional regulations limiting their autonomy were more likely to find themselves in morally distressing situations. Nurses may be unable to apply their moral knowledge and skills to advocate for patients. Moreover, nurses may construct their moral knowledge from the patient's wishes and care preferences, especially regarding end-of-life care. Nikbakht et al. [28] conducted a phenomenological study to explore nurses' experience of moral distress in a long-term care facility. Nurses frequently experienced moral distress when their competence in patient care was dismissed, their patients' preferences were neglected, and they felt intimidated while advocating

for patients. Ko et al. [27], using a grounded theory study, highlighted two essential values—accountability and patient-centered care—that nurses use to build their moral judgment when encountering an ethical situation.

In conclusion, moral judgments can lead to valid or invalid judgments about situations that produce conflicting decisions. Nonetheless, moral judgment is necessary in most morally distressing situations. This raises a significant question: do nurses possess the necessary moral knowledge, skills, and expertise to effectively engage in the decision-making process related to ethical issues in healthcare? We cannot generalize and claim that all nurses possess moral competency and moral judgment capacity, but as direct HCPs, nurses are responsible for implementing decisions and experiencing outcomes. Therefore, their moral knowledge should be respected and considered in ethical decision-making.

### 3.2.3. Presence of constraints

Constraints may prevent individuals from implementing ethical actions and are critical to moral distress [14,20,35]. Exploring the constraints that lead to moral distress and individuals' responses have become ways of measuring the frequency and intensity of moral distress [13,35]. Several studies have described constraints [35,23] or barriers [27,29] associated with moral distress. Constraints were grouped according to their root causes at three levels: the individual level [33,35,25,27,28] which includes factors related to the nurse, patient, and patient's family; the team level [33,35,27,32,29], which provides for factors related to the team or unit involved in the morally distressing situation; and the system level [33,35,32,29] which includes institutional and policy factors. At the individual level, nurse-related constraints include a lack of competency, training, and preparedness [30,25,28,32]; role ambiguity [21,23,32]; lack of professional autonomy [23,31,25,32]; role conflict [21,26,32]; and compromised integrity [21]. Regarding patient and patient family-related constraints, studies have reported that patients and their families lack cooperation [24,27], hold cultural values and beliefs [33,27], follow patient and family wishes [33,24,28], and have religious beliefs that may lead to moral distress [33,26]. Ko et al. [27] highlighted several constraints related to the patient and the patient's family. In the home care setting, lack of family cooperation and not following care instructions can worsen the patient's condition and increase the burden of care on home care nurses, which results in moral distress. When the patient or patient's family shares cultural values that contradict professional moral practices and increase the patient's suffering, nurses are restrained from taking the right course of action because of these cultural beliefs and values. Prompahakul et al. [33] highlighted that nurses experienced moral distress when adhering to the family's wishes and implementing unnecessary or inappropriate treatment. Questioning the capacity of parents to make valid or correct decisions regarding their child is another source of moral distress, especially when their decision contradicts the healthcare team's recommendation and is not made in the child's best interest but rather to meet the parent's interest [21,24].

At the team level, constraints included improper communication [20,23], unhealthy work environments, lack of collaboration [33,24], working with incompetent colleagues [33,27,32,29], obstinacy in treatment planning [30,23], bullying [29], powerlessness [33], lack of professional autonomy [33,31,25], and lack of involvement in the decision-making process [30,23]. De Brasi et al. [20] reported that nurses encountered moral distress due to poor communication with physicians as they were not involved in the decision-making process. Regarding working with incompetent colleagues, nurses are frequently challenged with the dilemma of either remaining silent to protect their coworkers from maintaining team unity or reporting them and becoming labeled whistleblowers. Woods [29] reported that 36.4% of the nurses ($n = 412$) considered working with incompetent colleagues a source of moral distress. Petersen and Melzer [30] conducted a quantitative study in Germany and reported that half of the enrolled nurses reported moral distress related to witnessing patient suffering due to inadequate physician orders. One-third reported moral distress secondary to working with incompetent colleagues, and one-third of the participants reported moral distress because of insufficient staffing [30].

At the system level, Woods [29] identified the healthcare system and the healthcare delivery system as potential constraints. Wachholz et al. [32] reported that the power of hierarchy may limit nurses' autonomy in the decision-making process and create an unhealthy working environment. Moreover, other studies reported a lack of resources [26,27,32], increased workload [30,26,27], a shortage of staff [30,25,26,28], and a lack of administration and manager support [33,29] as constraints to moral decision-making. Thorne et al. [24] identified different relational dynamics, institutional cultures, and powers of hierarchy as barriers that significantly affect the moral decision-making process during challenging clinical scenarios that trigger moral distress among HCPs. Powerlessness as a constraint was evident at the three levels. Nurses might be disempowered to adhere to standard nursing practice because of families' wishes, physicians' orders, incompetent colleagues, or organizational policies or instructions [33,23,28]. In decision-making, nurses perceive themselves as less important than others (patients, patient's families, physicians, and administrators). In contrast, Burton et al. [21] stated that most nurses perceived themselves as valuable participants in team meetings and patient care planning conversations despite their opinions not always being appreciated: "You have a voice, but sometimes it is a matter of if it is going to be received well or not." Morley et al. [13] argue that moral distress can exist without constraints. They provide two examples to illustrate this: first, when faced with a dilemma, nurses may experience distress because they must choose between two equally undesirable actions, both of which are supported by ethical principles. Second, nurses may experience distress when dealing with uncertainty because they are unsure about the best action. In both cases, no internal or external factors prevent nurses from taking action. McCarthy and Monteverde [14] disagreed with the expanded definition of moral distress, which suggested that moral distress can occur in the absence of constraints. They suggest that constraints are necessary and that moral distress can only happen if moral agents are prevented from ethical action due to organizational or other constraints. Kim et al. [2] consistently incorporated constraints in their definition of moral distress and linked these constraints to factors beyond HCPs' direct control. In conclusion, constraints are necessary for nurses' moral distress. The constraints can be individual-related, team-related, and institutional-related.

### 3.2.4. Taking the wrong ethical action (moral wrongdoing)

Morally, wrongdoing mainly depends on knowing the right action but acting contradictory. Ko et al. [22] presented nurses' views of wrongdoing in terms of medical decisions that fail to meet the optimum benefit of patients in two situations. The first situation relates to patients' wishes not meeting the optimum benefit. The second situation relates to healthcare agents' wishes not aligning with the patient's best interests from a nursing perspective. In both situations, nurses are restricted as they have to respect patient autonomy and professional duty. Epstein et al. [35] stated that moral distress occurs when nurses' voices are not heard and they are forced to act against their professional, ethical beliefs. Perceived pressure to perform the wrong action is the core

definition of moral distress. McCarthy and Monteverde [14] supported Epstein et al. [35] in considering moral wrongdoing a necessary condition for moral distress. As moral agents, nurses may find themselves in situations where they are compelled to violate their moral standards. Wachholz et al. [32] revealed that approximately half of the participants were compelled to perform morally wrong actions against their professional judgment. Consequently, wrong moral action may lead to feelings of fury and reduced moral agency [13]. Therefore, moral distress, usually associated with moral wrongdoing, may not apply to dilemmas or uncertainty. This is because there is no explicit wrong action in such cases. To present another view, Dorman and Bouchal [34] argued that uncertainty created an internal conflict that arose from nurses' feelings of following the wrong moral action. The uncertainty of the outcomes produced a 50:50 chance of wrongdoing and initiated an internal conflict. Once the nurses confirmed that the provided care was not to the best of the patient's benefit, the internal conflict changed to moral distress. In conclusion, morally wrong actions are contradictory to the right moral action. Nurses who can identify the correct moral action will also be able to locate morally wrong actions. Moral wrongdoing occurs when nurses cannot perform the right moral action due to external constraints or limitations, which results in moral distress.

#### 3.2.5. *Moral suffering or associated feelings*

Moral suffering represents the consequences, the related signs and symptoms, or the impact of moral distress. McCarthy and Monteverde [14] described emotional suffering as an essential characteristic of moral distress. Moral distress is caused by the experience of psychological distress following a moral event [13]. Dorman and Bouchal [34] consider perceived suffering an attribute of moral distress. Studies have shown that moral distress may impact physical [21,26,34], emotional [2,13,21,24,26,27,34,29], and psychological well-being [13,24]. Burton et al. [21] reported that initially motivated nurses felt physically, cognitively, and emotionally depleted due to moral distress. Moral distress may thus threaten the retention of expert nurses in the nursing profession [30,34,29]. Physically, nurses who experience moral distress have reported experiencing sleep deprivation [29], poor health status [30], and increased sick leave [30,24]. Afoko et al. [26] conducted a qualitative study and reported that nurses experienced a loss of appetite, headache, fatigue, and sleep disturbances due to moral distress. Different emotional and psychological responses to moral distress were reported among the included studies. Ko et al. [27] reported that nurses' emotional responses can be explicit and implicit. Nurses respond explicitly to morally distressing situations by threatening and scolding, but in other situations, they respond implicitly by keeping their feelings of self-blame and tears to themselves. Other studies have described experiences of frustration [13,23], inadequacy [29], demoralization [29], sadness [13,26], fear [13,20], powerlessness [13,33,23,28], anger [20,26,27], guilt [20], and blunted emotions [24]. Kim and Shelton [2] reported that moral agents experienced regret. Their definition denotes distress as a distinct moral feeling compared to painful feelings such as guilt. Moral distress is considered a threat to the nursing profession. Woods [29] reported that because of moral distress, 48% of nurses in their study considered leaving the profession. In agreement, several studies reported high levels of burnout [22,34], reduced job satisfaction [34], unhealthy work environments [34], career change [30], and poor team dynamics [34] as consequences of morally distressing experiences.

## 4. Discussion

The experience of moral distress often begins with facing morally conflicting situations, which arise from various sources such as treatment plans, professional and personal values, team dynamics, complex clinical contexts, and patient-centered care. For instance, Thorne et al. (2018) highlighted that moral conflicts in a neonatal intensive care unit often stem from the complexity of the clinical environment, which creates a tense atmosphere emotionally, physically, and psychologically [24]. Furthermore, Prompahakul et al. (2018) identified that issues surrounding end-of-life care are a major source of moral conflict, contributing to about 80% of moral situations experienced by nurses [33].

Moral distress is closely linked to a clash between personal and professional values within the healthcare environment, particularly when nurses feel that patients are denied dignified care or adequate information [22]. The individualized nature of moral distress further complicates these experiences, as it is shaped by personal experiences and perspectives [2,13]. Dorman and Bouchal made a crucial distinction between moral distress and other moral challenges, such as moral dilemmas and moral uncertainty. They argued that moral distress occurs when a nurse knows the correct action but cannot achieve it due to external constraints, unlike moral uncertainty, where outcomes are either uncertain or not preferable [34].

As identified by many studies, the key element of moral distress is knowing the right action but being unable to execute it. Thorne et al. discussed how this inability to act on one's ethical beliefs leads to moral distress, particularly when healthcare professionals cannot effectively integrate their knowledge into practice [24]. Ko et al. further explored how moral judgment in these scenarios is guided by accountability and patient-centered care while emphasizing that conflicts between professional and personal values complicate moral judgment [27]. Moreover, Epstein et al. (2019) argued that moral distress must be based on professional standards rather than individual beliefs, yet they acknowledged that it is challenging to fully separate personal emotions from the moral judgment process [21,22,35].

Professional autonomy is another critical factor influencing moral judgment. Research indicates that limited autonomy exacerbates moral distress, particularly when nurses are excluded from decision-making or forced to adhere to treatment plans that conflict with their professional judgment [31,25]. This lack of autonomy hampers moral reasoning and limits nurses' ability to advocate effectively for their patients, thus contributing to increased moral distress.

Constraints play a fundamental role in moral distress by preventing nurses from taking ethical actions. These constraints exist at individual, team, and system levels. On an individual level, factors such as insufficient competency, role ambiguity, and compromised integrity contribute to moral distress, while patients' cultural values or lack of cooperation can also pose significant challenges [30,25,28,32]. At the team level, moral distress often stems from poor communication, lack of collaboration, and working alongside incompetent colleagues. For example, De Brasi et al. identified that poor communication with physicians and limited involvement in decision-making significantly contribute to nurses' moral distress [20]. Power dynamics within healthcare teams also play a role, limiting autonomy and contributing to feeling undervalued [30,23,29].

Institutional constraints, such as resource limitations, high workloads, and insufficient administrative support, are critical

contributors to moral distress at a broader, systemic level. Afoko et al. highlighted that limited resources often force nurses to use alternative and sometimes unsafe equipment, leading to moral distress [26]. Additionally, hierarchical structures within institutions usually restrict nurses' participation in ethical decision-making, thus exacerbating moral distress [33,24,32]. Some researchers, like Morley et al., argue that moral distress can occur without such constraints, while others maintain that these constraints are necessary conditions for moral distress to manifest [13,14].

The concept of moral wrongdoing is central to moral distress, particularly when nurses know the correct action but are forced to act against their ethical beliefs. Epstein and Whitehead (2019) pointed out that moral distress frequently results from nurses being silenced or compelled to act contrary to their professional judgment, which creates a profound sense of powerlessness [35]. This distress can also occur when nurses face decisions between two morally acceptable options, and the outcome of their choice is later viewed as morally wrong or detrimental to the patient, as suggested by Dorman and Bouchal [34].

Moral suffering, a significant outcome of moral distress, represents the emotional and psychological toll it takes on healthcare workers. Studies indicate that moral distress can negatively impact nurses' physical, emotional, and psychological health, resulting in sleep deprivation, deteriorating health, and increased sick leave [21]. Emotional responses include helplessness, powerlessness, frustration, and demoralization [13,33,24,26,27,29]. The cumulative nature of moral distress, referred to as the "crescendo effect," suggests that repeated exposure without resolution escalates distress, thus impacting long-term professional satisfaction and integrity.

The emotional toll associated with moral distress can threaten nurse retention, with studies showing that nearly half of surveyed nurses considered leaving the profession due to moral distress [29]. Such findings are consistent with evidence linking moral distress to burnout, decreased job satisfaction, and poor team dynamics, all of which contribute to an unhealthy work environment and increase the likelihood of career change among nurses [30,34,29]. Consequently, addressing moral distress is crucial to enhancing nurses' well-being and ensuring the profession's sustainability.

In conclusion, moral distress originates from the inability to act according to one's ethical beliefs, influenced by individual, team, and systemic constraints. Understanding these contributing factors is essential to mitigate the effects of moral distress, promote professional satisfaction, and maintain the integrity of healthcare workers. Addressing these challenges proactively can reduce moral suffering and improve the overall work environment for nurses, ultimately enhancing patient care quality.

## 5. Strength and limitations

Moral distress in healthcare represents a significant challenge, influencing HCPs, their practices, patient outcomes, and organizational cultures. Moral distress is a complex construct, emphasizing that heightened awareness and understanding among healthcare workers can lead to better recognition and management of such situations. Professionals should be empowered through ethical training to help alleviate moral distress. Healthcare organizations should foster ethical environments and establish clear policies to encourage open discussion and provide crucial support. The limitations arise from diverse methodologies used in moral distress studies, making comparing and synthesizing findings challenging. Variations in study design, measurement tools, and populations constrained the formation of broad conclusions. Despite these challenges, diverse studies have offered valuable insights into the characteristics of moral distress. While this study specifically focused on nurses, the exclusion of other healthcare practitioners, such as pharmacists, social workers, and therapists, was noted. This focus on nursing may limit the generalizability of the findings across the entire healthcare profession, and future research should aim to include a broader range of healthcare providers to gain a more holistic understanding of moral distress in the healthcare setting. Moreover, as moral distress research evolves, this review might not encompass all recent theories or developments related to moral distress.

## 6. Conclusion

This study revealed that moral distress is a complex phenomenon, lacking agreement on a specific definition. The description and definition of moral distress are highly debated, making it challenging to identify the defining characteristics. However, the review revealed the main characteristics of moral distress. Moral events are necessary for moral distress, with differences underlining the types of these events. Most of the included studies proposed moral judgment or knowing the right ethical action as a necessary condition for moral distress, with some reservations from other studies due to uncertainty and dilemmas. Most studies suggested that constraints were essential conditions for moral distress. A few studies posited that moral distress may occur without constraints. Similarly, moral wrongdoing is the mirror of knowing the right ethical action. Finally, all the studies in this review agreed that moral suffering is the central figure of moral distress despite the underlying constraints, dilemmas, or uncertainties.

## Data availability statement

The datasets generated during and/or analyzed during the current study are available in the supplementary document repository and listed in the reference list.

## CRediT authorship contribution statement

**Mohannad Aljabery:** Conceptualization, Methodology, Validation, Formal analysis, Investigation, Data curation, Writing - original draft, Writing - review & editing, Project administration. **Isabel Coetzee-Prinsloo:** Supervision, Project administration. **Annatjie van der Wath:** Formal analysis, Writing -review & editing. **Nathira Al-Hmaimat:** Conceptualization, Methodology, Writing - review & editing.

## Declaration of competing interest

The authors declare no conflict of interest regarding this article.

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## Appendices. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ijnss.2024.10.005.

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