

How healthcare workers experience moral distress while navigating ethical complexity: a qualitative study

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Abstract

Background

Moral distress is a well-documented phenomenon among healthcare workers (HCWs) and is associated with negative psychological outcomes and detrimental impact on patient care, staff wellbeing and health system sustainability. This study presents a secondary analysis of qualitative data collected to explore HCWs' experiences of ethical encounters, in which moral distress emerged as a prominent, unprompted theme.

Methods

Data were drawn from four focus groups (n=26), conducted with registered health professionals at an Australian teaching hospital. Participants reflected on a progressively complex fictional patient case study. Although the primary study did not set out to investigate moral distress specifically, its prominence across the focus groups warranted secondary analysis. Using a combined inductive and deductive coding approach, an a-priori code of "moral distress" was applied. Codes were iteratively developed into themes and are presented in a descriptive framework. This study is reported in line with Consolidated Criteria for Reporting Qualitative Research (COREQ).

Results

Participants described moral distress arising from three interrelated drivers: (1) Constrained agency and voice, where an inability to raise ethical concerns, not being heard or acknowledged or having to enact others' decisions. (2) Systemic constraints, including organisational hierarchy, resource and logistical limitations and the sense of being overwhelmed by structural and societal factors. (3) Finally, deficits in preparedness and understanding, including a lack of ethical deliberative frameworks, insufficient training and shouldering an unreasonable ethical burden in decision making was described. Participants also identified protective factors contributing to what we term "moral safety"; cultivating shared understanding through dialogue and support, camaraderie and collaboration among colleagues.

Conclusion

Moral distress among HCWs is experienced through a cumulative interplay of personal, relational and institutional factors. Our findings demonstrate that this distress is experienced as they navigate the ethical complexity embedded in clinical practice. Interventions focused on individual resilience risk mislocating responsibility for what is a systemic issue. Our findings highlight the need for structural responses: procedural frameworks for ethical deliberation, organisational cultures that reduce hierarchical barriers to voice, and formal spaces for collective processing of morally difficult experiences. Our conceptual framework offers a foundation for future research and targeted institutional interventions.

Trial Registration

Not Applicable.

Background

Ethical complexity is a common feature of healthcare provision. (1–3) Instances which require healthcare workers (HCWs) to use moral judgement, navigate moral dilemmas or moral uncertainty are closely linked with various definitions of moral distress. (4) Common triggers include ethically complex situations involving perceived futility, constrained autonomy, powerlessness and limited agency. (5–8) As such, moral distress and other phenomena, such as moral trauma, moral injury, moral residue and moral uncertainty are prominent in healthcare environment (5) (9–13).

Moral distress in particular has gained increasing scholarly attention alongside growing awareness of this phenomenon among HCWs and the institutions in which they practice. (3), (14) First introduced to the healthcare literature by Jameton (1984), moral distress was defined as arising "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action". (15) While foundational, some have argued that this conception is unnecessarily narrow. (16)

A central limitation of Jameton's framing is the reliance on an HCW having a high degree of moral certainty about what *ought* to be done. Life as a moral agent is complex and even when a situation is in the hands of highly experienced moral actors, the answer to the normative question "what should I do?" can remain unclear. (17) As such, several authors have proposed refined definitions of the phenomenon. For example, Morley et. al. (2019) defines moral distress as combination of the experience of a moral event, the experience of psychological distress, and a causal relation between the two. (4)

It is well documented that HCWs who experience moral distress suffer negative psychological impacts, which in turn lead to detrimental effects on quality of patient care, staff wellbeing, and the overall performance and sustainability of healthcare systems. (7) (18–26) Compounding the challenges that moral distress presents for HCWs, literature points to a persistent gap in education and support for HCWs when it comes to equipping them to navigate moral complexity. (27–29) Hence, advancing our understanding of moral distress, including how and when it is experienced, and how it can be mitigated against and resolved, is important for HCWs, the services they work within, and the people entrusted to their care.

In this paper, we present findings from a secondary analysis of a qualitative study we undertook with HCWs to understand their experience of ethical encounters in the hospital setting. (27) We describe how our participants characterise the ways in which moral distress is experienced and identify the personal, relational and institutional factors that contribute to it. In parallel, we report on the conditions our participants told us are necessary to mitigate against moral distress and create a culture where navigating ethical complexity and moral events can occur without leading to moral distress. In doing so, we contribute to the growing discourse around moral distress in HCWs and illustrate the complex interplay that is found within this phenomenon. We also provide recommendations for targeted institutional responses to mitigate against it.

Methodology

We employed a qualitative approach in this study informed by the theoretical perspective of social constructivism. (30) We conducted secondary analysis of data collected as part of an original research study. (27) The primary study focussed on ethical encounters of health professionals. While exploration of moral distress was not a prespecified goal, its identification was such a prominent theme that secondary analysis of the data set used in this study was warranted. Secondary analysis of a self-collected data set is appropriate if seeking to investigate new research questions to those explored in the primary research. (31,32)

Method

Participants

Using purposive sampling, we recruited registered health professionals who were currently employed in a large teaching hospital in Australia. A total of 26 participants attended one of four focus groups held on the hospital sites. Potential participants were invited to attend focus groups through posters on notice boards and/or emails and contacted author JD to express interest in the study and receive a participant information sheet and consent form. All participants provided written informed consent prior to commencement of the focus groups.

Participating organisation

The research was conducted in a large public teaching hospital in a capital city in Australia.

Data collection

Four focus groups were facilitated by author JD in August 2024 with one additional author (SO, DF, TH). JD had no prior relationship with any participants. The focus groups lasted 2 hours and participants were invited to reflect on a patient case study presented in three parts with progressive stages gradually increasing in acuity and complexity. At each stage of the case study, participants were asked (1). Does ethics have any relevance in this moment? If so, what relevance? (2). Are there any ethical questions to consider in this encounter? (3). How well prepared do you feel to deal with any ethical questions in this encounter? Focus groups were audio recorded and transcribed using otter.ai software and all transcripts were checked for accuracy against the original audio by all authors (DF; TH; SO and JD) during the data familiarisation phase. The focus group guide and case study is provided in **Supplementary File 1**.

Data analysis

Analysis of the data set in the primary study used reflexive activities from the outset whereby all authors undertook data immersion, reflection and refinement during data collection and throughout data analysis activities. (33) A combination of inductive and deductive coding approaches were used, informed by Fereday and Muir-Cochrane. (34) This approach allowed for data to be organised into themes while guided by the research questions in the primary study. The steps of the data analysis process were recorded and managed through Microsoft word then Microsoft excel. Data were organised into a descriptive framework that all authors discussed, revised and then agreed to for the final presentation of results. All decisions from line-by-line coding through to grouping and theme development and the resultant framework were documented. The process of data analysis for the primary study is available in the original article. (27)

While conducting line by line analysis on the primary study and subsequent meetings to discuss initial and developing findings, the authors recognised a prominent code had started to develop related to a moral event and associated psychological distress which was categorised as “Moral Distress/Injury”. This was noted by all authors and was observed across all focus groups, and a decision was made to apply an a-priori code of ‘Moral Distress/Injury’ to the data set. While the primary study determined that feelings of discomfort, uncertainty and even conflict were ways in which health professionals in the study experienced ethical encounters, the descriptions of moral distress were significant, both in number of identified codes, consistency across focus groups, and depth of participant description, which we determined warranted secondary analysis.

The process of secondary analysis commenced with a review of the codes categorised as “Moral Distress/Injury” in the original study. In light of Morley et. al.’s definition of moral distress (see background above), authors independently assessed each of these codes to determine whether they comprised reflection on a moral event and resulting psychological distress. (4) Differences in interpretation were resolved through discussion until consensus was reached. Where consensus existed that a code fit with this definition, these quotes were included in the secondary analysis with the more precise code “Moral Distress”. SO re-reviewed the full transcripts and extracted further quotes which met this definition.

All authors then reviewed the full set of extracted “Moral Distress” codes and agreed or disagreed with the determination that the participant statement was linked to moral distress. Any remaining differences in interpretation were explored through discussion until a shared understanding of inclusion or exclusion was reached. Once agreement was obtained, SO and DF independently analysed all “Moral Distress” codes and developed an initial set of sub-codes. This was managed collaboratively within Microsoft excel. SO and DF met on multiple occasions to compare interpretations, refine sub-codes, and explore the relationship between them in reference to the research question “How do healthcare workers experience moral distress while navigating ethical complexity?” This latter step led to the development of a number of themes which captured recurring patterns in how participants described experiencing moral distress.

The analysis progressed iteratively from participant quotations to initial sub-codes and then to themes. These were compared and clustered according to their meaning and contribution to the research question. For example, initial sub-codes relating to not being heard, enacting decisions made by others, inability to raise concerns and a lack of confidence in speaking up were clustered under the theme of “constrained agency and voice”. The same process led to the development of the remaining themes. These themes were subsequently organised in the conceptual framework presented in **Figure 1**.

Each analytical step, from line-by-line coding of the participants’ words, through to coding of the data was documented in Microsoft excel and is detailed in **Supplementary File 2** (for the original data analysis Durkin and colleagues (27) and **Supplementary File 3** for the secondary analysis.

Data analysis activities

D: Trustworthiness/rigour

All stages of data analysis were conducted with a commitment to transparency among the research team. An audit trail of all decisions and interpretations was documented throughout the primary research process and subsequent secondary analysis to maintain credibility and the investigator (SO) kept detailed field notes that are essential for successful qualitative research. **(30,35)** All authors were involved in the development of a study protocol which guided all stages of the research process from data collection through to reporting results. The study is reported in line with consolidated criteria for reporting qualitative research (COREQ) (36) and can be found in **Supplementary File 4**.

Results

Participant Characteristics

This study draws on the perspectives of 26 healthcare workers who participated across four focus groups. Participants were recruited from a large Australian teaching hospital and represented a broad cross-section of clinical and professional disciplines. The sample included nurses (n = 14), medical practitioners (n = 7), and allied health professionals (n = 4), working across acute, community, and leadership roles. Areas of practice included intensive care, neurosurgery, geriatrics, mental health, general medicine, cancer services, disability services, end-of-life care, and senior management. **Table 1** presents participant and focus group characteristics and is reproduced from the original study. (27) For ease of reporting, participants are collectively referred to as healthcare workers (HCWs). Consistent with the reporting approach adopted in the original study, quotations are attributed to focus groups rather than individual participants to protect anonymity.

Table 1; Participants in this study

Participant	Professional Group
Participant 1 (FG1)	Medical
Participant 2 (FG1)	Allied Health
Participant 3 (FG1)	Allied Health
Participant 4 (FG1)	Nursing
Participant 5 (FG1)	Medical
Participant 6 (FG1)	Nursing
Participant 7 (FG1)	Medical
Participant 1 (FG2)	Nursing
Participant 2 (FG2)	Medical
Participant 3 (FG2)	Nursing
Participant 4 (FG2)	Nursing
Participant 5 (FG2)	Nursing
Participant 6 (FG2)	Nursing
Participant 1 (FG3)	Nursing
Participant 2 (FG3)	Allied Health
Participant 3 (FG3)	Allied Health
Participant 4 (FG3)	Medical
Participant 5 (FG3)	Nursing
Participant 6 (FG3)	Medical
Participant 7 (FG3)	Medical
Participant 1 (FG4)	Medical
Participant 2 (FG4)	Medical
Participant 3 (FG4)	Nursing
Participant 4 (FG4)	Nursing
Participant 5 (FG4)	Nursing
Participant 6 (FG4)	Nursing

Conceptual framework

Our analysis generated five themes. Three themes related to drivers of moral distress (Constrained Agency and Voice; System Constraints; Preparedness and Understanding). Two themes related to factors which mitigate against moral distress, which we describe as moral safety (Cultivating Shared Understanding; Support, Camaraderie and Collaboration). These themes are represented in the conceptual framework in **Figure 1**. The findings underpinning each theme are presented below.

Drivers of Moral Distress

Constrained Agency and Voice

When describing moral distress, participants reflected on the way in which lack of agency and voice contributed to the experience. This was expressed in several ways, including the experience of having to enact the decisions of others, not being heard when ethical tensions are being discussed and considered, and low confidence in raising ethical concerns.

A number of participants described their experience of constrained agency in relation to decision-making. This was related to the place of their profession within the health care context (for example, nurses reflected on constrained agency in relation to doctors) or their relative seniority. Participants described the experience of moral distress in settings of constrained agency as the feeling of being unable to

to influence decisions and advocate effectively for patients.

For example, one participant observed:

"...even some of our nurse leaders, because I hear about it that they kind of feel sometimes a bit helpless in terms of how they influence the decision" (FG2)

Participants also described the experience of moral distress in relation to enacting others' decisions, particularly where others' decision-making is experienced as morally problematic or the rationale for the decision is opaque. One participant used the example of physical restraint for a patient to illustrate:

"I'm using mittens on stroke patients, but she wasn't a stroke patient. So, does she fit into that? And I'm sure there have been meetings in, you know, higher levels than us, but me at the bedside, trying to manage this person and holding this nasogastric tube" (FG2)

Participants identified that not having their views heard or acknowledged during ethically challenging situations was related to experiences of moral distress. This was identified both through personal experiences and observed encounters. For example, one participant reflected on the impact of a colleague's ethical concern being ignored:

"And that might mean that that person, that person in the room, that healthcare person won't have, won't ever speak up again, and will either get really, really miserable and sad and give up being a healthcare professional, or just never, never want to engage again in that discussion" (FG4)

Another participant made a link between constrained voice, not being heard, and enacting another's decisions:

"how psychologically damaging that can be for the nurse who's delivering that treatment, especially if they don't feel like they're being heard" (FG4)

Participants also reflected on deficits in shared language which, combined with low confidence, was described as a barrier to raising ethical concerns and related to the experience of moral distress. For example, one participant observed that:

"I experienced all the time nursing staff not feeling, I guess, confident enough to, or I guess, skilled enough in ethical conversations to escalate things further to doctors. So, we'd have conversations in the tearoom about how wrong things were and how we were over treating someone who was essentially on death's door, but not having the confidence, or I guess sometimes, just not being really acknowledged." (FG4)

Systemic Constraints

Participants reflected on the way in which the experience of systemic constraints contributed to moral distress. Specifically, participants reflected on the role of hierarchy; logistics and processes; and feeling overwhelmed by the system.

A number of participants reflected on the way in which an organisational hierarchy is related to the experience of moral distress. Participants observed that where ethical concerns were prevalent, the more senior a decision-maker is, the less likely other HCWs were to raise concerns. For example, one participant reflected that:

"because they're senior, so that the team under that person can't really challenge that senior person, and they're bringing in their own ethics and internal moral compass and everything influencing that decision, rather than what does the actual patient want in that moment? And so that's difficult when it's a really senior person." (FG4)

Another participant noted how hierarchies between professions, most prominently between nursing and medicine, can contribute to moral distress. As one participant observed:

"nurses feel they're torturing almost by continuing that treatment for them, but their specialist wants them, in inverted commas, wants them to continue, or feels like it's appropriate for them to continue, and I don't feel, I mean, they mustn't feel like they can have that conversation." (FG4)

Participants also identified that limitations related to logistics, processes, resources, and time could contribute to moral distress. Participants observed that these kinds of constraints created tensions between ethical goals (what ought to be done) and possible actions (what can be done). As one participant observed in relation to logistic and process constraints:

“Can we rehabilitate this whatever the situation is for this patient to then be open to going through the treatment or not, and do they need psychological input? But in a practical sense, that's really hard. Often you come to that question and think, yeah, they would really benefit from that. But neuro psych, neuropsychology doesn't accept patient referrals. And you know, in the practical sense, often you can't get it in if you wanted to get it for your patient.” (FG3)

Participants offered similar reflections in relation to resource constraints:

“I'm like, no, it doesn't matter. We have to keep trying. But then the other part of me is like, resources aren't infinite, and, you know, people aren't going to help themselves. At what point I feel like, at some point you have to stop. So I don't know whether that's my ethical mind, or whether it's as I was saying, kind of like my morals or don't know, wrestle with that.” (FG3)

Resource constraints also led participants to reflect on the experience of moral distress in relation to health inequity:

“I'm feeling quite, almost distressed. I think this kind of the because it's right, like, rationally, you go, I have limited resources. I want to give it to the person who's going to be able to use it like that makes perfect rational sense. But I'm thinking of the other side, of kind of working in the homeless community, you know, the pre-existing conditions, knowing that if a person's got cancer, we're going to say like, forget it. You know, there isn't much happening there because of the where they live, the poor conditions, their bodies, their history of trauma, like the whole rest of it. And those years, they get lost.” (FG1)

Finally, participants described feeling moral distress in relation to the enormity and challenges felt across the healthcare system and more broadly across society. Participants wrestled with their limited agency in this setting, as well as the limited impact any of their actions can have in achieving good and enduring health care outcomes. One participant linked this to feelings of hopelessness:

“[it] can seem hopeless that we have, we have very limited control over people's lives outside of the hospital, and all those other factors that intersect with health, and it can seem futile and hopeless sometimes because we can't control all those other things” (FG2)

Relatedly, other participants observed that enormity of the system level challenges faced in health care led them to detach from the ethical salience of their work and similarly contributed to the experience of moral distress.

Preparedness and Understanding Deficits

Participants identified that deficits in preparedness for the ethics of their work, and understanding of ethical concepts, contribute to moral distress. This was described in relation to a lack of competence in ethical deliberation, a paucity of experience and training in ethics, and a lack of preparedness for the ethical weight of decisions being made, particularly in relation to patient care. This deficiency was experienced by participants in the immediacy of decision-making and over the course of time, with some reflecting that decisions and distress stayed with them for years.

Contributing to moral distress, participants described a lack of confidence in ethical deliberation, understood as a structured process for raising and working through the ethically significant dimensions of an ethical decision. Where such skills or processes are lacking, participants described moral distress in relation to ambiguous decisions around patient care:

"no framework like to work through it in my own...you just work through it by discussing it with other people and maybe bringing it up, like in this situation, to reaffirm that I wasn't assaulting someone all these years later. Like, I don't know, it would be good to have a framework." (FG1)

In a related reflection, one participant observed that a lack of explicit deliberation introduces confusion around the ethics of decisions:

"we think about overting (sic.) the ethical process, as opposed to just looking at what the decision was, give us a little bit more security in that decision making, if that makes sense, whereas just having an absence of that, we just left with that sense of, is this? Is this a personal opinion which feels very feels like a poor response, feels like, you know, not doing the work." (FG3)

Deficits in experience and training in ethics, as distinct from processes of ethical deliberation, were also described as related to the experience of moral distress. One participant described that a lack of conceptual tools to recognise the difference between their own ethical commitments and decision-making around patient care could contribute to confusion and distress:

"But not everybody has those tools and has necessary things in that way. And I think that's where, in terms with nurses like we're so empathetic we can't sort of separate that. And then that's where we fall into strife with compassion fatigue and things like that, because we have difficulties really separating the two and really understanding our own personal morals as opposed to ethical decision making and where the line is drawn." (FG3)

A similar observation about a lack of conceptual clarity was made by another participant:

"I think there's a lot of, I think people muddle the sort of ethics and morals in a way where they're not very clear on, you know, ethical guidelines, as opposed to their own personal moral beliefs. And I think sometimes that is where the often how clinicians at the bedside might get quite distressed or upset or, you know, feel like they the decisions that they make at the bedside might in conflict sometimes between those two things." (FG3)

The ethical weight of clinical decisions was identified as a factor in moral distress. Participants identified that clinicians are regularly tasked with decision-making that carries profound impacts on patients, families and the community. One participant suggested that this degree of decision-making weight is unreasonable, and noted the distress that carrying such decisions causes:

"What would be easiest would be to be like it's some other that's responsible for making the distributive justice decision. So as an individual clinician, I just want to be told, if you're over 80 and your frailty status is above seven, you don't get ICU, you don't get ICU, because we've decided that on a, on a national level, but that's like on the one hand, you kind of want to do that, because you kind of go, I shouldn't, I shouldn't be having to balance those potentially competing interests." (FG1)

Another participant reflected on the experience of the weight of ethical decision-making in complex situations and its link with moral distress:

"Are we comfortable with it being us as like we want that responsibility as well, and sometimes, you know, if something sort of is more black and white, maybe we're more happy to sort of be the decision makers over that, whereas, like this sort of more murky world, it would be nice if someone else could, like, make that decision and not sleep at night." (FG1)

Relatedly, one participant described the weight of ethical responsibilities carried by clinical decision-makers, and their lack of comfort in holding these:

"that's the thing that's most uncomfortable for me, is like, actually, what is my like when it comes to fairness, what is my what is my role in in fairness? Like, is that something that sits with a clinician." (FG1)

Moral Safety

In addition to their reflections on moral distress and those factors that contribute to it, participants described conditions which protect against the experience of moral distress. We refer to these under the theme of moral safety. In their descriptions of conditions which contribute to moral safety, we found that participants offered reflections within two central categories: Cultivating shared understanding, and support, camaraderie and collaboration.

Cultivating Shared Understanding

Participants described intentional sharing about decision-making, including ethical deliberation, as contributing to moral safety. As one participant reflected:

"as soon as everyone's on board and has an understanding of what we're doing for an individual patient, that can sometimes just, you just, you see it settle." (FG1)

This was seen as a critical tool in addressing the fact that HCWs can have different views about the ethics of clinical decision-making. As one participant observed:

"What we decide to offer and not decide to offer needs to be fully shared. You might have somebody in the team who's absolutely convinced that we shouldn't offer this treatment to this person and vice versa, you have someone who goes completely the other way." (FG3)

Another participant observed that a diversity of views does not necessarily result in moral distress for those HCWs who do not agree with particular decision-making. They offered that robust deliberation, and a commitment to follow up, acted to support moral safety and mitigate distress:

"...because we're all different, we all make, we all have the different background and life experience, and the reason we make a decision is based on things that we're often not even conscious of. So, by having that discussion, though, you are allowing people to express their concerns or their thoughts, or what they think, and then we also have a responsibility, I think, to go back to those people so that they're okay, or they know how to get okay about that outcome." (FG4)

Support, camaraderie and collaboration

Participants also identified that support, camaraderie and collaboration are central to moral safety. In one instance, camaraderie and collaboration was linked to the intrinsic reliance HCWs have on each other, which helps to create moral safety in complex environments:

"I think we all kind of rely on each other, and you have those discussions together, and I think that's how we can still stay doing the work we do, because you have each other to kind of talk about what you're experiencing, what your thoughts are" (FG1)

Another participant observed that these practices, which happen 'ad-hoc', often contribute to moral safety:

"We discuss a lot of stuff. You know, ad hoc, at the bedside, at the deck, in the staffroom, and we do have debriefing amongst ourselves, with the nurses, this happened today, and then we deal with it ourselves that way. And then we come to a moral safe place like, yes, maybe what we do is wrong, why we do it is correct, and then that's how we live with it" (FG2)

Furthermore, some participants noted the role an institution's culture plays in supporting environments of moral safety, linking a positive culture and relationships of respect between peers to the capacity for HCWs to raise and deliberate on ethical concerns.

"I think that's where, like hospital culture and interdisciplinary respect comes into something that needs to always be considered, because if that's going well, then people will feel safe discussing these clinical situations" (FG1)

The role of a positive culture was seen as supporting HCWs to continue their work in the ethically complex setting of healthcare. One participant observed how a culture which supports “communities of care” among HCWs provides safety when navigating potentially distressing territory.

“...because there will be suffering in this environment, like, yeah, just goes with the territory. But how do we create communities of care for each other, where it's able to hold the suffering for each other and therefore, and therefore for the families and their patients as well. So that's creating a culture, and what? What are the components of that culture that can be created.” (FG1)

These findings regarding moral safety inform the discussion below and contribute to our interpretation of the factors that may mitigate moral distress.

Discussion

Our study has implications for understanding how moral distress is conceptualised, the impact of moral distress, the drivers of moral distress, and protective factors that foster moral safety.

Conceptualising Moral Distress

As noted earlier, there has been an evolution in how moral distress is conceptualised in the literature. While many recognise the validity of Jameton's (1984) original definition of the phenomenon, *“when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action”*, more contemporary formulations resist the attempt to frame moral distress in terms of moral certainty. (15) Our study confirms this critique. While some of our participants described moral distress in terms which align to Jameton's definition, most experienced distress in the absence of moral certainty.

Furthermore, for some of our participants, it was precisely the ambiguity of decision-making, before, during and after a moral event, that created distress. In our study, reflections on moral distress regularly emerged as participants reflecting on situations characterised by competing values, limited information, resource constraints and disagreement between stakeholders. In this way, they showed that the experience of moral distress is intrinsically linked to the experience of navigating ethical complexity. We found that episodes of moral conflict, dilemma and uncertainty can themselves result in moral distress. (16) This suggests that moral distress should not be understood only as a consequence of a constraint which follows from an HCW's judgment about what ought to be done but can arise during the process of ethical deliberation itself. Our findings therefore support broader conceptions of moral distress that recognise its relationship with moral uncertainty and disagreement. They also support the integration of richer accounts of HCW's lived experiences into ongoing efforts to conceptualise the phenomenon and identify its salient features.

Causes and Impact of Moral Distress

Literature shows the frequency of experiencing moral distress is significant, particularly among junior doctors and nurses. (37,38) One report found that nearly one quarter of HCWs experienced at least moderate impairment in social or professional functioning related to moral distress which can become chronic if this distress is unaddressed ((39)). Causes of moral distress are multifactorial and impacted by the context and constraint within which HCW's work. (12) **(40,41)** These experiences often lead to cumulative psychological impacts and can adversely affect personal wellbeing, workplace relationships, and career sustainability. (19, 26, **42–44**)

Our study supports these findings. We also found new dimensions of the cause of moral distress. Several participants observed how the quality of professional relationships is bound to the experience of moral distress. Participants reflected that professional relationships characterised by mistrust and lack of collaboration contribute to moral distress. In addition, communication had a significant place in participants' descriptions of moral distress. Several participants noted that moral distress was linked to a lack of clarity surrounding complex ethical decision-making and an inability to effectively communicate concerns, whether through difficulties articulating those concerns or having them heard by others. Our study suggests that further efforts which contend with the impact of moral distress should attend to the relational nature of the phenomenon and the way in which communication is bound together with it are significant drivers.

Drivers of Moral Distress

Constrained Agency and Voice

Our participants identified having their voice heard and acknowledged as central to their sense of agency in ethically complex clinical situations. To advocate for a patient is to enact a professional moral responsibility, a reflection of the long-standing view that health care "is at heart a moral enterprise and those who practice it are de facto members of a moral community". (45) This approach resists the false dichotomy between the technical and cultural dimensions of clinical practice: the goods pursued in clinical decisions are simultaneously moral and technical. Recognising this overlap supports treatment choices oriented toward outcomes perceived as good and it supports the correlative recognition that the risk of moral distress is intrinsic, not accidental, to the work of health care. (46)

When healthcare workers cannot exercise moral agency and voice in their work, this foundational responsibility is compromised. Participants located the barriers structurally. This included the quality of intercollegiate interactions, skill deficits, and role configurations. This can lead to situations wherein some staff are expected to enact decisions made by others without any opportunity to contribute to those decisions or to meet their own moral obligations. As Haydon and Brown illustrate, both the process of decision-making and the decision itself carry ethical weight, and poor navigation of either can produce moral distress. (47)

Two barriers to exercising moral agency and voice emerged from participants' accounts: first, insufficient language to raise a concern or confidence to act in accordance with it. Second, the absence of colleagues prepared to hear the concern or structures and teams ready to respond to it.

As such, mitigation against the risk of moral distress needs to operate at two levels simultaneously. First, at the individual level, education alongside deliberate cultivation of a shared moral vocabulary should equip staff to name and receive concerns with clarity and act accordingly. Second, at the organisational level, it is essential to establish structures and norms that prioritise listening, particularly to the "powerless" enactors of decisions, making concerns audible to those with decisional authority. This organisational practice of listening to colleagues and embedding their moral insights into decision-making, reflects, and is continuous with, the practice of listening to patients and families. At both levels, insights embedded through active listening enhance the impact of technical expertise. (48)

Systemic Constraints

Participants located moral distress in the architecture of the system in which an action or an inability to act occurs. Although our study captured more expansive reflections on moral distress than Jameton's (1984) original definition, this aspect of our findings was coherent with his insight that moral distress can occur when an agent knows the right action to take but is constrained from taking it. (15) However, our findings extend this by showing that the constraint is rarely singular. It operates simultaneously at multiple levels. At the interpersonal level, in hierarchical relationships that determine whose ethical reasoning within a situation carries weight, at the organisational level, in referral pathways, available services and finite time, and at the societal level, in social determinants that no clinical encounter can meaningfully resolve. Understood in light of these findings, moral distress is not simply a discrete event where an individual moral agent experiences a constraint. Instead, it is the cumulative experience of working within a layered set of constraints, each of which creates impediments to achieving an outcome consistent with the HCW's concept of good.

Where hierarchy is experienced as a constraint, particularly in relation to opaque or contested decision-making, our study reveals an epistemic and hierarchical dimension of moral distress which rests alongside more practical constraints. When continuing treatment is described as "almost torturing" a patient, as one of our participants did, while feeling unable to surface this concern, moral distress emerges from both the clinical reality and from the asymmetric communicative and agency structure that renders the individual HCW's moral concern inadmissible.

Logistical and societal pressures contribute to moral distress at a social level, and present potentially intractable problems. Importantly, our participants accepted that an intrinsic dimension of their work was making difficult decisions, but they also bore witness to the costs of this responsibility. Some of our participants described their own agency in terms which reckoned with the limitations of what they could achieve. In one case, moving from patient to ward to state to world, and registering honestly that their clinical actions are small relative to the determinants of health they confront.

Our study has important implications for how moral distress is conceived and responded to. Interventions oriented primarily toward individual resilience or coping risk locating responsibility for moral distress and its resolution with the individual clinician. Correlatively, interventions which are oriented towards mitigating against moral distress by increasing ethical agency could potentially exacerbate moral distress by over-stating the scope of any individual's moral agency. Hence, there is a correlative need for responses which attend to the level at which the constraints that drive of moral distress actually operate: cultivating organisational cultures that flatten the hierarchical barriers which constrain agency and voice; redesigning processes and allocating resources to narrow the gap between aspirational and achievable care; and advocacy directed at the upstream socioeconomic and cultural determinants of health. At the same time, the intractability of the ethical dimension of care that our participants described should give pause. Some aspects of moral complexity and constraint are an irreducible feature of caring, attentively, within imperfect systems. Frameworks for supporting healthcare workers will need to make space for HCWs to operate in this space confidently while mitigating against the shift from the appropriate moral burden of the work to moral distress. (49)

Preparedness and Understanding Deficits

Participants in our study described the place of preparedness in the experience of moral distress. This operated at three levels; procedural, conceptual and structural. Where any were absent, this becomes a source of moral distress. At the procedural level, participants identify the lack of a structured framework for ethical deliberation. In the absence of this, decisions can be reducible to personal opinion, made without "doing the work", and clinicians are left uncertain as to whether decision-makers have adequately integrated ethical considerations in decisions. Descriptions of moral distress that persisted for years, in some cases requiring later conversation to "reaffirm" the decision was sound, point to what is lost when this in-the-moment scaffolding, or a procedurally clear process is missing. This suggests that an unresolved deliberation cannot easily be settled in retrospect.

At the conceptual level, preparedness involves the capacity to distinguish one's own personal values from the ethical analysis at hand. Participants identified this as a particular site of distress for those who experience deep compassion for their patients and who find it difficult to separate their personal moral response from the ethical analysis required of them in role. (50)

At the structural level, participants raised a more fundamental question: given the moral significance of some of the ethical decisions in health care, is it appropriate that individual clinicians are asked to shoulder this burden? Distributive justice judgements, such as who is admitted to ICU and who is not, are regularly held by individual clinicians. In our study, these were experienced as burdens that might more appropriately sit at population or policy levels, freeing clinicians to support individual patient preferences without simultaneously adjudicating over resource allocation. The discomfort here is not a deficit of personal preparedness but a recognition that the system has displaced ethically heavy work onto bedside clinicians who have neither the mandate nor the structural support to carry it.

Taken together, the three levels suggest that the absence of preparedness produces moral distress in two distinct ways: when clinicians lack the tools to deliberate well, and when the weight of what they are asked to deliberate exceeds what any individual practitioner could reasonably hold. Responses which mitigate against moral distress will therefore need to operate at all three levels: building procedural frameworks for in-the-moment deliberation, supporting conceptual education and interdisciplinary understanding, and re-examining which moral burdens are appropriately carried by the individual clinician.

Protective mechanisms that foster moral safety

Participants in our study offered insights into how they currently mitigate against moral distress. They described a climate of moral safety, in which the morally significant dimensions of clinical decisions can be surfaced, voiced, processed and acted upon collectively. This illustrates the importance of organisational culture and intercollegiate relationships which are used to create, as one participant described it, “communities of care for each other”.

In cultivating a shared understanding, participants identified that a process of dialogue, performed during or immediately following decision-making, which illuminates the rationale (both clinical and ethical) can mitigate against moral distress. Importantly, this observation applied even where there was ethical disagreement: participants explicitly recognised a spectrum of viewpoints, and highlighted that processes designed to cultivate shared understanding mitigated against moral distress even where differing views persisted. Education and experience were both seen as protective here: formal ethics education provides shared frameworks and vocabulary, while accumulated clinical experience builds the more tacit capacity to “sit with uncertainty” and enter into constructive dialogue about it. This resonates with Rushton's (2022) framing of moral resilience as a relational rather than purely individual capacity. (37) The fact that participants located this work primarily in informal, peer-led spaces is significant: it suggests that some of the most important moral processing in healthcare is currently happening outside of, rather than within, formal organisational structures.

Importantly, our findings suggest that mitigating against moral distress does not require reducing exposure to ethical challenges. Participants in our study did not hold the view that ethical complexity ought to be removed from the remit of HCW practice. On the contrary, they recognised that ethical complexity is intrinsic to the work of healthcare. Instead, they described moral safety in terms of conditions which enabled the experience of ethical complexity to be named, deliberated, and worked through collectively. In this way, moral safety can be understood as the creation of conditions within which HCWs can navigate the ethical complexity of their work in ways which do not inevitably lead to moral distress.

Conclusion

This study offers insights into how healthcare workers experience moral distress. Our participants spontaneously reflected on their and others' experiences of moral distress in focus groups designed to reflect on the ethical significance of the hospital environment. This suggests that the experience of moral distress in clinical work is not abstract but lives close to the surface of professional experience and activated by encounters with ethical complexity. Participants articulated these experiences without prompting, reflecting a deep attunement to the moral dimensions inherent in healthcare.

Our findings demonstrate that moral distress does not arise from a single cause but from an interplay of personal, collegial, and institutional factors. These layers interact and compound, and any meaningful response to moral distress must engage with this complexity. This has direct implications for how healthcare institutions respond to moral distress in their workforce. Interventions focused primarily on individual resilience risk mislocating the problem, placing the burden of an organisational and systemic issue onto individual clinicians who are already navigating constrained circumstances. Instead, our findings point toward the need for structural responses: building deliberative frameworks that support in-the-moment ethical reasoning; cultivating organisational cultures that flatten hierarchical barriers to voice; and creating formal spaces for the collective processing of morally difficult experiences. Crucially, when a healthcare worker experiences moral distress, this should be understood as evidence of ethical attunement and their commitment to the values that underpin good care.

Further Research

Our conceptual framework synthesises these findings and provides a foundation for understanding the drivers of moral distress and the conditions that foster moral safety. While this study illuminates the nature and texture of moral distress as it is experienced by healthcare workers, important questions remain. In particular, the relative contribution of personal, collegial, and institutional factors to the onset and severity of moral distress, and the differential impact of these drivers across professional roles, clinical settings, and individual circumstances. Further empirical work, including quantitative and mixed-methods studies informed by our conceptual framework is needed to address this gap and to enable the design of targeted, evidence-based interventions. Until these questions are answered, organisations risk responding to moral distress in ways that are well-intentioned but insufficiently specific. The present study provides a necessary foundation for that next step.

Declarations

Data Availability

Data supporting the findings of this study are available in the supporting information of this article.

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None

Authors Contributions

All authors made substantial contributions to the conception, design and conduct of this project. All authors were involved in data collection, analysis and the interpretation of the data into the conceptual framework and generation of codes and themes. All authors collaborated to writing for draft preparation and further reviewing and editing. All authors agreed on the final version of this manuscript.

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Author Information

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Ethics Declarations

The study has Institutional ethics approval from the St Vincent’s Hospital Melbourne Human Research Ethics Committee (Approval Number 2024/SSA00079). Participants were invited to take part in the study through group emails and posters places in locations around the hospital. All participants were provided with a participant information sheet, a consent form, and a withdrawal from participation form. Participants were free to withdraw from the study at any point. No participants chose to withdraw.

Written informed consent was obtained for all participants.

Participants are quoted according to the convention used in our original study ((27)), in which participant/focus group numbers are used to maintain confidentiality.

Psychological support was offered to all participants, and they were encouraged to access this support if they felt distressed at any time during the focus groups.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

Trial Registration

Not applicable.

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Figures

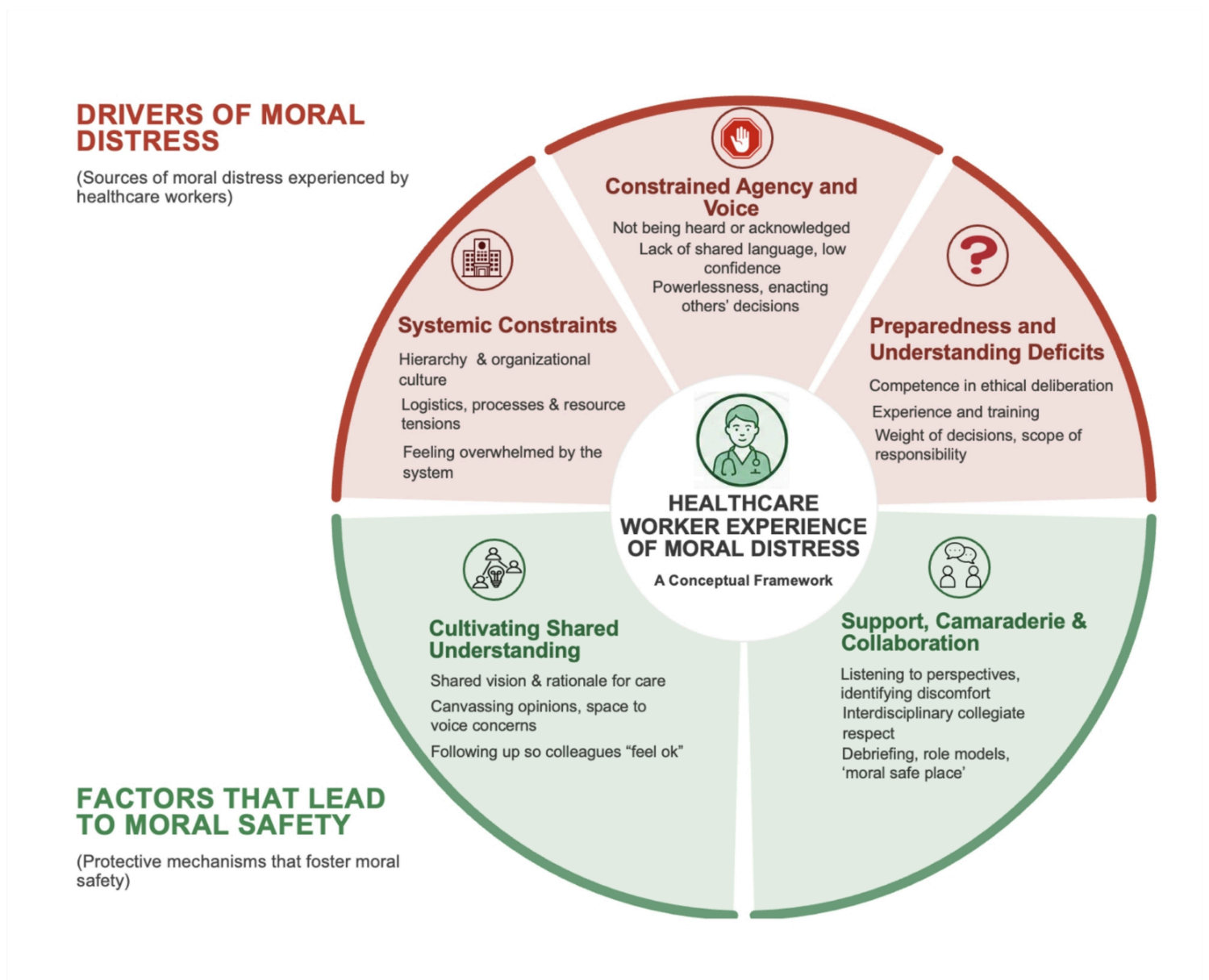


Figure 1

Conceptual Framework of Study Findings

Supplementary Files

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