Society of Medical Education & Research

2023, Volume 3, Page No: 310-323
ISSN: 3108-5059

Asian Journal of Ethics in Health and Medicine

Moral Distress at the Intersection of Law and Ethics: A Thematic Synthesis in Hospital Nursing

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Abstract

One of the most significant difficulties in healthcare environments stems from the ongoing clash between statutory obligations and the core values of care ethics. These situations frequently trigger moral distress, burnout, and a serious disruption in healthcare workers' professional roles. The current study set out to explore and describe the key aspects and effects of such conflicts, specifically within hospital-based nursing practice. The study used thematic synthesis to integrate findings from qualitative research. Researchers conducted a systematic search across major national and international academic databases, focusing on publications from 2010 to 2025. Ultimately, 15 qualitative studies met the inclusion criteria and were selected for analysis; all investigated legal–ethical conflicts in hospital environments. Data synthesis proceeded through open and axial coding, culminating in the creation of overarching analytical themes. The analysis produced four primary themes along with twelve supporting subthemes: (1) patient autonomy versus legal protection, (2) organizational directives and resource allocation versus moral duty of care, (3) defensive documentation versus ethical transparency, and (4) hierarchy, inequality, and professional silence versus justice and integrity. These ongoing conflicts regularly caused moral distress, a gradual weakening of professional identity, and considerable emotional pressure on healthcare staff. Legal–ethical conflicts exert a deep influence on individual caregivers and the overall culture of healthcare institutions. Addressing their harmful consequences requires well-coordinated changes across multiple levels: embedding ethics education and practical decision-making skills into nursing training programs, modernizing legal regulations to accommodate greater situational flexibility, and developing robust psychosocial and ethical support mechanisms for personnel who repeatedly face these moral challenges. Implementing such comprehensive strategies can narrow the divide between legal rules and compassionate care, ultimately supporting greater ethical alignment, long-term professional resilience, and stronger trust across healthcare systems.

Keywords: Moral distress, Legal–ethical conflict, Nursing ethics, Professional identity, Ethical decision-making, Hospital care

Introduction

The persistent tension between legal responsibilities and the principles of care ethics is a central issue confronting health systems worldwide. This friction arises whenever legal mandates, workplace policies, or institutional rules conflict with the fundamental values, convictions, and ethical standards that shape caregiving practices [1]. When this occurs, healthcare providers face intricate choices that extend beyond purely clinical or humanitarian outcomes to include serious legal and organizational repercussions [2].

This research draws on two fundamental concepts that must be clearly defined, as they guide both data interpretation and the overall theoretical framework. First, "ethics of care" describes an ethical standpoint that prioritizes relational duties, judgments shaped by specific contexts, and a focused awareness of vulnerability and the unique needs of particular individuals, rather than

Access this article online https://smerpub.com/

Received: 27 May 2023; **Accepted:** 02 September 2023

How to cite this article: Yarahmadi S, Cheraghian T, Jafarifar S. Moral Distress at the Intersection of Law and Ethics: A Thematic Synthesis in Hospital Nursing. Asian J Ethics Health Med. 2023;3:310-23. https://doi.org/10.51847/SJx4O1C8tc

relying on generalized rules or universal standards. In everyday application, this perspective highlights the importance of meeting others' needs, preserving meaningful relationships, and tailoring responses to the distinctive features of each clinical scenario [3, 4].

Second, "professional identity" concerns how practitioners see themselves in their roles and the norms they internalize through formal education, professional socialization, routine workplace activities, and regulatory guidelines. This identity encompasses cognitive, normative, and emotional dimensions and plays a major role in shaping how practitioners understand conflicts, defend their decisions, and interact with patients, families, and fellow professionals [5, 6].

To situate this investigation within a broader theoretical landscape, it is necessary to connect it to well-established approaches in bioethics and care ethics. The principlist model in biomedical ethics, especially as presented by Beauchamp and Childress in their 2019 edition of Principles of Biomedical Ethics, rests on four fundamental principles—respect for autonomy, nonmaleficence, beneficence, and justice. These principles provide a widely accepted framework for analyzing moral problems in healthcare and for examining the tensions that arise between legal demands and ethical responsibilities in real-world clinical settings [7].

In comparison, the ethics of care approach, originally shaped by the influential contributions of Noddings [8] and Tronto [9], emphasizes relational accountability, sensitivity to context, and the ethical weight of being attentive and responsive to others. Rather than depending on detached principles, care ethics focuses on the situated, interpersonal aspects of moral choices. This makes it especially valuable when exploring situations in which institutional or legal requirements conflict with the relational needs of patients and their families.

The idea of moral distress, first proposed by Jameton [10] and later expanded by Corley [11], offers a useful psychological and moral perspective for investigating the consequences of these clashes. When caregivers face the same ethically problematic scenarios repeatedly and feel blocked from following their own sense of right and wrong, this often creates lasting moral residue and what has been called the crescendo effect, according to Epstein and Hamric [12].

Meanwhile, the emerging concept of moral resilience, as articulated by Rushton, recasts moral suffering as a potential catalyst for personal development and positive change rather than mere exhaustion. It highlights the importance of reinforcing both personal and organizational capacities to safeguard moral wholeness even in the face of strong structural and legal demands. Taken together, these lenses—principlism, care ethics, moral distress, and moral resilience—provide the main theoretical grounding for this synthesis. They allow for a full exploration not only of the different kinds of legal–ethical conflicts seen in nursing work but also of their emotional and professional fallout, along with possible ways to support recovery and maintain integrity when dealing with these difficulties [13].

In everyday healthcare work, ethical, legal, and mixed ethical-legal conflicts form three related but distinct areas. Ethical conflicts happen when professional responsibilities, deeply held values, or commitments to care come into opposition—for example, when trying to honor a patient's right to choose while also doing what seems best for their well-being. Legal conflicts arise when staff are forced to follow laws, rules, or organizational policies that do not align with their ethical or clinical thinking, such as rules requiring continued treatment even when the patient or family wants it stopped. Ethical-legal conflicts arise where these two areas meet, so that obeying the law simultaneously produces moral distress by going against core ethical beliefs or care principles. In hospital environments, these overlaps feel especially sharp, since nurses and doctors must continually balance legal duties with their relational and ethical responsibilities to patients. Clearly separating these types of conflict helps set the boundaries of this synthesis and stresses its main interest in the zone where legal rules and ethical duties collide. This way of distinguishing them matches previous conceptual studies that separate ethical and legal approaches to decision-making in healthcare [7, 14].

In intensive care units (ICUs), frequent cases involve arguments over whether to continue or discontinue life-support treatments, disagreements between the care team and family representatives [15], and difficulties caused by regulations that do not align with patients' actual needs [16]. In the same way, in psychiatric hospital wards—particularly with involuntary admissions—team members are regularly required to apply forceful measures like seclusion or giving medication against the patient's will. These actions can directly contradict their ethical duty to protect patient autonomy and human dignity [17-19].

In forensic mental health services and care for patients who pose high risks, rules focused on security and protection often outweigh caring priorities. This situation creates ongoing tension between the caregiver's professional role and their legal duties [20, 21]. Similarly, palliative care wards sometimes face legal barriers to end-of-life choices that make it harder to offer care shaped around each patient's personal values and preferences [22].

Events such as the COVID-19 pandemic have made these conflicts much more severe. During such crises, decisions about how to share scarce resources and prioritize patients can clash strongly with healthcare workers' moral values. The result is often moral distress, deep feelings of guilt, and in some situations, healthcare professionals choosing to leave their jobs earlier than planned [23].

The effects of these conflicts are complex and span several layers. On a personal level, staff members may experience moral distress, emotional burnout, and growing doubts about their professional selves [1]. At the organizational level, frequent conflicts can lower job satisfaction, weaken the overall standard of care, and increase unhappiness among patients and their relatives [24]. Looking more broadly at society, these problems can gradually weaken people's confidence in the entire healthcare system.

Even though the issue is clearly serious, the available research remains scattered and often limited to specific settings or countries. Most earlier studies have focused on a single environment, such as ICUs or psychiatric wards, or examined only the legal or ethical side, with little effort to examine how the two interact in complex ways [2, 19]. This limitation underscores the need for a broad qualitative synthesis—one that brings together findings from many studies to provide a comprehensive view of what these conflicts involve, the effects they produce, and the strategies that might help people cope.

For this reason, the present study aims to carry out a qualitative synthesis of the current literature on conflicts arising between legal obligations and the ethics of care in hospital settings.

Materials and Methods

Research approach

We conducted a systematic review and a thematic synthesis of qualitative studies examining conflicts between legal requirements and the ethics of care in hospital environments. The goal was to bring together and interpret the existing evidence about how healthcare providers and patients experience these tensions between legal rules and care ethics principles. Thematic synthesis enables researchers to integrate findings from separate qualitative studies into a broader, unified conceptual framework through open coding, ongoing comparison, and theme development [25]. This review was planned and written in accordance with the ENTREQ (Enhancing Transparency in Reporting the Synthesis of Qualitative Research) statement.

Search strategy

A systematic literature search covered the years 2010 to 2025 and included both national databases (SID, Magiran, IranDoc) and leading international databases (PubMed, Scopus, Web of Science). To find suitable studies, we combined keywords linked to care ethics, legal conflict, moral distress, end-of-life care, compulsory treatment, caregiving ethics, ethical challenges, and qualitative methods, using logical operators (AND, OR, NOT) and appropriate date limits.

One example of the search strategy applied was: ("ethics of care" OR "moral distress" OR "ethical dilemma") AND (law OR legal OR regulation OR coercion OR "involuntary treatment") AND ("intensive care" OR ICU OR hospital setting OR emergency department OR general ward OR "special ward") AND (qualitative OR interview OR "focus group" OR ethnography).

Inclusion criteria

Studies were selected if they used qualitative approaches such as phenomenology, grounded theory, ethnography, or conventional content analysis; presented original empirical findings on the lived experiences of healthcare professionals, patients, or family members regarding tensions between legal or regulatory duties and care ethics; and were conducted exclusively in hospital settings. Only studies published in English or Persian qualified for inclusion.

Exclusion criteria

Studies were left out if they relied solely on quantitative methods; consisted of systematic reviews, opinion pieces, or purely legal discussions lacking any empirical qualitative material; focused only on legal issues or only on ethical issues without exploring how the two interact in real clinical situations; were duplicates; or did not provide enough methodological detail for proper evaluation. Non-peer-reviewed publications were also excluded.

Study selection

The initial search produced 347 records. After eliminating 128 duplicates, 219 records were left for screening of titles and abstracts. From these, 142 were removed because they failed to meet the inclusion criteria (e.g., quantitative-only designs, unrelated settings, or the absence of a legal–ethical dimension). The remaining 77 articles underwent a detailed review. At this stage, another 62 studies were excluded for various reasons: not empirical (n = 35), lacking a legal element (n = 19), or inadequate qualitative material (n = 9). In the end, 15 qualitative studies met all inclusion criteria and were included in the synthesis. The entire selection process is shown in the flow diagram **(Figure 1).**

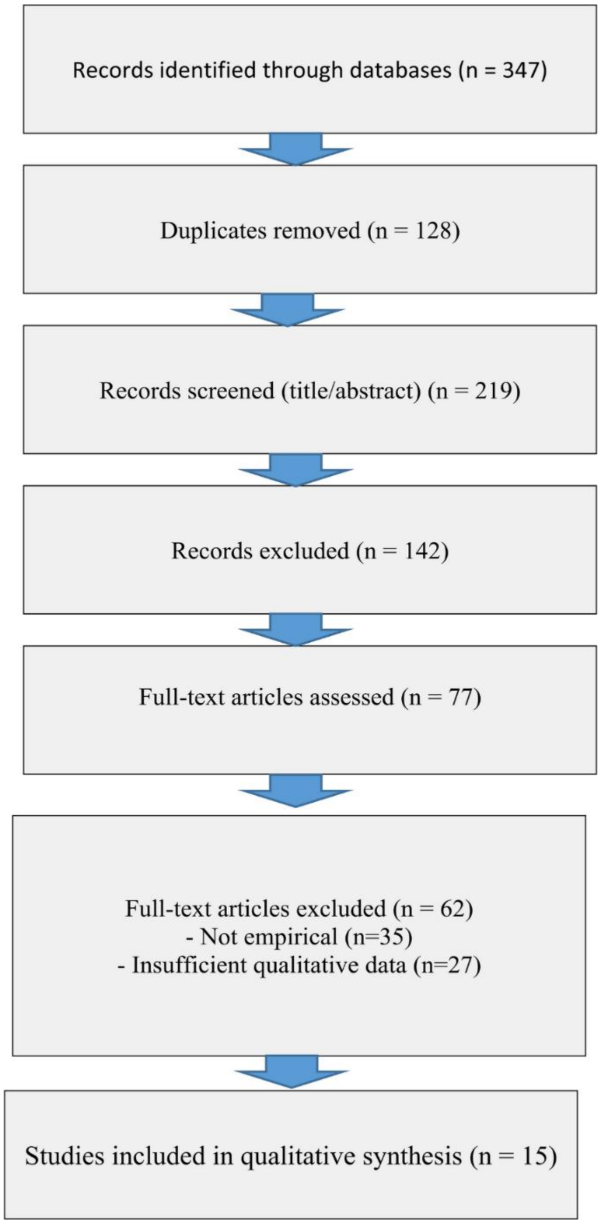

Figure 1. Study selection flow diagram. From: Legal and ethical conflicts in hospital settings: thematic synthesis of qualitative studies focused on nursing practice

Critical appraisal and risk of bias

The quality of the included studies was assessed using the Critical Appraisal Skills Program (CASP) checklist. Two researchers independently rated each study against ten items that addressed clarity of research aims, suitability of the chosen design, quality of data collection, thoroughness of analysis, clarity of findings, and overall research contribution. Any differences in scoring were settled through joint discussion until agreement was reached.

To maintain clear methodological standards, we compiled a summary of the CASP assessments for all 15 studies. Ten of them satisfied most or all of the CASP standards, with only minor shortcomings. Four studies displayed moderate methodological issues, primarily involving limited researcher reflexivity and reduced transparency in data analysis. One study had notable weaknesses in sampling strategy and interpretive depth. No studies were removed solely based on quality scores. Instead, the appraisal findings helped determine how much weight and credibility each study should carry in the synthesis. Papers with stronger methods received greater emphasis in building analytical themes, while those with clearer limitations served mainly to provide supporting context rather than to drive core thematic development.

Disagreements between the two reviewers regarding CASP scores occurred in three studies (20%). These were settled by revisiting the original articles together and reaching a consensus. A third senior researcher (S.Y.) stood ready to help if needed, but full agreement was achieved without external arbitration.

Data extraction

Essential information pulled from each study included basic details (publication year, country, clinical setting), the research approach used, primary results, representative participant quotations, and the authors' own interpretations. To verify accuracy, a second reviewer independently re-checked 30% of all extracted material.

Data analysis

The analysis process followed the procedure suggested by Thomas and Harden [25]: (1) line-by-line open coding of the main findings and quotations from every study; (2) creation of axial codes by organizing related open codes into groups; (3) building descriptive themes by combining axial codes; (4) developing analytical themes that revealed connections across themes and allowed construction of a unified conceptual framework. During the repeated coding and synthesis, analytic saturation occurred when no new codes or subthemes emerged after thoroughly reviewing the last three studies. This stage signaled that the coding structure had stabilized and the themes covered the material comprehensively. All codes and emerging themes were regularly reviewed in team meetings to maintain conceptual coherence and minimize individual researcher bias. Whenever differing interpretations of codes surfaced, the team resolved them through discussion and recorded the decisions in analytic memos and updated codebooks.

Trustworthiness and reliability

Credibility, dependability, confirmability, and transferability were strengthened through several strategies: triangulation among the review team throughout the coding and synthesis stages; external peer review conducted by two specialists in medical ethics and qualitative methodology; and the upkeep of a detailed audit trail that recorded all analytical choices along with reflexive conversations among the researchers about their interpretive assumptions.

Results and Discussion

Examination of the 15 qualitative studies uncovered four primary themes, together with 12 associated subthemes. These themes illustrate the varied experiences of healthcare providers, patients, and families regarding conflicts between legal obligations and care ethics across different hospital environments **(Tables 1 and 2).**

Table 1. Summary of key findings from qualitative studies (n = 15). From: Legal and ethical conflicts in hospital settings: thematic synthesis of qualitative studies focused on nursing practice

Study	Setting	Objective	Methodology	Key results
Falcó-Pegueroles *et al*. [23]	ICU–Spain, Italy	To examine ethical conflicts and decision-	Qualitative phenomenological study	Professionals experienced tension between patient-centered ethics and pandemic-related legal/institutional

		making during COVID-19		restrictions (e.g., visitation limits, resource allocation), often acting against their moral values.
Davoudi *et al*. [26]	Emergency Department–Iran	To explore challenges surrounding informed consent processes	Qualitative descriptive study	Emergency personnel experienced conflict between ethical obligations and legal expectations, as urgent interventions were often performed without comprehensive informed consent, requiring a balance between legal compliance and life-saving priorities.
Yarahmadi *et al*. [27]	ICU–Iran	To explore inequity in ICU service delivery	Critical ethnography	Staff recognized the ethical duties of equity and dignity but faced institutional pressures (e.g., equipment reuse, cost-saving measures) that conflicted with these principles, creating tension between policy obligations and ethical care.
Zali [28]	Hospital settings–Iran	To examine nurses' experiences of legal and ethical issues in post-resuscitation care	Qualitative descriptive study	Post-resuscitation pressures sometimes led to care deviating from guidelines, and documentation was occasionally adjusted to reflect that all required care had been delivered.
Godskesen [29]	Hospital-based clinical research units–Sweden	To examine challenges in obtaining informed consent in clinical research	Qualitative descriptive study	Nurses faced tension between ensuring fully informed, voluntary consent and meeting institutional/legal requirements for recruitment timelines and documentation, sometimes prioritizing procedural compliance.
Kukkurainen [30]	ICU–Finland	To explore how ICU nurses perceive and manage ethical dilemmas in clinical research	Qualitative descriptive study	Nurses experienced conflicts between ethical principles (autonomy, non-maleficence) and research regulations requiring strict consent procedures, even when patients were unable to consent.
Morley *et al*. [31]	ICU–USA	To explore ethical challenges during COVID-19 and nurses' perceptions of delivering quality care, including moral resilience	Qualitative descriptive study	Nurses encountered conflicts between ethical principles and institutional/legal mandates, particularly when pandemic-era resource allocation policies clashed with their commitment to equitable and compassionate care.
Usberg *et al*. [32]	Hospital settings–Estonia	To describe nurses' experiences of ethical conflicts	Phenomenological study	Nurses reported tensions between ethical standards and institutional/legal rules, especially when directives undermined patient rights, safety, or professional integrity.
Oerlemans *et al*. [33]	ICU–Netherlands	To investigate ethical dilemmas influencing ICU admission and discharge decisions	Qualitative descriptive study	Findings indicated a clash between ethical responsibilities and institutional/legal requirements, as clinicians were sometimes obligated to act contrary to their judgment regarding patient autonomy and best interests.
Vargas *et al*. [34]	ICU, Emergency	To examine nurses' experiences and	Qualitative content analysis	Nurses reported tensions between ethical values and legal duties when providing

	Department–Brazil	ethical challenges when managing court-mandated hospital admissions requiring ICU care		involuntary care under court orders, often conflicting with principles of autonomy and informed consent. This created moral uncertainty, particularly when patients were kept in overcrowded or inadequately resourced environments.
Malekzadeh [35]	Acute care settings–Iran	To examine ethical challenges in COVID-19 patient care	Qualitative descriptive study	Limited institutional support and weak accountability sometimes compelled clinicians to prioritize legal/organizational directives over patient autonomy, generating ethical–legal conflict.
Rashidi [36]	Acute care settings–Iran	To explain ethical challenges in caring for COVID-19 patients	Qualitative descriptive study	Public health measures (e.g., restricting family presence) created tension between legal/institutional duties and ethical commitments to compassionate, family-centered care.
Jørgensen and Kollerup [37]	Hospital settings–Denmark	To explore ethical dilemmas in nursing documentation practices	Qualitative content analysis	Ethical tensions arose in documentation practices, where nurses had to balance respect for autonomy with non-maleficence, particularly between written records and verbal communication.
Hussain [38]	Critical care units–Pakistan	To investigate ethical challenges faced by critical care nurses	Qualitative descriptive / mixed-methods	Findings emphasized the necessity for institutional backing, practical ethics education, and clear guidelines to support nurses in addressing professional challenges.
Bruce [39]	ICU–USA	To explore ICU clinicians' experiences of moral distress	Qualitative descriptive study	Clinicians reported conflict between ethical duties and legal/institutional mandates to continue non-beneficial life-sustaining treatments, leading to moral distress when ethical judgment was overridden.

Table 2. Main themes, subthemes extracted from the studies (n = 15). From: Legal and ethical conflicts in hospital settings: thematic synthesis of qualitative studies focused on nursing practice.

Primary theme	Subthemes
Patient consent and autonomy versus legal and procedural protections	• Use of defensive or potentially coercive consent practices [26-28] • Compromised voluntariness in decision-making [29-31] • Influence of structural and clinical paternalism [26, 32]
Organizational directives and resource distribution versus ethical obligations of care	• Challenges related to triage and limited resources [27, 33, 34] • Tension between policy frameworks and clinical discretion [33, 35] • Restrictions conflicting with compassionate care delivery [23, 31, 36]
Record-keeping and legal safeguarding versus ethical openness	• Defensive or inaccurate documentation practices [27, 28] • Administrative burden reducing time for patient care [27, 37] • Inadequate or weak ethical governance systems [23, 38]
Inequality, hierarchy, and team relations versus justice and professional integrity	• Favoritism and disparities in care provision [27] • Suppression of nursing voices within hierarchical systems [32, 33] • Moral distress linked to legally required but non-beneficial treatments [33, 38, 39]

Consent and patient autonomy vs. legal and procedural safeguards

This theme describes the ongoing conflict between patients' fundamental ethical entitlement to self-determination and the rigid institutional or legal rules that control consent processes and decision-making. In hospital environments, medical staff frequently feel constrained by administrative routines that prioritize legal safeguards over genuine ethical caregiving.

Defensive or coercive consent forms

In multiple studies, consent documents were viewed primarily as tools to shield healthcare professionals from liability rather than as means to genuinely protect patient rights. Obtaining consent was repeatedly portrayed as a routine administrative requirement carried out without meaningful conversation or genuine understanding [26-28].

"In reality, consent documents mainly safeguard the doctor rather than the patient. From a legal standpoint, they serve the interests of physicians more than those of patients." [26].

Threats to voluntariness

Research indicated that true informed consent is frequently undermined in urgent care situations. The need to satisfy legal or procedural requirements, along with patients' reduced ability to engage during emergencies, turns the consent process into little more than a paperwork exercise rather than a meaningful ethical interaction [29-31].

"The printed consent materials … appeared overly long and packed with details. This heavy volume of information overwhelmed patients, many of whom ended up skipping or failing to understand it." [29].

Structural and medical paternalism

The studies demonstrated how deeply rooted medical hierarchies and the paternalistic atmosphere in hospitals often erode patient autonomy. Doctors commonly positioned themselves as the only legitimate decision-makers, while any attempts by patients to raise questions were discouraged or even met with disapproval [26, 32].

"In the culture of this emergency department, patients have no real say in decisions. The doctor alone holds the authority to decide." [26].

Institutional directives and resource allocation vs. ethical duty to care

This theme highlights the legal–ethical strains that arise when hospital policies or administrative instructions govern the distribution of limited resources, thereby restricting clinicians' capacity to make ethically sound judgments.

Triage and scarcity dilemmas

The included studies reported significant moral distress among clinicians who had to choose which patients would gain access to scarce ICU beds. Even though these triage choices often complied with institutional or legal guidelines, they frequently clashed with the clinicians' moral obligation to provide fair and compassionate care [27, 33, 34].

"We constantly encounter ethical, personal, and professional dilemmas … because of the overwhelming patient load and the shortage of ICU beds, we are left having to choose who gets to live and who does not." [27].

Policy guidelines vs. clinical judgment

The studies indicated that strict legal and administrative regulations governing ICU admissions and discharges frequently clashed with clinicians' moral and professional assessments. Adhering to these policies occasionally required denying care that the healthcare team considered ethically warranted [33, 35].

"There existed an implicit understanding among ICU doctors that the patient least likely to benefit would be moved … Yet the official guideline prevented that kind of judgment." [33].

Restrictions vs. compassionate care

Research highlighted how infection-control rules enforced during the COVID-19 pandemic, such as bans on family visits and strict isolation measures, conflicted with the ethical obligation to provide compassionate, family-oriented care. Healthcare workers reported intense moral distress when patients passed away without loved ones present [23, 31, 36].

"Patients passing away in the hospital with no family members permitted to visit during their final weeks, especially in the early phase of the pandemic. It was utterly devastating." [31].

Documentation and legal protection vs. ethical transparency

This theme covers the ethical repercussions of overly legalistic record-keeping practices and institutional accountability mechanisms. The pressure to create legally defensible documentation often took precedence over the ethical ideals of honesty, openness, and patient-centered care.

Defensive or falsified Documentation

The included studies showed that clinical documentation was sometimes used more as a means of protection against potential lawsuits than as an accurate account of the care provided. Clinicians reported modifying records to make them appear fully compliant with regulations, prioritizing institutional safety over ethical honesty [27, 28].

“Medical charts can be phrased so that they look as though every required intervention has been carried out.” [28].

Administrative overload is limiting patient care

The studies revealed that the extensive paperwork required for legal accountability was perceived as reducing the time available for actual patient care. Clinicians expressed frustration that a large portion of their workday was spent on paperwork rather than direct bedside interaction [27, 37].

“I must finish all these documents and reports … I end up spending a great deal of time on administrative tasks, which keeps me away from my patients.” [27].

Weak ethics governance structures

Research indicated that hospital ethics committees frequently lacked sufficient power or proper integration within the institution to resolve legal–ethical conflicts effectively. Consequently, moral concerns were often postponed or handled inadequately [23, 38].

“The results indicate that ethics committees usually have inadequate authority … which restricts their ability to settle ethical-legal disputes.” [38].

Inequity, hierarchy, and team dynamics vs. justice and professional integrity

This theme illustrates how imbalances of power, rigid organizational hierarchies, and social inequalities inside hospitals create tensions between legal standards, professional ethics, and the principle of justice.

Nepotism and unequal service delivery

Favoritism and social connections influenced how care was distributed. Patients with influential family members or political ties often received better or faster treatment, which clearly violated ethical standards of fairness and equality [27].

“The nurse noted that the patient in bed 4 belonged to Mr. A’s family. He asked us to give him extra attention.” [27].

Hierarchical suppression of nurses’ voices

The studies found that nurses were regularly denied meaningful roles in ethical decision-making due to strict hierarchical systems. Legal and institutional power, often given primarily to physicians, often prevented nurses from speaking up on behalf of patients’ moral needs [32, 33].

“I’m the doctor, so I’m always in charge … The patient wants me to clarify what the physicians decided, but I’m not permitted to do that.” [32].

Moral distress from legally mandated non-beneficial treatments

Research showed that healthcare professionals suffered moral distress when laws or hospital policies required them to prolong treatments that offered no real benefit or were considered futile. These cases clearly demonstrated the clash between the ethical duty of beneficence and the legal obligation to obey [33, 38, 39].

“Conflicts within the team were a major cause of distress … especially when it involved continuing life-support measures that provided no benefit.” [39].

The results of 15 qualitative studies conducted across a variety of clinical settings reveal that healthcare professionals frequently face tensions between their ethical responsibilities and the demands imposed by law or institutional policies. Four interconnected themes—Consent and patient autonomy versus legal safeguards; institutional directives and resource allocation versus the ethical duty to provide care; documentation and legal protection versus ethical transparency; and inequity, hierarchy, and team dynamics versus justice and professional integrity—demonstrate the structural, procedural, and cultural origins of these conflicts. Together, they underscore the profound moral challenges inherent in clinical practice, where what is legal does not necessarily align with what is ethically correct.

In numerous studies, healthcare professionals reported that consent procedures, which were originally designed to uphold patient autonomy, are often used as protective mechanisms to shield healthcare institutions, nurses, and clinicians from potential lawsuits [26-28]. This pattern aligns with earlier research showing that consent processes are commonly simplified into routine administrative tasks instead of serving as meaningful ethical conversations [23, 31]. When consent is secured quickly, under pressure, or with overly complicated legal terminology, patients' ability to make free and well-informed choices is significantly undermined.

These results reinforce Beauchamp and Childress's four core bioethical principles—autonomy, beneficence, nonmaleficence, and justice [7]—by illustrating how an overemphasis on legal rules within institutions can distort their application in practice [40]. From a human rights perspective, the rights to health and human dignity go far beyond mere procedural compliance; they demand genuine respect for and safeguarding of the patient's decision-making power within formal systems [41]. In emergencies and research settings [29, 30], the law's strict requirement for detailed documentation ironically weakens the very autonomy it aims to uphold. Comparable issues were identified by Afenigus and Sinshaw [42], who noted that nurses working in Ethiopian intensive care units faced serious ethical dilemmas when delivering treatment to incapacitated patients without obtaining complete informed consent.

Furthermore, research conducted in hierarchical hospital environments [26, 32] indicated that medical paternalism persists in restricting patients' involvement in decisions. Legal structures often fail to address this imbalance and may even reinforce it by formally empowering physicians to control decision-making. Consequently, the core issue extends beyond a simple clash between law and ethics; it concerns the gap between merely following legal requirements and delivering care that feels morally genuine.

The second theme highlights the ethical problems arising from limited resources and policy-guided treatment. In critical care settings [27, 33, 34], practitioners regularly encounter life-or-death decisions shaped by institutional triage protocols. Although these guidelines may comply with legal notions of fair resource distribution, they often conflict with clinicians' ethical obligation to act compassionately and promote patient well-being.

This conflict was particularly apparent throughout the COVID-19 pandemic [23, 31, 36], as strict public health rules—such as prohibitions on family visits or enforced isolation—compelled clinicians to override their moral instincts in favor of providing compassionate, family-oriented support. These observations echo the Falcó-Pegueroles *et al.* [23] study, which documented that critical care nurses suffered moral distress when obliged to implement legal directives that prevented patients from receiving emotional comfort during end-of-life care. Ethically speaking, such findings expose the vulnerability of context-dependent morality—the harmony between professional values and external rules—and demonstrate that legal policies intended to ensure system-wide fairness can, instead, cause moral harm at the individual patient level.

These encounters with moral conflict frequently lead to moral distress, a factor increasingly acknowledged as a key challenge for clinicians. Contemporary studies associate moral distress with a sense of fractured professional identity and burnout among nurses, while also emphasizing the value of moral resilience—the ability to maintain personal integrity and regain moral perspective despite external pressures [43]. Enhancing moral resilience via targeted ethics training, open reflective discussions, and organized debriefing sessions can help reduce the damaging impact of legal-ethical conflicts on clinicians' sense of professional self [43-45].

The third theme illustrates how documentation practices, accountability measures, and institutional oversight—fundamental elements of legal protection—can inadvertently weaken ethical standards. Investigations [27, 28, 37] revealed that healthcare staff frequently record procedures not as they actually occurred, but as they ought to have occurred, to maintain legal protection. Such defensive charting shifts medical records away from being instruments of patient support toward serving as self-defense tools. The heavy administrative workload associated with regulatory compliance further removes nurses from hands-on patient interaction [27]. As one participant noted, the large volume of paperwork "caused me to be distant from my patients." This situation reveals a fundamental contradiction: although documentation promotes legal transparency, it reduces moral and relational openness.

In addition, inadequate institutional support for ethics [23, 38] intensifies this separation. Ethics committees were often portrayed as powerless when it came to addressing clashes between legal obligations and ethical judgment. While earlier reviews only highlighted these shortcomings [46], a closer examination uncovers their underlying causes: unclear legal status, confusion with management committees, and limited funding. These factors render ethics committees marginal instead of central to decision-making processes. Meaningful change demands a redefinition of their role—providing them with authority to monitor decisions, integrating them into policy development, and including frontline clinical staff—to shift them from ceremonial entities into effective bridges between legal rules and ethical practice.

The last theme places legal-ethical tensions within larger social, cultural, and organizational contexts. Disparities in power and status are deeply embedded in hospital environments, influencing both patients' access to services and staff's ability to exercise ethical judgment. In certain environments [27], favoritism and social connections dictated the standard of care, breaching the ethical ideal of justice and contradicting legal expectations of equal access. The hierarchical silencing of nurses' perspectives [32, 33] further shows how official legal and institutional structures limit opportunities for moral input. Despite their strong ethical drive to advocate for patients, nurses are frequently prevented—either by law or professional norms—from questioning physicians' choices. This leads to moral silencing, an issue extensively examined in existing nursing ethics research [23, 27, 31].

Moreover, the persistence of legally required yet non-beneficial treatments [29, 38] illustrates how regulations can sustain moral distress. Healthcare providers forced to continue pointless life-support measures described profound ethical struggles, a trend supported by additional research [47, 48]. These cases demonstrate that legal pressures to "do everything possible" can directly oppose ethical responsibilities to ease suffering and honor patient dignity. Overall, this theme emphasizes that justice in healthcare encompasses more than fair allocation of resources; it also requires moral equity—the freedom for every healthcare professional to follow their conscience while operating within legal boundaries.

Across all four categories, the present synthesis reveals a clear and recurring pattern: while the law establishes the structural limits of healthcare delivery, ethics supplies its essential moral foundation. When legal and institutional demands take precedence, ethical standards gradually weaken, leading to heightened moral distress and growing professional detachment. Resolving these tensions demands comprehensive systemic approaches. First, consent processes need to be made more humane by adopting shared decision-making frameworks that combine necessary legal records with genuine relational conversation. Second, ethical considerations should be integrated directly into the creation of institutional policies, so that protocols for triage, documentation, and risk management reflect both ethical values and legal requirements. Third, hospital ethics committees must be granted real decision-making power to effectively connect governance structures with moral practice. Finally, nurturing moral courage and encouraging open dialogue across professions can reduce the silencing impact of hierarchical systems.

In the end, true alignment between law and ethics cannot be achieved solely through strict adherence; it emerges from reflective equilibrium—a continuous process of negotiation that honors both regulatory duties and moral insight. By gaining a deeper understanding of how legal–ethical conflicts arise in everyday clinical settings, healthcare organizations can move toward environments that are not only legally secure but also morally equitable. Further evidence indicates that engaging patients and families in important treatment decisions helps reduce conflict and improve overall satisfaction [2]. Developing and applying moral resilience techniques — such as cognitive reframing and peer support — can better prepare staff to handle the pressures generated by these conflicts [24]. Current literature positions organizational and individual interventions — including ethics consultation, peer support networks, and moral resilience training — as effective ways to actively transform moral suffering rather than simply lessening its effects; adopting these approaches may therefore reduce moral residue and the crescendo effect noted in earlier studies [12, 13].

This synthesis has several limitations. The majority of the included studies were conducted in settings with specific legal and cultural contexts, which may limit the applicability of the results elsewhere. Nonetheless, the synthesis provides a useful understanding of shared ethical–legal difficulties found across varied healthcare systems. The quality of reporting varied considerably, especially regarding descriptions of legal and institutional contexts. Despite thorough searching, some pertinent sources, particularly grey literature, may have been overlooked. The results of this synthesis should therefore be considered alongside differences in national legal, regulatory, and cultural environments. Several of the included studies were conducted in countries with differing laws on consent, mental health, and involuntary treatment, as well as varied definitions of professional roles; these contextual factors likely influence both the form that conflicts take and how staff perceive them. For this reason, broad universal statements are avoided, and attention is drawn to areas where the themes seem to depend on specific contexts. Future primary studies should directly examine how legal structures and cultural norms shape tensions around professional identity and ethical dilemmas in care.

To advance understanding in this area, future research should conduct qualitative investigations in a wider range of cultural and legal contexts, particularly in developing nations; assess the impact of organisational interventions aimed at reducing legal-ethical conflicts; investigate the perspectives of patients and families rather than focusing exclusively on staff views; and integrate qualitative and quantitative approaches to measure the effects of these conflicts on mental health, job satisfaction, and quality of care.

Conclusion

This qualitative synthesis, centered on nursing practice, demonstrates that legal–ethical conflicts in hospital settings are not merely occasional moral challenges but persistent systemic issues that undermine professional identity, moral resilience, and the overall standard of care. Going beyond simple recognition of the problem, the findings emphasize the pressing need for coordinated action at organizational, educational, and policy levels. Hospital leaders should create environments that actively support ethical practice and incorporate regular debriefing and opportunities for moral reflection. Lawmakers are urged to revise overly rigid legal structures that hinder ethical caregiving and to reinforce the role of institutional ethics committees as effective links between legal rules and clinical practice. Nurse educators and healthcare managers must incorporate training in ethical decision-making and moral resilience into educational programs and ongoing professional development. In the final analysis, aligning legal requirements with the fundamental moral principles of caregiving is vital for safeguarding both the integrity of healthcare professionals and the trust of patients.

Acknowledgments: The authors would like to sincerely thank all colleagues and participants in the included studies for their valuable contributions.

Conflict of Interest: None

Financial Support: None

Ethics Statement: None

References

1. Kayser JB, Kaplan LJ. Conflict management in the ICU. Crit Care Med. 2020;48(9):1349–57.
2. Hawryluck L, Sibbald R, Chidwick P. The standard of care and conflicts at the end of life in critical care: lessons from medical-legal crossroads and the role of a quasi-judicial tribunal in decision-making. J Crit Care. 2013;28(6):1055–61.
3. Nortvedt P, Hem MH, Skirbekk H. The ethics of care: role obligations and moderate partiality in health care. Nurs Ethics. 2011;18(2):192–200.
4. Bertaud S, Wilkinson D, Kelley M. The heart of palliative care is relational: a scoping review of the ethics of care in palliative medicine. BMC Palliat Care. 2025;24(1):150.
5. Sarraf-Yazdi S, Pisupati A, Goh CK, Ong YT, Toh YR, Goh SPL. A scoping review and theory-informed conceptual model of professional identity formation in medical education. Med Educ. 2024;58(10):1151–65.
6. Cornett M, Palermo C, Ash S. Professional identity research in the health professions-a scoping review. Adv Health Sci Educ Theory Pract. 2023;28(2):589–642.
7. Beauchamp T, Childress J. Principles of biomedical ethics: marking its fortieth anniversary. Am J Bioeth. 2019;19:9–12.
8. Noddings N. Caring: A Relational Approach to Ethics and Moral Education. 2nd ed. University of California Press; 2013.
9. Tronto J. Moral Boundaries: A Political Argument for an Ethic of Care. Routledge. 1993. doi.org/10.4324/9781003070672
10. Jameton A. Dilemmas of moral distress: moral responsibility and nursing practice. AWHONN’s Clin Issues Perinat Womens Health Nurs. 1993;4(4):542–51.
11. Corley MC. Nurse moral distress: a proposed theory and research agenda. Nurs Ethics. 2002;9(6):636–50.

12. Epstein EG, Hamric AB. Moral distress, moral residue, and the crescendo effect. J Clin Ethics. 2009;20(4):330–42.
13. Rushton CH. Moral Resilience: Transforming Moral Suffering in Healthcare. Oxford University Press; 2024. doi.org/10.1093/oso/9780197667149.001.0001
14. McGrath PD, Forrester K. Ethico-legal issues in relation to end-of-life care and institutional mental health. Aust Health Rev. 2006;30(3):286.
15. Mehter HMMJ, Clark JA, Wiener RS. Physician approaches to conflict with families surrounding end-of-life decision-making in the intensive care unit: a qualitative study. Ann Am Thorac Soc. 2018;15(2):241–9.
16. Choong K, Cupido C, Nelson E, Arnold M, Burns D, Cook K. A framework for resolving disagreement during end of life care in the critical care unit. Clin Invest Med. 2010;33(4):E240–53.
17. Lindgren BM, Ringnér A, Molin J, Graneheim UH. Patients' experiences of isolation in psychiatric inpatient care: insights from a meta-ethnographic study. Int J Ment Health Nurs. 2018;28(1):7–21.
18. Molloy L, Beckett P, Chidarikire S, Cutler N, Isobel S, Murphy G. Mental Health Nurses' Enforcement of Involuntary Care in Inpatient Settings: A Meta-Ethnography. Int J Ment Health Nurs. 2025;34(3):e70044.
19. Pariseau-Legault P, Vallée-Ouimet S, Jacob JD, Goulet MH. Intégration des droits humains dans la pratique du personnel infirmier faisant usage de coercition en santé mentale: recension systématique des écrits et méta-ethnographie. Rech Soins Infirm. 2020;142(3):53–76.
20. Hellzén O, Hammarström L, Ekman O, Devik SA. A meta-ethnographic review of forensic psychiatry inpatient care: nursing staff experiences of the nurse-patient encounter. Issues Ment Health Nurs. 2023;44(12):1226–36.
21. Pols J. Enforcing patient rights or improving care? The interference of two modes of doing good in mental health care. Sociol Health Illn. 2003;25(4):320–47.
22. Schofield G, Dittborn M, Huxtable R, Brangan E, Selman LE. Real-world ethics in palliative care: a systematic review of the ethical challenges reported by specialist palliative care practitioners in their clinical practice. Palliat Med. 2020;35(2):315–34.
23. Falcó-Pegueroles A, Bosch-Alcaraz A, Terzoni S, Fanari F, Viola E, Via-Clavero G. COVID-19 pandemic experiences, ethical conflict and decision-making process in critical care professionals (Quali-Ethics-COVID-19 research part 1): an international qualitative study. J Clin Nurs. 2023;32(15–16):5185–200.
24. Vanderspank-Wright B, Efstathiou N, Vandyk AD. Critical care nurses' experiences of withdrawal of treatment: a systematic review of qualitative evidence. Int J Nurs Stud. 2018;77:15–26.
25. Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. BMC Med Res Methodol. 2008;8(1):45.
26. Davoudi N, Nayeri ND, Zokaei MS, Fazeli N. Challenges of obtaining informed consent in emergency ward: a qualitative study in one Iranian hospital. Open Nurs J. 2017;11:263–76.
27. Yarahmadi S, Soleimani M, Gholami M, Fakhr-Movahedi A, Madani SMS. Health disparities in service delivery in the intensive care unit: a critical ethnographic study. Nurs Crit Care. 2025;30(3):e13170.
28. Zali M, Rahmani A, Powers K, Hassankhani H, Namdar-Areshtanab H, Gilani N. Nurses' experiences of ethical and legal issues in post-resuscitation care: a qualitative content analysis. Nurs Ethics. 2023;30(2):245–57.
29. Godskesen T, Björk J, Juth N. Challenges regarding informed consent in recruitment to clinical research: a qualitative study of clinical research nurses' experiences. Trials. 2023;24(1):801.
30. Kukkurainen A, Keränen T, Reinikainen M, Halkoaho A. Navigating ethical dilemmas in intensive care clinical research from the perspectives of nurses: a qualitative study. Scand J Caring Sci. 2025;39(1):e70025.
31. Morley G, Copley DJ, Field R, Zelinsky M, Albert NM. RESPONDER: a qualitative study of ethical issues faced by critical care nurses during the COVID-19 pandemic. J Nurs Manag. 2022;30(7):2403–15.
32. Usberg G, Uibu E, Urban R, Kangasniemi M. Ethical conflicts in nursing: an interview study. Nurs Ethics. 2021;28(2):230–41.
33. Oerlemans AJM, van Sluisveld N, van Leeuwen ESJ, Wollersheim H, Dekkers WJM, Zegers M. Ethical problems in intensive care unit admission

and discharge decisions: a qualitative study among physicians and nurses in the Netherlands. BMC Med Ethics. 2015;16(1):9.
34. Vargas MA, Ramos FR, Schneider DG, Schneider N, dos Santos AC, Leal SM. Hospitalization by court order: ethical dilemmas experienced by nurses. Rev Gaucha Enferm. 2013;34(1):119–25.
35. Malekzadeh R, Amirkhanlou A, Abedi G, Araghian Mojarad F. Ethical challenges of care and treatment for patients with COVID-19 in a hospital from the perspective of service providers. 2021;140:140.
36. Rashidi K, Goudarzi F, Fadavi M, Akrami F. Ethical challenges experienced by physicians and nurses in caring for patients with COVID-19: a qualitative study. Shiraz E-Med J. 2022;23(12):e127365.
37. Jørgensen L, Kollerup MG. Ethical dilemmas in nursing documentation. Nurs Ethics. 2022;29(2):485–97.
38. Hussain S, Ullah A, Ullah A. Nurses' experiences with ethical dilemmas in critical care settings: a mixed-method study at Saidu Teaching Hospital. Medtigo J Med. 2025;3(1):e30623135.
39. Bruce CR, Miller SM, Zimmerman JL. A qualitative study exploring moral distress in the ICU team: the importance of unit functionality and intrateam dynamics. Crit Care Med. 2015;43(4):823–31.
40. Varkey B. Principles of clinical ethics and their application to practice. Med Princ Pract. 2021;30(1):17–28.
41. Nampewo Z, Mike JH, Wolff J. Respecting, protecting and fulfilling the human right to health. Int J Equity Health. 2022;21(1):36.
42. Afenigus AD, Sinshaw MA. Ethical dilemmas and decision-making in emergency and critical care nursing in Western Amhara region, Northwest Ethiopia: a multi-method qualitative study. BMC Nurs. 2025;24(1):295.
43. Galanis P, Moisoglou I, Katsiroumpa A, Vraka I, Siskou O, Konstantakopoulou O. Moral resilience reduces levels of quiet quitting, job burnout, and turnover intention among nurses: evidence in the post COVID-19 era. Nurs Rep. 2024;14:254–66.
44. Browning ED, Cruz JS. Reflective debriefing: a social work intervention addressing moral distress among ICU nurses. J Soc Work End Life Palliat Care. 2018;14(1):44–72.
45. Imbulana DI, Davis PG, Prentice TM. Interventions to reduce moral distress in clinicians working in intensive care: a systematic review. Intensive Crit Care Nurs. 2021;66:103092.
46. Raoofi S, Arefi S, Khodayari Zarnaq R, Azimi Nayebi B, Mousavi MSS. Challenges of hospital ethics committees: a phenomenological study. J Med Ethics Hist Med. 2021;14:26.
47. Dzeng E, Colaianni A, Roland M, Levine D, Kelly MP, Barclay S. Moral distress amongst American physician trainees regarding futile treatments at the end of life: a qualitative study. J Gen Intern Med. 2016;31(1):93–9.
48. Brender TD, Axelrod JK, Weiss Goitiandia S, Batten JN, Dzeng EW. Clinicians' perceptions about institutional factors in moral distress related to potentially nonbeneficial treatments. JAMA Netw Open. 2025;8(6):e2516089.