Society of Medical Education & Research

2026, Volume 6, Issue 1, Page No: 52-61
ISSN: 3108-5059

Asian Journal of Ethics in Health and Medicine

Moral Distress as Ethical Intelligence: What Clinician Discomfort Reveals About Healthcare Institutions

Emma Wilson[1]*, Frederik De Jong[2], Lara Peters[2]

[1]Department of Moral Distress and Institutional Ethics, Faculty of Medicine, University of Edinburgh, Edinburgh, United Kingdom.
[2]Department of Healthcare Organisations and Ethical Intelligence, Faculty of Medicine, Utrecht University, Utrecht, Netherlands.

***E-mail** ✉ emma.wilson@ed.ac.uk

Abstract

Moral distress is usually treated as a burden to be reduced through coping, resilience, or psychological support. That response can be appropriate, yet it may also individualize a problem whose ethically relevant causes lie partly in clinical routines, authority relations, resource constraints, and institutional decision structures. This conceptual–institutional article develops an alternative but deliberately limited account: moral distress can function as ethical intelligence. On this account, clinician discomfort is neither mere emotion nor moral proof. It is a defeasible source of ethically relevant information that may warrant institutional attention when connected to recurrent constraints, converging reports, proximate knowledge of practice, corroborating evidence, and plausible preventability. The analysis distinguishes competing interpretations of moral distress, clarifies why psychometric measurement cannot determine moral correctness, and proposes credibility conditions for moving from first-person experience toward institutional inference. It then reconstructs that movement as a signal-to-system diagnostic process in which recognition, corroboration, pattern concentration, ethical interpretation, and provisional institutional diagnosis remain conceptually distinct. Alternative explanations and normalization can weaken, redirect, or conceal the signal. The proposed account therefore resists both therapeutic reductionism and epistemic overreach. Its practical implication is procedural: institutions should create conditions in which morally troubling experience can be heard, interpreted, and investigated without treating distress intensity as a threshold for wrongdoing. The framework remains a conceptual synthesis rather than a validated diagnostic model, and its transferability across professions, specialties, and jurisdictions requires empirical testing.

Keywords: Moral distress, Ethical intelligence, Institutional ethics, Moral agency, Ethical climate, Organizational learning

Introduction

Reinterpreting clinician discomfort

Moral distress is commonly encountered as an individual experience: frustration, guilt, anger, compromised integrity, or the sense of being unable to practise in accordance with professional commitments. Yet the conditions that generate such experiences are often distributed across systems rather than located within the clinician alone. Contemporary analysis of moral stress and distress under pressure shows that institutional rules, scarcity, organizational demands, and constrained professional action can become part of the moral problem itself [1]. Reinterpreting clinician discomfort therefore requires a shift in analytic level. The clinician may need support, but the institution may also need information.

Recent qualitative evidence makes this shift difficult to dismiss. Clinicians describing potentially nonbeneficial treatment have identified institutional factors as contributors to moral distress [2], while a recent scoping review shows that nursing moral distress arises from

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

Received: 17 November 2025; **Accepted:** 24 February 2026

How to cite this article: Wilson E, De Jong F, Peters L. Moral Distress as Ethical Intelligence: What Clinician Discomfort Reveals About Healthcare Institutions. Asian J Ethics Health Med. 2026;6(1):52-61. https://doi.org/10.51847/JS2GF2hPM4

heterogeneous sources rather than one stable mechanism [3]. Heterogeneity matters because it blocks a simple inference from "distress occurred" to "the institution acted wrongly." The same felt disturbance may arise from preventable organizational constraint, unavoidable tragedy, disagreement among defensible values, inadequate communication, professional hierarchy, or incomplete information. Distress therefore requires interpretation before it can support institutional judgment.

The opposite danger is to translate morally troubling experience too quickly into a generic wellness category. Healthcare workers during the first COVID-19 surge described forms of moral suffering that were not exhausted by burnout language [4]. At the same time, moral distress itself remains conceptually contested, including disagreement over whether constrained moral action is necessary to the phenomenon [5]. The argument developed here occupies the space between those problems. Moral distress is proposed as defeasible ethical intelligence: morally salient experience that can direct attention toward possible failures in care, relationships, authority, or institutional design while remaining open to correction. The contribution is therefore not that distressed clinicians know the moral truth. It is that institutions may lose ethically relevant knowledge when they treat discomfort only as a symptom to be managed.

Competing accounts of moral distress

Different institutional responses follow from different assumptions about what distress signifies. One interpretation treats moral distress primarily as pathology or burden. Its ethical priority is relief: reduce suffering, protect well-being, and prevent deterioration. A second reads persistent distress as evidence of insufficient resilience or coping capacity. These approaches can identify genuine needs, but when made dominant they risk relocating organizational conflict into the clinician. By contrast, Tigard argues that moral distress may sometimes have positive value because it can reflect morally serious engagement rather than simple dysfunction [6]. This makes distress potentially informative without making suffering itself desirable.

Agency complicates the picture further. A framework focused on nurse leaders shows that moral distress changes meaning when the distressed person also occupies a position of organizational responsibility [7]. Related conceptual work argues that moral agency and moral distress should not be treated as mutually exclusive states [8]. A clinician may retain partial agency while still being constrained by hierarchy, resources, policy, or collective decisions. This matters institutionally because "support the individual" and "change the organization" are not interchangeable responses.

A relational account makes power and moral community even more explicit. Feminist empirical bioethics has argued that narrow definitions can miss how relationships and power shape morally troubling experience [9]. From the analysis above, six institutional readings become visible: burden, resilience deficit, conscience signal, constrained agency, relational warning, and system-learning signal. These are not competing diagnoses with fixed boundaries. They are interpretive lenses that foreground different loci of responsibility and therefore different risks of error. The same episode may involve genuine suffering, constrained agency, and a system condition worth investigating.

Table 1 presents the six manuscript-derived readings of clinician moral distress and shows how each institutional interpretation illuminates one aspect of the experience while potentially obscuring another.

Table 1. Six institutional readings of clinician moral distress and the errors each invites

Interpretive Reading	What Becomes Visible	Likely Institutional Reflex	What the Reading Can Obscure	Evidence Status
Burden	Suffering, depletion, impaired well-being	Support and harm reduction	The ethical source of the suffering	Evidence-grounded interpretation
Resilience Deficit	Capacity to withstand moral adversity	Coping or resilience intervention	Structural constraints and power	**Proposed critical reading**
Conscience Signal	Moral attention to a troubling situation	Ask what the distress may be tracking	Sincere conviction can still be mistaken	Evidence-informed interpretation
Constrained Agency	Limits on acting, challenging, or influencing decisions	Examine authority and role design	Agency may remain despite constraint	Evidence-informed interpretation
Relational Warning	Hierarchy, power, and damaged moral community	Examine relationships and voice conditions	Not every disagreement reflects domination	Evidence-informed synthesis

System-Learning Signal	Recurring discomfort as information about organizational conditions	Investigate institutional patterns	Distress may be overread as institutional proof	**Proposed synthesis** grounded in system-level analysis

Note: The six-reading arrangement is an original proposed synthesis. The categories organize distinct institutional interpretations emerging from the completed argument; they do not constitute a validated classification.

The matrix matters because institutional error can occur in either direction. A burden frame may protect the clinician while leaving the generating condition untouched. A conscience frame may preserve moral meaning while granting too much authority to conviction. A system-learning frame may expose organizational problems while encouraging premature attribution. The appropriate institutional response therefore depends not merely on whether distress exists, but on what explanatory work remains to be done.

Why distress is neither mere emotion nor moral proof

The ethical-intelligence account must avoid two symmetrical mistakes. The first dismisses distress because it is affective. Emotion is then treated as noise surrounding the "real" ethical question. The second grants distress an authority it cannot bear: because the experience is morally intense, the clinician's interpretation is treated as substantively correct. Measurement research demonstrates why neither move is justified. Existing instruments operationalize moral distress and moral injury in heterogeneous ways, reviews report variation in measurement properties, and recent work can validate a particular measure within a defined context without validating the moral judgment attached to any individual score [10-12]. Measurement can therefore improve descriptive precision while leaving normative adjudication open.

Context also shapes what a distress report means. In long-term-care nursing, moral sensitivity and ethical climate have been associated with relationships involving moral distress and competence [13]. Those findings are not causal proof, but they illustrate why distress cannot be interpreted apart from the moral and organizational environment in which it is expressed. One clinician may experience a patient's refusal as morally distressing because beneficence feels frustrated; another may regard the same refusal as an ethically demanding but justified exercise of autonomy. Both experiences can be sincere. Sincerity tells the institution that something morally important is being perceived, not that the correct interpretation has already been reached.

This is why ethical intelligence must be defeasible. A distress signal should be capable of gaining or losing warrant as facts, corroboration, competing duties, patient values, legal constraints, and organizational conditions are examined. Defeasibility is not skepticism toward clinicians; it is the discipline that permits their testimony to count as evidence without converting testimony into verdict. The same principle protects clinicians from another burden: they should not have to demonstrate institutional wrongdoing merely by proving that they suffered. Distress establishes the moral salience of an experience for the person reporting it. Institutional judgment requires an additional step—asking what generated the experience, whether the relevant constraint was justified, whether others encounter it, and where responsibility plausibly resides.

Ethical intelligence as an epistemic concept

"Ethical intelligence" is used here to describe an informational function, not a psychological trait, score, competency, or superior moral faculty. Conceptual analysis has shown that moral distress cannot be reduced to a single formula in which a clinician knows the right action and is prevented from performing it [14]. The present proposal builds on that caution. Distress can be epistemically useful even when the clinician does not possess a fully settled moral conclusion. It may identify a point of friction: a policy that repeatedly forces value trade-offs, a hierarchy that restricts challenge, a resource arrangement that makes good care difficult, or a relationship in which professional obligations become hard to enact.

Such information is partly situated. Empirical bioethics research on nurses' experiences suggests that relational and contextual dimensions become visible through first-person accounts that abstract definitions can miss [15]. Proximity to practice can therefore confer access to morally relevant detail. It does not confer infallibility. A bedside clinician may see the human burden of a policy with unusual clarity while lacking information about competing obligations at service or system level. Ethical intelligence is best understood as perspectival evidence that enters deliberation rather than authority that ends it.

Moral distress in end-of-life care also illustrates how the experience can affect clinicians and their engagement with care beyond a momentary feeling [16]. Structured

peer approaches aimed at nurturing moral community offer one way of making such experience discussable rather than privately absorbed [17]. The proposed epistemic move is therefore from felt disturbance to an articulable ethical question. What value appears threatened? What action or inaction produced the concern? Which constraints are clinical, relational, organizational, legal, or resource-based? Which are modifiable? Ethical intelligence becomes institutionally useful when these questions convert discomfort into a claim capable of examination.

Conditions affecting the credibility of moral distress

If distress is information, institutions require a way to assess its credibility without pretending to calculate moral truth. The available evidence points first to context. Ethical climate is associated with nurses' moral distress, while race-, gender-, and profession-sensitive analysis shows that distress and related outcomes can vary across social and occupational locations [18, 19]. These findings justify attention to the environments in which distress is generated and reported. They do not justify treating any demographic or professional group as inherently more or less credible.

Organizational support introduces another important distinction. Mixed-method evidence suggests that perceived organizational support can influence nurses' ability to handle and resolve ethical value conflicts [20]. Yet support, conflict occurrence, and distress after conflict are not identical phenomena. A supportive institution cannot promise the absence of moral distress because some situations remain tragic, uncertain, or ethically contested even when organizational processes are sound. Credibility assessment should therefore ask whether distress plausibly identifies a remediable condition, not whether a well-run organization ought to eliminate the feeling.

From the argument developed so far, eight qualitative tests of warrant emerge: recurrence, convergence, proximity, power asymmetry, preventability, corroboration, temporal consistency, and plausible alternative explanation. They are proposed as questions, not scores. None is necessary in every case, and none is independently sufficient. A singular severe event may warrant immediate inquiry without recurrence; power asymmetry can explain silence without proving the speaker correct; preventability can make a problem actionable without making the underlying act morally wrong. The purpose of the criteria is therefore not classification but disciplined resistance to premature institutional inference.

Table 2 converts these manuscript-derived credibility conditions into questions that expose both overinterpretation and under-recognition.

Table 2. Qualitative tests for deciding when moral distress warrants institutional inference

Proposed Test	Institutional Question	What Can Strengthen Warrant	Inferential Error Constrained
Recurrence	Does a similar ethical concern reappear?	Repeated comparable episodes	Treating one reaction as a stable organizational pattern
Convergence	Do independent perspectives identify the same difficulty?	Agreement across roles or sources	Mistaking repetition of one account for corroboration
Proximity	Who directly encountered the practice or consequence?	First-hand access to relevant events	Ignoring situated knowledge or granting it absolute authority
Power Asymmetry	Could hierarchy shape action, silence, or reporting?	Evidence of constrained voice or relational power	Equating silence with absence of ethical concern
Preventability	Is the relevant constraint institutionally modifiable?	Identifiable organizational contributors	Confusing tragic inevitability with institutional failure
Corroboration	What additional evidence supports or challenges the account?	Testimony, records, measures, or other perspectives	Treating emotional intensity as evidence
Temporal Consistency	Does the concern persist under comparable conditions?	Durable ethically relevant pattern	Overreading a transient condition
Alternative Explanation	What competing account could better explain the distress?	Serious testing of contextual or construct alternatives	Converting sincere distress into automatic moral proof

Note: The eight-test matrix is an original proposed synthesis derived from the completed conceptual argument. It is not a psychometric instrument, scoring rule, diagnostic threshold, or hierarchy of credibility.

The matrix reframes credibility as disciplined comparison rather than ranking. A signal becomes more institutionally persuasive when different forms of evidence converge and less persuasive when an alternative explanation better fits the circumstances. Importantly, the criteria can also expose false reassurance. Apparent absence of recurrence may reflect unsafe reporting conditions, whereas apparent convergence may merely reproduce one dominant professional interpretation. Credibility therefore concerns the quality of the inference, not the quantity of distress.

From individual experience to institutional diagnosis

The decisive conceptual movement is from "I am morally distressed" to "this institution may have an ethical problem." Qualitative work with emergency physicians shows that clinicians can experience moral distress through organizational and contextual constraints embedded in everyday practice [21]. Such reports matter because proximity gives clinicians access to details that may remain invisible at managerial distance. Still, first-person testimony identifies an institutional hypothesis; it does not complete the institutional judgment.

The distinction becomes particularly important where morally charged practices are also shaped by legitimate safety obligations. ICU nurses describing distress around physical-restraint decisions have reported workload, staffing conditions, and unilateral orders among the factors structuring their experience [22]. Those observations can make organizational contributors visible without establishing that restraint was always unjustified or that every constraint was preventable. The same account can therefore contain ethically significant information and remain open to competing interpretation. Institutional ethical diagnosis is proposed here as a disciplined and revisable judgment that a sufficiently serious or recurrent pattern of clinician moral distress plausibly reflects an ethically relevant organizational condition. The route to such a judgment is not an accumulation of emotional intensity. Clinician-level experiences must first become recognizable as morally salient signals. Their factual and testimonial basis must then be examined. Independent convergence and temporal pattern should be distinguished from simple repetition. Ethical interpretation must ask what values, obligations, authority relations, and preventable constraints are implicated. Only after those steps can a system-level inference acquire substantial warrant.

At each point, the inference may weaken or change direction. A contextual account may better explain the experience; an unusual circumstance may prove transient; or factual corroboration may fail. Normalization creates the inverse epistemic hazard. When troubling conditions become routine, clinicians may cease naming them, reduce expectations of change, or adapt their practice, so diminishing expressed distress cannot safely be equated with ethical improvement. The figure derived from this argument therefore narrows multiple clinician signals through successive forms of interpretive discipline while retaining a separate attenuation channel. It stops at provisional institutional diagnosis because institutional response has not yet been conceptually developed at this point in the manuscript.

Figure 1 presents the manuscript-derived signal-to-system pathway from dispersed clinician discomfort to provisional institutional ethical diagnosis.

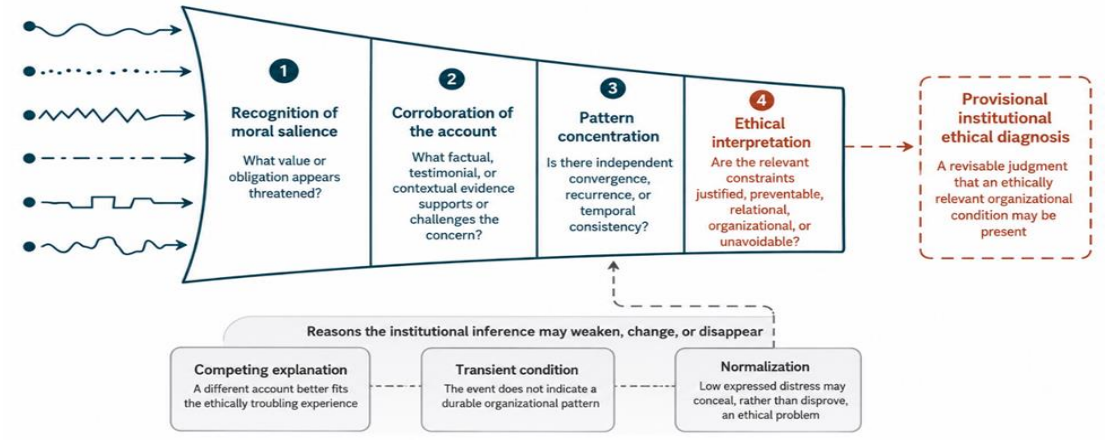

Figure 1. From dispersed moral-distress signals to provisional institutional ethical diagnosis

Recurrent distress and organizational pattern recognition

Institutional significance becomes more plausible when morally troubling experiences recur under comparable conditions. Evidence from healthcare workers in public-health emergencies links moral distress with features of the work environment, supporting the relevance of organizational context when similar concerns appear repeatedly [23]. Recurrence, however, is not equivalent to proof. Repeated distress may reflect a persistent institutional constraint, but it may also arise because clinicians repeatedly encounter an unavoidable clinical reality or a policy whose burdens remain ethically defensible.

Temporal information strengthens pattern interpretation because it distinguishes momentary reaction from durable exposure. Longitudinal research has associated moral distress with burnout and consideration of leaving hospital employment across time [24]. That evidence does not establish that distress independently causes workforce exit. It does show why organizations should not assume that morally troubling experiences are self-limiting. Critical qualitative work in pediatric oncology similarly demonstrates how nurses' counter-stories can expose recurring conditions under which they feel unable to practise as they believe they should [25]. Narrative recurrence can therefore reveal structures hidden by official descriptions of routine practice, although shared narratives still require independent examination.

The proposed institutional logic is consequently pattern-sensitive but not pattern-dependent. Convergence across people, roles, episodes, or records can increase the warrant for investigating a system condition, especially when the same constraint repeatedly obstructs valued forms of care. Yet a singular event involving profound coercion, avoidable harm, or serious professional compromise may justify immediate scrutiny without waiting for repetition. Conversely, numerous reports can remain misleading when they reproduce the same incomplete interpretation. Organizational pattern recognition should therefore ask whether signals are sufficiently independent, temporally coherent, and tied to a common institutional feature. Its purpose is to convert recurrence into a question about structure, not into a numerical threshold for ethical failure.

False positives, normalization, and strategic misuse

An ethical-intelligence account becomes unsafe if it lacks a theory of error. Moral distress and moral injury overlap conceptually, but available scholarship does not justify treating them as interchangeable, and professional moral experience must also be interpreted against ethical, legal, and professional norms [26, 27]. A clinician can therefore be intensely and sincerely distressed even when fuller examination supports the contested decision. The experience remains morally important because it identifies perceived conflict; what it cannot establish by itself is where the error, if any, resides.

A proposed false positive occurs when moral distress is interpreted as evidence of an institutional ethical defect that the available facts and normative analysis do not sustain. Competing explanations include incomplete information, conflicting but defensible values, grief, uncertainty, role misunderstanding, or moral injury. Calling such cases false positives should not pathologize the clinician or imply that the distress was unreal. The error lies in the institutional inference, not necessarily in the experience.

Normalization creates the reverse danger. Repeated exposure to troubling conditions may reduce expressed distress because clinicians adapt expectations, disengage, cease reporting, or leave. Counter-stories are important precisely because dominant organizational narratives can make such constraints appear ordinary [25]. Low distress may therefore represent ethical accommodation rather than ethical success. Strategic misuse is possible from both directions: clinicians may invoke moral distress to resist justified institutional decisions, while organizations may use resilience, professionalism, or "normal pressure" to neutralize unwelcome criticism. The framework grants neither party epistemic privilege. It instead requires reasons, evidence, and an account of power. Institutions should be able to conclude that a distress report was morally significant without finding institutional wrongdoing, while also recognizing that an absence of reported distress cannot certify institutional adequacy.

Institutional listening, investigation, and response

Once moral distress has sufficient warrant for institutional attention, response should begin by preserving its informational value rather than rushing either to reassurance or culpability. A feasibility study of Moral Spaces indicates that structured ethical discussion can support nurses' ethical confidence and competence [28]. This supports the feasibility of creating spaces in which clinicians can articulate concerns, but it does not establish that reflective discussion corrects structural

problems or improves clinical outcomes. Listening is therefore best understood as an entry point into inquiry.

Intervention-development research further shows that responses to moral distress can be constructed through both evidentiary and ethical reasoning [29]. Building from the preceding analysis, this article proposes an institutional architecture with three distinct functions: protect the signal, test the inference, and close the response. Protection includes accessible listening and safeguards against silencing where hierarchy makes reporting costly. Testing requires factual investigation, comparison with other perspectives, pattern interpretation, and escalation when the concern exceeds local authority. Closure requires deciding whether redesign, accountability, monitoring, or an explanation of non-action is warranted. Organizational support is relevant because it can affect clinicians' ability to handle and resolve ethical value conflicts [20], but supportive culture cannot substitute for investigation.

The architecture also places obligations on institutions when the original interpretation is not confirmed. A defensible response should explain what was examined, what competing considerations mattered, and why change was or was not justified. This avoids treating "no institutional violation found" as equivalent to "nothing morally significant occurred." Conversely, redesign should follow identified and modifiable contributors rather than distress intensity. Monitoring should examine whether the relevant condition recurs without converting moral-distress scores into organizational ethics scores. Accountability should track warranted responsibility rather than formal rank alone. These distinctions turn institutional responsiveness into an epistemic process: the organization must show that it can hear ethically significant information, test it fairly, and return reasons to those who supplied it.

Table 3 distils this manuscript-derived response architecture into three institutional functions and the transitions that prevent listening from becoming symbolic or investigation from becoming presumptive.

Table 3. Protecting, testing, and closing the institutional response to credible moral distress

Institutional Function	Manuscript-Derived Components	What The Function Accomplishes	Failure To Avoid
Protect The Signal	Listening; safe reporting; protection from silencing	Preserves morally relevant testimony for examination	Treating support as the endpoint
Test The Inference	Investigation; corroboration; pattern interpretation; proportionate escalation	Determines whether an organizational condition plausibly contributes	Presuming wrongdoing because distress is intense
Close The Response	Redesign where justified; monitoring; accountability; reason-giving feedback	Connects findings to action or explained non-action	Symbolic listening, unbounded redesign, or unexplained closure
Cross-Cutting Safeguard	Organizational support without substituting support for inquiry	Helps clinicians handle ethical conflict while preserving institutional responsibility	Individualizing an organizational problem

Note: The three-function architecture and ordering are an original proposed synthesis. The components are evidence-informed but do not constitute a validated implementation pathway.

Limitations of the ethical-intelligence account

The account is conceptually ambitious but empirically unvalidated. Institutional responses to moral distress are shaped by organizational history, resources, professional norms, and jurisdiction. Canadian ethicists and healthcare leaders reflecting on pandemic moral distress identified context-dependent lessons rather than a universal response model [30]. Specialty differences further restrict transferability: a systematic review of acute mental-health nursing identifies setting-specific sources and limitations in the available evidence [31]. A framework developed partly from nursing-dominant literature should therefore not be presumed to transfer unchanged to medicine, allied health, trainees, or other institutional settings.

Conceptual breadth is another vulnerability. Qualitative work on nurses' moral suffering emphasizes multidimensional and context-sensitive experience [32]. If ethical intelligence becomes an umbrella for every morally troubling feeling, it will lose discriminative value; if it becomes too narrow, it may exclude precisely

the weak, relational, or normalized signals institutions most need to hear.

Empirical evaluation should therefore test both false positives and false negatives. Prospective multisite studies could compare distress reports with independently examined organizational conditions, alternative constructs, patient or family perspectives, policies, staffing records, and ethics-consult data. Longitudinal and mixed-method designs are particularly important for determining whether the proposed credibility conditions improve institutional recognition without merely increasing the volume of escalated concerns. Testing should also sample institutions with low reported distress, because absence of complaint may reflect good ethical conditions, successful suppression, professional adaptation, or workforce selection. Comparative designs should therefore examine reporting opportunity and institutional response capacity alongside distress itself rather than treating observed prevalence as a direct measure of ethical quality.

Conclusion

Moral distress can be harmful without being epistemically empty, and morally significant without being morally decisive. The ethical-intelligence account proposed here holds those propositions together. Clinician discomfort can direct attention toward constraints, relationships, routines, and authority structures that deserve examination, but its institutional force depends on disciplined interpretation rather than emotional intensity.

This approach changes the organizational question from whether distress should be believed or eliminated to what the distress may reveal, what evidence supports that interpretation, what alternatives remain plausible, and who is responsible for responding. Recurrence can strengthen a signal without becoming a threshold; normalization can conceal ethical problems; and supportive listening can fail if it never reaches investigation or reasoned closure.

The framework is not a diagnostic instrument, causal model, or implementation protocol. Its contribution is conceptual and procedural: institutions should treat credible moral distress as potentially valuable ethical information while preserving uncertainty, contestability, and the possibility of justified disagreement. Whether this approach improves recognition of institutional ethical problems remains an empirical question.

Acknowledgments: None

Conflict of Interest: None

Financial Support: None

Ethics Statement: None

References

1. Buchbinder M, Browne A, Berlinger N, Jenkins T, Buchbinder L. Moral stress and moral distress: Confronting challenges in healthcare systems under pressure. Am J Bioeth. 2024;24(12):8-22. doi:10.1080/15265161.2023.2224270
2. 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). doi:10.1001/jamanetworkopen.2025.16089
3. Karasinski M, Lomba de Oliveira E, de Souza Pousa VL, Massaneiro dos Santos GC, Corradi Perini C. Sources of moral distress in nursing professionals: A scoping review. Nurs Ethics. 2025;32(5):1528-44. doi:10.1177/09697330241312382
4. Sherman M, Klinenberg E. Beyond burnout: Moral suffering among healthcare workers in the first COVID-19 surge. Soc Sci Med. 2024;340:116471. doi:10.1016/j.socscimed.2023.116471
5. Morley G, Ives J, Bradbury-Jones C, Irvine F. What is 'moral distress'? A narrative synthesis of the literature. Nurs Ethics. 2019;26(3):646-62. doi:10.1177/0969733017724354
6. Tigard DW. The positive value of moral distress. Bioethics. 2019;33(5):601-8. doi:10.1111/bioe.12564
7. Miller PH. Moral distress among nurse leaders: A conceptual framework. Nurs Ethics. 2025;32(7):2163-74. doi:10.1177/09697330251339420
8. Morley G, Sankary LR. Re-examining the relationship between moral distress and moral agency in nursing. Nurs Philos. 2024;25(1). doi:10.1111/nup.12419
9. Morley G, Bradbury-Jones C, Ives J. Reasons to redefine moral distress: A feminist empirical bioethics analysis. Bioethics. 2021;35(1):61-71. doi:10.1111/bioe.12783

10. Houle SA, Ein N, Gervasio J, Plouffe RA, Litz BT, Carleton RN, et al. Measuring moral distress and moral injury: A systematic review and content analysis of existing scales. Clin Psychol Rev. 2024;108:102377. doi:10.1016/j.cpr.2023.102377
11. Giannetta N, Villa G, Pennestrì F, Sala R, Mordacci R, Manara DF. Instruments to assess moral distress among healthcare workers: A systematic review of measurement properties. Int J Nurs Stud. 2020;111:103767. doi:10.1016/j.ijnurstu.2020.103767
12. Girela-Lopez E, Beltran-Aroca CM, Boceta-Osuna J, Aguilera-Lopez D, Gomez-Carranza A, Lopez-Valero M, et al. Measuring moral distress in health professionals using the MMD-HP-SPA scale. BMC Med Ethics. 2024;25(1):41. doi:10.1186/s12910-024-01041-z
13. Oh GY, Song YM. Moral distress and nursing competence: The mediating role of moral sensitivity and ethical climate. Nurs Ethics. 2025;32(7):2100-16. doi:10.1177/09697330251366611
14. Tigard DW. Rethinking moral distress: Conceptual demands for a troubling phenomenon affecting health care professionals. Med Health Care Philos. 2018;21(4):479-88. doi:10.1007/s11019-017-9819-5
15. Morley G, Bradbury-Jones C, Ives J. What is 'moral distress' in nursing? A feminist empirical bioethics study. Nurs Ethics. 2020;27(5):1297-314. doi:10.1177/0969733019874492
16. Lee MN, Kwon SH, Yu S, Park SH, Kwon S, Kim CH, et al. Unveiling nurses' end-of-life care experiences: Moral distress and impacts. Nurs Ethics. 2024;31(8):1600-15. doi:10.1177/09697330241246086
17. Morley G, Sankary LR. Nurturing moral community: A novel moral distress peer support navigator tool. Nurs Ethics. 2024;31(5):980-91. doi:10.1177/09697330231221220
18. Xue K, Shang J, Yang C, Pan L, Shi H, Zeng Y. Nurses' moral distress and ethical climate: A systematic review and meta-analysis. Nurs Ethics. 2025;32(7):1981-97. doi:10.1177/09697330251350384
19. Delgado-Ron JA, Tiwana MH, Murage A, Morgan R, Purewal S, Smith J. Moral distress, coping mechanisms, and turnover intent among healthcare providers in British Columbia: A race and gender-based analysis. BMC Health Serv Res. 2024;24(1):925. doi:10.1186/s12913-024-11377-2
20. Skyvell Nilsson M, Gadolin C, Larsman P, Pousette A, Törner M. The role of perceived organizational support for nurses' ability to handle and resolve ethical value conflicts: A mixed methods study. J Adv Nurs. 2024;80(2):765-76. doi:10.1111/jan.15889
21. Liu J, Dai F, Song Q, Sun J, Liu Y. "I feel like I'm walking on eggshells": A qualitative study of moral distress among Chinese emergency doctors. BMC Med Ethics. 2024;25(1):72. doi:10.1186/s12910-024-01074-4
22. Sarmadi S, Zare-Kaseb A, Sanaie N, Borhani F. ICU nurses' moral distress in decisions to implement physical restraints. Nurs Ethics. 2026;33(5):1363-83. doi:10.1177/09697330261428625
23. Bondjers K, Glad AK, Wøien H, Wentzel-Larsen T, Atar D, Reitan SK, et al. Moral distress and protective work environment for healthcare workers during public health emergencies. BMC Med Ethics. 2024;25(1):103. doi:10.1186/s12910-024-01098-w
24. Maunder RG, Heeney ND, Greenberg RA, Jeffs LP, Wiesenfeld LA, Johnstone J, et al. The relationship between moral distress, burnout, and considering leaving a hospital job during the COVID-19 pandemic: A longitudinal survey. BMC Nurs. 2023;22(1):243. doi:10.1186/s12912-023-01407-5
25. Molinaro ML, Polzer J, Laliberte Rudman D, Savundranayagam M. "I can't be the nurse I want to be": Counter-stories of moral distress in nurses' narratives of pediatric oncology caregiving. Soc Sci Med. 2023;320:115677. doi:10.1016/j.socscimed.2023.115677
26. Čartolovni A, Stolt M, Scott PA, Suhonen R. Moral injury in healthcare professionals: A scoping review and discussion. Nurs Ethics. 2021;28(5):590-602. doi:10.1177/0969733020966776
27. Day P, Lawson J, Mantri S, Jain A, Rabago D, Lennon R. Physician moral injury in the context of moral, ethical and legal codes. J Med Ethics. 2022;48(10):746-52. doi:10.1136/medethics-2021-107225
28. Morley G, Copley DJ, Bena JF, Morrison SL, Field RB, Gorecki J, et al. "Moral spaces": A feasibility study to build nurses' ethical confidence and competence. Nurs Ethics. 2025;32(3):782-97. doi:10.1177/09697330241284356

29. Deschenes S, Kunyk D, Scott SD. Developing an evidence-and ethics-informed intervention for moral distress. Nurs Ethics. 2025;32(1):156-69. doi:10.1177/09697330241241772
30. Clark DBA, Smith K, Alonso-Prieto E, Virani A. Addressing moral distress during the COVID-19 pandemic: Insights about future directions from Canadian ethicists and healthcare leaders. Nurs Inq. 2025;32(4). doi:10.1111/nin.70051
31. Lamoureux S, Mitchell AE, Forster EM. Moral distress among acute mental health nurses: A systematic review. Nurs Ethics. 2024;31(7):1178-95. doi:10.1177/09697330241238337
32. Seidlein AH, Schilder M, Miskine R, Schöner A, Mai T. Nurses' experiences of moral suffering: A qualitative interview study. Nurs Ethics. 2026;33(2):566-83. doi:10.1177/09697330251395211