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Nicole Felix-Tovar Date

Moral Suffering in Nursing and Medicine:
An Erosion of Professional Identity and the Virtue of Integrity

By

Nicole Felix-Tovar
Master of Arts
Bioethics

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Ira Bedzow, Ph.D.
Advisor

_____

Jonathan Crane, Ph.D.
Committee Member

_____

Hilary Mabel, JD
Committee Member

Accepted:

_____

Kimberly Jacob Arriola, Ph.D, MPH
Dean of the James T. Laney School of Graduate Studies

_____

Date

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Nicole Felix-Tovar
B.S., Emory University, 2023

Advisor: Ira Bedzow, Ph.D.

An abstract of
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Abstract

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By Nicole Felix-Tovar

Nursing and medicine are not only technical professions but inherently moral ones, grounded in a shared moral purpose of prioritizing patient well-being. Clinicians are expected to uphold both clinical competence and moral character, often under conditions that challenge their ability to do so. Moral suffering is a term used to describe the moral anguish that arises when clinicians are unable to act in alignment with their deeply held moral and professional values. It encompasses experiences of moral distress and moral injury, which are increasingly understood within the discourse as existing along a continuum of severity. While first explored in nursing through the concept of moral distress, moral suffering is increasingly recognized as affecting physicians as well, particularly in relation to systemic and institutional pressures. Persistent constraints—such as resource limitations, administrative demands, and conflicting institutional values—create conditions that obstruct ethical clinical practice. These barriers not only prevent clinicians from fulfilling their moral purpose but also contribute to the erosion of professional identity and moral integrity. As a result, moral suffering has become a significant concern, deeply impacting clinician well-being and the quality of patient care. This thesis approaches moral suffering through the lens of virtue ethics, framing it as not only a reaction to external constraints but also a gradual deterioration of moral character. Integrity is identified as the central, unifying virtue essential to ethical practice in both nursing and medicine. Yet, despite being expected by healthcare institutions, integrity is often compromised by the very systems within which clinicians work. Addressing moral suffering requires more than resilience training or ethical guidelines; it demands institutional accountability and environments that support the cultivation and protection of clinicians' moral character. There is an ethical urgency to support nurses and physicians not only as healthcare professionals but as moral agents striving to act with integrity in the face of adversity.

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Introduction

Clinicians drive the moral endeavor that is healthcare. Nurses and physicians are responsible not only for exercising their technical competencies but also for navigating decisions that can profoundly empower or compromise their patients' well-being. As physician-bioethicist Edmund D. Pellegrino and philosopher David C. Thomasma write about physicians and the medical profession, "Medicine is a moral community because it is at heart a moral enterprise and its members are bound together by a common moral purpose."[1] That common moral purpose is to act in ways that prioritize and promote patient well-being. Medicine—and nursing—then, are not simply professions. Medicine and nursing are moral communities of trained practitioners, each with distinct roles, yet united by a shared commitment to providing care to patients that is technically competent, ethically grounded, and morally responsible.

Moral and ethical challenges are an inevitable aspect of clinical practice. Physicians and nurses regularly face situations where they must navigate competing demands and limited resources that may fall outside the direct scope of patient care but nonetheless shape their ability to care for patients effectively. For instance, a physician might prescribe the most effective medication for a patient's condition, only to learn that it is not covered by insurance. The alternative, though financially covered, is less effective and comes with harsher side effects. Similarly, a nurse may be instructed to move quickly from one patient to the next to stay on schedule, even when their patient is clearly distressed and needs more time, comfort, or explanation. Challenges like these

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[1] Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice* (Oxford, UNITED STATES: Oxford University Press, Incorporated, 1993), 3.

often require clinicians to make or witness decisions that neither serve their patients' best interests nor align with their own moral or ethical beliefs. Nurses and physicians must continually exercise their clinical expertise while confronting obstacles that hinder them from fulfilling their moral purpose of prioritizing and promoting their patients' well-being.

While ethical and moral challenges may be inevitable, the growing intensity of moral suffering among clinicians has become a significant concern, sparking discourse among healthcare professionals, stakeholders, and the general public. This makes the topic both timely and highly relevant to bioethics, as it directly addresses the ethical implications of clinician well-being and its impact on patient care. The purpose of this thesis is to examine the experiences of *moral suffering* in medicine and nursing and its resulting erosion of professional identity and moral integrity among nurses and physicians, a detrimental experience that is central to the issue of diminished well-being among these clinicians.

Building on the work of nurse-bioethicist Cynda Hylton Rushton, who describes *moral suffering* as a broad conceptual container for the ethical anguish experienced in clinical practice, I use the term in this thesis to encompass specific forms such as *moral distress* and *moral injury*. *Moral suffering* arises from the tension between a healthcare professional's aspirational moral character and the systemic forces that either facilitate or hinder the embodiment of virtues essential to their practice—a moral character that institutions and society expect them to embody. By the end of this thesis, I examine the concept through a virtue ethics lens, framing moral suffering as not only a reaction to

constraints but also a deeper erosion of moral character in the face of institutional and systemic adversity.

Chapter 1 of this thesis explores the evolving discourse on moral suffering in nursing and medicine. In this chapter, I examine the historical context and definitions of moral suffering, highlighting the overlap between moral distress and moral injury, and introduce key concepts such as *moral residue* and *constraint*. I provide an expanded definition of the term *constraint*, a significant obstacle preventing clinicians from acting in alignment with their moral and professional values.

Chapter 2 investigates moral suffering through the constraints present in nursing and medicine. I consider how constraints at the individual, work environment, and systemic levels shape the development of moral suffering among nurses, while for physicians, the divergence of purpose between physicians and healthcare institutions influences their development. In this chapter, I identify a key distinction between the two fields: nurses' moral suffering is often rooted in interpersonal and workplace-level constraints, while physicians' moral suffering tends to stem from broader systemic and institutional pressures.

Chapter 3 examines interventions aimed at addressing moral suffering among nurses and physicians, focusing on both the strategies recommended in the literature and those implemented in practice. In this chapter, I distinguish between interventions targeting nurses, which primarily address individual and institutional factors, and those aimed at physicians, which require broader systemic changes. I introduce frameworks like the AACN's 4A's, Cynda Rushton's concept of *moral resilience*, and Wendy Dean's Relational Repair Model to guide the development of interventions. Five real-world

examples of interventions at the individual, interprofessional, and institutional levels are reviewed to evaluate their alignment and effectiveness in alleviating moral suffering.

Chapter 4 considers moral suffering through the lens of virtue ethics. In this chapter, I examine how virtues—particularly integrity—are central to ethical practice in nursing and medicine and are embedded in professional codes, oaths, and expectations. Drawing on Aristotelian philosophy and the work of scholars such as Pellegrino and Thomasma, I argue that the all-encompassing virtue of integrity is essential to a clinician's professional identity and ability to prioritize patient well-being. I expand the definition of moral suffering to include the erosion of both professional identity and moral integrity caused by persistent constraints.

Chapter 1:

Defining Moral Suffering and its Symptoms in Nursing and Medicine

1.1 Introduction

Nurse-bioethicist Cynda Hylton Rushton explains *moral suffering* as the "anguish experienced in response to moral harms, wrongs or failures and unrelieved moral stress."[2] The communication of moral suffering—including its terminology, definitions, and symptoms—has historically varied among different groups of clinicians. This chapter explores the evolving definitions and symptoms of moral suffering in nursing and medicine, particularly through what I categorize as the prominent forms under its umbrella: *moral distress* and *moral injury*. When referencing the work of scholars, I will use the terminology they adopt, while recognizing here that it falls under the broader umbrella of moral suffering. While moral distress has traditionally been associated with nurses and, more recently, moral injury with physicians in the discourse, the experiences described by both groups often overlap, particularly concerning the concept of *constraint*. This overlap raises questions about whether these terms accurately represent fundamentally distinct experiences or stages along a continuum of moral suffering.

1.2 The Moral Suffering Discourse in Nursing

In healthcare, research exploring the interconnectedness of morality, workplace conditions, and negative impacts on well-being began with a focus on nurses. In his

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[2] Cynda Hylton Rushton et al., "Invisible Moral Wounds of the COVID-19 Pandemic: Are We Experiencing Moral Injury?," ed. Melissa Kurtz Uveges, *AACN Advanced Critical Care* 32, no. 1 (March 15, 2021): 120, https://doi.org/10.4037/aacnacc2021686.

1984 book *Nursing Practice: The Ethical Issues*, Andrew Jameton introduced the term *moral distress* to describe the complex personal conflict nurses experience when their morality or professional ethics clash with external pressures present in their workplace. His definition of moral distress is widely recognized and frequently cited as the foundational account of this form of moral suffering. Since Jameton's exploration of moral and ethical problems in nursing, understanding of the phenomenon of moral distress has been continually examined and redefined by scholars of various disciplines, both within and later outside of the nursing discourse.

In *Nursing Practice*, Jameton defined *moral distress* as the experience in which a nurse "knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action."[3] Jameton further proposed that moral distress is one of three different types of moral and ethical problems that can arise in the hospital, alongside *moral uncertainty* and *moral dilemmas*.[4] He distinguishes the three by explaining that *moral uncertainty* arises when "one is unsure what moral principles or values apply, or even what the moral problem is," while a *moral dilemma* arises when "two (or more) clear moral principles apply, but they support mutually inconsistent courses of action."[5] Jameton's account of moral distress emphasizes two key conditions that encapsulate the experience: the individual's certainty in their judgment of the morally "right" course of action, and the presence of an "institutional constraint" that prevents them from acting in alignment with that judgment. The condition of *constraint* will be further developed throughout this chapter, but in simple terms, Jameton's

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[3] Andrew Jameton, *Nursing Practice: The Ethical Issues* (Prentice-Hall, 1984), 6.
[4] Ibid.
[5] Ibid.

"institutional constraint" refers to an obstacle imposed by the healthcare organization in which a nurse works that limits their ability to act in alignment with their moral judgment, such as a policy or rule. Implicit to Jameton's account of moral distress is the dissonance or *moral compromise* that results from a constraint, where a nurse's belief about what ought to be done conflicts with what they actually can do, mainly due to factors beyond their control.

In a 1987 article on moral distress in nursing, nurse Judith Wilkinson expanded on Jameton's traditional definition of moral distress, defining it as the "psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision."[6] In subsequent work on the topic, Wilkinson examined the causes and effects of moral distress, and in doing so stated that "moral distress occurs when situational constraints prevent a nurse from implementing a moral decision she or he has made."[7] Wilkinson's explanations of moral distress align with the conditions embedded in Jameton's traditional definition but also incorporate the resulting psychological toll as a central aspect of the phenomenon. This creates a compounded definition that connects cause and effect in the experience of moral distress. Moral distress can thus be understood as an adverse moral experience that negatively affects various aspects of a nurse's health, including the psychological domain, which is detrimental to their overall well-being.

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[6] Judith M. Wilkinson, "Moral Distress in Nursing Practice: Experience and Effect," *Nursing Forum* 23, no. 1 (1987): 16, https://doi.org/10.1111/j.1744-6198.1987.tb00794.x.

[7] Judith M. Wilkinson, "Moral Distress: A Labor and Delivery Nurse's Experience," *Journal of Obstetric, Gynecologic & Neonatal Nursing* 18, no. 6 (November 1, 1989): 514, https://doi.org/10.1111/j.1552-6909.1989.tb00503.x.

Decades after Jameton's conceptualization of moral distress, bodies such as the American Association of Critical-Care Nurses (AACN), a professional nursing organization, now offer resources to help nurses recognize and address symptoms of moral distress, some of which will be examined later in this chapter. Among their resources, the AACN defines moral distress as occurring "when you believe you know — or you are uncertain of — the ethically correct action to take and you are constrained from taking it. What distinguishes moral distress from other forms of distress experienced by nurses is that it threatens our core values and has ethical implications."[8] This explanation of moral distress aligns once again with the condition of constraint. It further emphasizes that the experience is not merely a superficial workplace stressor, but a deeper spiritual conflict that directly challenges a nurse's *core values*—the fundamental beliefs that guide their behavior, decisions, and actions.

Core values are integral to a person's *moral integrity*, a concept which has become increasingly prominent in the discourse on moral suffering since Jameton's account of moral distress. Philosophers Tom L. Beauchamp and James F. Childress defined *moral integrity* as "soundness, reliability, wholeness, and integration of moral character."[9] In the context of new graduate nurses, nurse Brighid Kelly argued in 1998 that "preserving moral integrity is akin to preserving self and identity. When moral integrity is threatened so are self and identity. For new graduate nurses, professional identity is a crucial aspect of self."[10] Kelly's work highlights the importance of a nurse's

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[8] "Moral Distress in Nursing: What You Need to Know," accessed February 4, 2025, https://www.aacn.org/clinical-resources/moral-distress#.

[9] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 5th ed. (Oxford University Press, 2001), 35–36.

[10] Brighid Kelly, "Preserving Moral Integrity: A Follow-up Study with New Graduate Nurses," *Journal of Advanced Nursing* 28, no. 5 (1998): 1137, https://doi.org/10.1046/j.1365-2648.1998.00810.x.

sense of accountability for proper patient care—the moral purpose of nursing—where their actions in the professional setting become incompatible with their criteria for "good" nursing, which are integral to their professional identity and moral integrity.[11]

The phenomenon of moral distress also brings attention to the ethical climate of a workplace, questioning the conditions that enable such constraints to arise. Notably, the AACN's definition of moral distress deviates from the traditional account by incorporating the possibility that a nurse could also be uncertain about the ethically correct action to take—an experience that Jameton had originally categorized separate from moral distress as *moral uncertainty*. While the AACN does not explicitly acknowledge this conceptual deviation within their resources, scholars of moral distress have debated it in the literature exploring its defining conditions.

In 2016, Stephen M. Campbell, Connie M. Ulrich, and Christine Grady proposed a broader definition of moral distress, seeking to account for situations that are not constraint-dependent—a condition inherent in Jameton's traditional account—but which they argue should still be considered cases of moral distress.[12] According to Campbell et al., Jameton and Wilkinson's definitions of moral distress are traditional and narrow, unable to encompass the following six cases that are constraint-independent: moral uncertainty, mild distress, delayed distress, moral dilemma, bad moral luck, and distress by association.[13] Campbell et al. acknowledge that Jameton initially distinguished *moral distress* from *moral uncertainty* and *moral dilemma*, but

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[11] Ibid, 1141-1142.

[12] Stephen M. Campbell, Connie M. Ulrich, and Christine Grady, "A Broader Understanding of Moral Distress," *The American Journal of Bioethics* 16, no. 12 (December 2016): 2, https://doi.org/10.1080/15265161.2016.1239782.

[13] Ibid, 3-6.

argue that moral uncertainty is not mutually exclusive with moral distress and both cases can result in similar feelings of guilt or self-criticism.[14] They also contend that moral dilemmas can also naturally lead to feelings of moral compromise and loss of well-being, just as being constrained from taking a morally right action can.[15] To encompass more cases that can be characterized within the phenomenon of moral distress, Campbell et al. proposed the following broader definition: "Moral distress = one or more negative self-directed emotions or attitudes that arise in response to one's perceived involvement in a situation that one perceives to be morally undesirable."[16] Another scholar advocating for a broader definition is bioethicist Carina Fourie, who similarly suggests that constraint should not be considered a necessary condition of moral distress.[17]

While moral distress remains the dominant term in the nursing literature on moral suffering, there is a now growing shift toward incorporating the concept of *moral injury* into the discourse. As a prominent voice in nursing and the phenomenon of moral suffering, Cynda Hylton Rushton has written extensively on the topic and, more recently, on the concept of *moral resilience*, which will be examined further in Chapter 3. In a 2021 article published in the AACN's *Advanced Critical Care* journal examining the invisible "moral wounds" of the COVID-19 pandemic, Rushton et al. highlight how nurses' experiences were intensified by the pandemic, leading to a heightened frequency

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[14] Ibid, 4.
[15] Ibid, 5.
[16] Ibid, 6.
[17] Carina Fourie, "Who Is Experiencing What Kind of Moral Distress? Distinctions for Moving from a Narrow to a Broad Definition of Moral Distress," *AMA Journal of Ethics* 19, no. 6 (June 1, 2017): 579, https://doi.org/10.1001/journalofethics.2017.19.6.nlit1-1706.

of ethical dilemmas.[18] The article offers a conceptual map of related concepts that fall under the umbrella of moral suffering, including moral distress and moral injury.[19] The researchers draw a parallel between moral distress in nursing and the experience of moral injury, which was originally associated with war veterans and identified by psychiatrist Jonathan Shay in 1994.

Rushton and colleagues further connect the concepts of moral distress and moral injury, explaining that "when moral distress is unrelieved or becomes chronic, or the intensity of it overwhelms a person's capacity to remain whole, it can lead to more severe forms of moral suffering, such as moral injury."[20] To define *moral injury*, the researchers borrow psychologist Brett Litz's definition of the term in the context of war veterans:

> Perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations… Moral injury requires an act of transgression that severely and abruptly contradicts an individual's personal or shared expectation about the rules or the code of conduct, either during the event or at some point afterwards. . . . The individual also must be (or become) aware of the discrepancy between his or her morals and the experience (i.e., moral violation), causing dissonance and inner conflict.[21]

The incorporation of moral injury as a form of moral suffering within the nursing perspective is significant for two main reasons. First, Litz's definition, which Rushton et al. reference, aligns with the broader definition of moral distress proposed by Campbell

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[18] Rushton et al., "Invisible Moral Wounds of the COVID-19 Pandemic: Are We Experiencing Moral Injury?," 119.

[19] Ibid, 122.

[20] Ibid, 121.

[21] Brett T. Litz et al., "Moral Injury and Moral Repair in War Veterans: A Preliminary Model and Intervention Strategy," *Clinical Psychology Review* 29, no. 8 (December 2009): 700, https://doi.org/10.1016/j.cpr.2009.07.003.

et al., wherein moral distress is not necessarily constraint-dependent. This is evident in Litz's definition, which includes "bearing witness to" or "learning" about acts that transgress one's morals, a situation that is not equivalent to being constrained from acting. The term moral injury, originally rooted in the military profession—which encompasses a distinct moral community with a different moral purpose—is now being integrated into the nursing literature. This integration marks an evolution in the understanding of moral suffering in nursing, allowing for effective comparison with the experiences of other moral communities, which can be helpful in developing targeted interventions to address the issue.

Second, the incorporation of moral injury into the nursing discourse, particularly as Rushton et al. have done, signifies an evolution in the understanding of moral suffering as a continuum of severity. In her other work, Cynda Rushton elaborates on *moral injury*, writing that it "incites conscience and impairs moral capability. In contrast to episodes of moral distress and moral outrage, the threat to integrity becomes an actual violation that erodes our moral core."[22] This explanation, in which *moral distress* is seen as adverse "episodes" or "events" that can culminate in a severe violation of integrity such as moral injury, aligns with the *Crescendo Effect*, a conceptual model proposed by Elizabeth Gingell Epstein and Ann Baile Hamric within the nursing context to help understand this phenomenon.

Epstein and Hamric's *Crescendo Effect* describes the interrelationship between *moral residue* and moral distress. *Moral residue* can be understood as the "lingering

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[22] Cynda Hylton Rushton, *Moral Resilience: Transforming Moral Suffering in Healthcare* (Oxford University Press, 2024), 66, https://doi.org/10.1093/oso/9780197667149.001.0001.

feelings after a morally problematic situation has passed."[23] The Crescendo Effect model describes the increase of moral distress and increase of moral residue as crescendos that build upon each other over time. The moral distress crescendo "generally occurs during a morally troubling patient trajectory (for example, prolonged aggressive treatment of a patient). At the conclusion of the patient crisis (that is, when the treatment is stopped or the situation is resolved), the clinicians' acute moral distress decreases."[24] While the experience of moral distress may decrease, Epstein and Hamric argue that the lingering feelings are not completely eliminated, representing a moral residue that serves as the new base line for the next experience of moral distress. They further explain that "over time, as repeated crescendos of moral distress are experienced, moral residue increases gradually — the second crescendo. Such a steady increase in baseline moral residue can create increasingly higher crescendos; new situations evoke stronger reactions as a clinician is reminded of earlier distressing situations."[25]

While Epstein and Hamric do not explicitly address moral injury as the culminating point of the Crescendo Effect, their conceptual model illustrates how various forms of moral suffering, such as moral distress and moral residue, can interact. As moral injury gains traction within both the nursing discourse and that of other healthcare professionals, this suggests the potential for moral injury to continue being incorporated into future research. This is especially relevant as scholars like Cynda Rushton increasingly position moral injury as the chronic and most severe form of

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[23] Elizabeth Gingell Epstein and Ann Baile Hamric, "Moral Distress, Moral Residue, and the Crescendo Effect," *The Journal of Clinical Ethics* 20, no. 4 (December 1, 2009): 332, https://doi.org/10.1086/JCE200920406.

[24] Ibid.

[25] Ibid, 333.

moral suffering, signaling a shift in the nursing discourse that both builds upon Jameton's foundational concept of moral distress and allows for comparisons of experiences with other groups, such as war veterans and, as this thesis more directly explores, physicians.

1.3 Symptoms of Moral Suffering in Nurses

Both Wilkinson's narrow definition and Campbell et al.'s broad definition of moral distress include references to symptoms that can arise as a result of the experience. In the context of moral suffering in healthcare, a *symptom* refers to an inward or outward manifestation, or both, in a clinician resulting from ethical conflicts and moral dilemmas they experience in their workplace. *Symptoms* of moral suffering are signs of the struggles they experience when their actions or professional roles conflict with their personal values, ethical principles, or the moral expectations of their profession. In this section, the research on symptoms of moral distress among nurses will be examined.

One tool frequently used in empirical research to evaluate moral distress is Mary C. Corley et al.'s 2001 Moral Distress Scale (MDS), a 30-item measure that assesses the degree to which moral distress is an element of a nurse's workplace experience, based on Jameton's conceptualization of the phenomenon.[26] The AACN provides resources to help nurses recognize moral distress, including an adaptation of the Moral Distress Thermometer (MDT), another screening tool first developed in 2013 by Lucia Wocial et

[26] Mary C. Corley et al., "Development and Evaluation of a Moral Distress Scale," *Journal of Advanced Nursing* 33, no. 2 (January 2001): 250, https://doi.org/10.1046/j.1365-2648.2001.01658.x.

al. to measure moral distress in nurses practicing in the hospital setting.[27] After selecting one of three possible workplace well-being syndromes the AACN presents—such as *burnout*, *compassion fatigue*, or moral distress—to identify their experience, nurses who choose moral distress can rate its severity on a scale from zero to 10.[28] To aid in self-assessment, the AACN provides a list of moral distress symptoms categorized into emotional, physical, and psychological domains, compiled from various research on the phenomenon. The symptoms in the emotional category include frustration, sadness, anger, powerlessness, anxiety, withdrawal, and guilt; in the physical category, symptoms include muscle aches, neck pain, headaches, diarrhea, heart palpitations, and vomiting; and in the psychological category, symptoms include depression, emotional exhaustion, loss of self-worth, nightmares, decreasing job satisfaction, and depersonalization of patients.[29]

The AACN's comprehensive compilation and categorization of symptoms into an accessible resource for nurses align with qualitative and quantitative studies that assess moral distress symptoms from the nurse's perspective across various healthcare settings and departments. Regarding the AACN's listed symptom of decreasing job satisfaction, data on moral distress among New Zealand nurses highlight its most severe result—

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[27] Lucia D. Wocial and Michael T. Weaver, "Development and Psychometric Testing of a New Tool for Detecting Moral Distress: The Moral Distress Thermometer," *Journal of Advanced Nursing* 69, no. 1 (2013): 167, https://doi.org/10.1111/j.1365-2648.2012.06036.x.

[28] American Association of Critical-Care Nurses, "Recognize and Address Moral Distress," 3, accessed April 1, 2025, https://www.aacn.org/~/media/aacn-website/clincial-resources/moral-distress/recognizing-addressing-moral-distress-quick-reference-guide.pdf. In their toolkit, the AACN defines *burnout* as "physical, mental and emotional exhaustion caused by workplace stress leading to disengagement and depersonalization." They define *compassion fatigue* as "physical, mental, and emotional weariness related to caring for those in significant pain or emotional distress."

[29] Ibid.

leaving their jobs—with 48% of nurses considering leaving their current positions due to moral distress.[30]

A qualitative study using focus groups to define and describe moral distress from the perspectives of 57 neonatal and pediatric critical care nurses found "factors closely aligned with components of moral distress reported in the literature."[31] Their data provided the following insights into the nurses' symptoms and experiences of moral distress:

> Nurses practicing in an environment that was not always consistent with their values and beliefs experienced cognitive, emotional, and, sometimes, physical angst over the delivery of care and potentially painful treatments that were perceived as futile. Participants who tried to reconcile their initial motivation to become a nurse reported feeling physically and emotionally depleted from moral distress. Nurses expressed the need to enact self-care in the form of compartmentalization, while still performing the caregiving tasks to the best of their abilities.[32]

These findings highlight the profound impact of moral distress on nurses' well-being and align with Kelly's account of the dissonance between a nurse's professional identity and moral integrity. While moral suffering is an inevitable aspect of healthcare, frontline nurses faced unprecedented ethical dilemmas and emotional strain due to the COVID-19 pandemic. A 2024 phenomenological study further illustrates how these challenges manifested during the crisis, shedding light on the enduring consequences of moral distress and its potential progression into moral injury. This study consisted of

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[30] M. Woods, "Moral Distress Revisited: The Viewpoints and Responses of Nurses," *International Nursing Review* 67, no. 1 (2020): 72, https://doi.org/10.1111/inr.12545.

[31] Melissa Burton et al., "Moral Distress: Defined and Described by Neonatal and Pediatric Critical Care Nurses in a Quaternary Care Free-Standing Pediatric Hospital," *Dimensions of Critical Care Nursing* 39, no. 2 (March 2020): 108, https://doi.org/10.1097/DCC.0000000000000403.

[32] Ibid.

interviews with 16 nurses in Ohio who cared for COVID-19 patients.[33] The authors categorized the reported "moral distress/moral injury" symptoms similarly to the AACN, grouping them into psychoemotional, spiritual, and physical domains, which the participants "lived with around the clock and throughout the duration of the pandemic."[34] These nurses reported psychoemotional symptoms including anxiety, depression, irritability, anger, fear, tearfulness, sadness, and frustration; spiritual symptoms included religious questioning and distrust; and the physical symptom reported was insomnia.[35] The study's authors warned that "if events leading to moral distress are persistent, they can reach the level of moral injury, which has significant existential consequences for the person experiencing multiple moral assaults."[36] The concern that instances of moral distress, manifested through various symptoms, could escalate over time into moral injury aligns with Epstein and Hamric's model of the Crescendo Effect, positioning moral injury as the most severe form of accumulation.

In response to the limited research on moral injury in nursing, Anastasi et al. conducted a systematic review examining moral injury and its mental health outcomes among nurses. The authors' analysis revealed "significant associations between moral injury, anxiety, and depression, along with a significant negative association with quality of life."[37] Although the authors acknowledge that "conceptual ambiguity surrounding moral injury, including its overlap with related phenomena like moral distress and

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[33] Pam Stephenson and Andrea Warner-Stidham, "Nurse Reports of Moral Distress During the COVID-19 Pandemic," *SAGE Open Nursing* 10 (April 1, 2024): 1, https://doi.org/10.1177/23779608231226095.

[34] Ibid, 2.

[35] Ibid.

[36] Ibid, 5.

[37] Giuliano Anastasi et al., "Moral Injury and Mental Health Outcomes in Nurses: A Systematic Review," *Nursing Ethics*, September 25, 2024, 1, https://doi.org/10.1177/09697330241281376.

burnout, could complicate the interpretation and application of findings," their data align with previous studies linking moral injury to mental health issues among other healthcare professionals.[38]

According to a secondary qualitative analysis of three cohorts of obstetric and neonatal nurses, Cheryl Tatano Beck found that "the order of frequency of moral injury symptoms from most often described to least often were moral concern, guilt, self-condemnation, betrayal, shame, forgiveness, and loss of trust."[39] Another review aimed to describe symptoms of moral injury empirically observed in nurses in the aftermath of a Patient Safety Incident (PSI), an ethical challenge defined as an "event or circumstance that resulted, or could have resulted, in unnecessary or unanticipated harm to a patient."[40] Among nurses in this situation, the authors identified "core" and "secondary" moral injuries: "core moral injury symptoms included guilt (67%), shame (71%), spiritual-existential crisis (9%), and loss of trust (52%). Secondary symptoms of moral injury included depression (33%), anxiety (57%), anger(71%), self-harm, (19%), and social problems (48%)."[41] Additional research is needed to better differentiate between core and secondary moral injuries, as this distinction could play a critical role in shaping targeted interventions and further the understanding of moral suffering within nursing.

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[38] Ibid, 17-18.

[39] Cheryl Tatano Beck, "Secondary Qualitative Analysis of Moral Injury in Obstetric and Neonatal Nurses," *Journal of Obstetric, Gynecologic & Neonatal Nursing* 51, no. 2 (March 1, 2022): 174, https://doi.org/10.1016/j.jogn.2021.12.003.

[40] Mady Stovall, Lissi Hansen, and Michelle van Ryn, "A Critical Review: Moral Injury in Nurses in the Aftermath of a Patient Safety Incident," *Journal of Nursing Scholarship* 52, no. 3 (2020): 321, https://doi.org/10.1111/jnu.12551.

[41] Ibid, 320.

The literature on symptoms of moral distress among nurses underscores the complex toll of working in ethically challenging environments. The AACN's categorization of symptoms provides a structured and digestible framework for understanding and assessing moral distress, and studies across various healthcare settings confirm their emotional, psychological, and physical symptoms. The overlap between moral distress and moral injury is becoming increasingly evident, with studies linking both to significant mental health challenges, including anxiety, depression, guilt, and loss of trust.

1.4 The Moral Suffering Discourse in Medicine

In a 2017 letter introducing an issue of the *AMA Journal of Ethics* on moral distress among physicians and medical students, editor Subha Perni cited Andrew Jameton's 1984 definition, highlighting its resonance with her own experiences and establishing it as the issue's central definition.[42] Perni elaborated that moral distress "as originally conceived by Jameton pertained to nurses and has been extensively studied in the nursing literature. However, until a few years ago, the literature has been silent on the moral distress of medical students and physicians."[43] At the time of the journal's issue, Perni and the contributing authors and researchers correctly recognized that the perspectives of physicians, in particular, had been previously overlooked in the literature on moral distress compared to nurses. The likely reason for this difference is the predominant use of *burnout* to characterize the phenomenon of diminished well-being among physicians, rather than other conditions such as moral distress.

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[42] Subha Perni, "Moral Distress: A Call to Action," *AMA Journal of Ethics* 19, no. 6 (June 1, 2017): 533, https://doi.org/10.1001/journalofethics.2017.19.6.fred1-1706.

[43] Ibid.

Psychologist Herbert Freudenberger defined *burnout* in 1975 as a variety of physical and behavioral symptoms that arise from the workplace leading to exhaustion by "making excessive demands on energy, strength, or resources."[44] Due to Freudenberger and the subsequent work of psychologists Christina Maslach and Susan Jackson, *burnout* is now understood as a "syndrome of emotional exhaustion, depersonalization, and reduced professional efficacy."[45]

The physician literature initially prioritized burnout over moral suffering because burnout, with its focus being on the individual rather than institutional or systemic factors, aligned more closely with the existing understanding of physician distress at the time.[46] However, in a 2018 article for *STAT*, psychiatrist Wendy Dean and plastic surgeon Simon Talbot notably introduced a shift in terminology, reframing the physician well-being condition from *burnout* to *moral injury*. In their article, Dean and Talbot argue that physicians resonate more with the term moral injury to describe their experiences and that it should be used instead of burnout because it unfairly "suggests a failure of resourcefulness and resilience."[47]

The term *moral injury*, now used in both the physician and nursing literature, is widely acknowledged in healthcare as having originated from the experiences of war veterans. To define *moral injury*, Dean and Talbot cite journalist Diane Silver's

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[44] Herbert J. Freudenberger, "Staff Burn-Out," *Journal of Social Issues* 30, no. 1 (1974): 159, https://doi.org/10.1111/j.1540-4560.1974.tb00706.x.

[45] Kim Mills, "Why We're Burned out and What to Do about It, with Christina Maslach, PhD," https://www.apa.org, accessed April 1, 2025, https://www.apa.org/news/podcasts/speaking-of-psychology/burnout.

[46] Wendy Dean, Simon Talbot, and Austin Dean, "Reframing Clinician Distress: Moral Injury Not Burnout," *Federal Practitioner* 36, no. 9 (September 2019): 401.

[47] Wendy Dean and Simon G. Talbot, "Physicians Aren't 'burning out.' They're Suffering from Moral Injury," *STAT* (blog), July 26, 2018, https://www.statnews.com/2018/07/26/physicians-not-burning-out-they-are-suffering-moral-injury/.

definition: “a deep soul wound that pierces a person’s identity, sense of morality, and relationship to society.”[48] Regarding the metaphor of physicians being on the “front lines” of healthcare like soldiers in battle, they clarify that the “moral injury of health care is not the offense of killing another human in the context of war. It is being unable to provide high-quality care and healing in the context of health care.”[49] In a later article, Dean and Talbot offer a definition of *moral injury* inspired by Brett Litz’s:

> Moral injury occurs when we perpetrate, bear witness to, or fail to prevent an act that transgresses our deeply held moral beliefs. In the health care context, that deeply held moral belief is the oath each of us took when embarking on our paths as health care providers: Put the needs of patients first.[50]

The "oath" Dean and Talbot refer to as the specific moral belief transgressed is the Hippocratic Oath, an ancient ethical code traditionally taken by physicians that emphasizes the commitment to provide care with respect and dignity for all patients, forming the foundation for professional integrity upon entering the profession.[51] Building on the idea of moral injury as a violation of deeply held moral beliefs, physician Kristine Olson offers a definition similar to those of Dean and Talbot, and of Litz. She underscores the intrinsic link between a physician’s moral identity and their profession, framing medicine not just as a job, but as a “calling”:

> Moral injury is marked by a transgression of one’s values. Medicine is considered a calling marked by aligning one’s values and abilities to serve a needed social or moral good with which one has an emotional connection and is central to one’s identity, to which one is devoted, will self-sacrifice

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[48] Ibid.
[49] Ibid.
[50] Dean, Talbot, and Dean, “Reframing Clinician Distress,” 400.
[51] “Oath of Modern Hippocrates,” *Penn State College of Medicine Current Students* (blog), accessed April 1, 2025, https://students.med.psu.edu/md-students/oath/. The Penn State College of Medicine provides one example of the Hippocratic Oath taken by medical students at their graduation.

> and typically go above and beyond.[52]

Olson's account of moral injury further agrees with the concept of medicine being a moral community, where personal and professional lives and actions are inextricably linked. In the article "Clarifying the Language of Clinician Distress," Wendy Dean, Simon Talbot, and Arthur Caplan elaborate on the terms used to discuss distress and argue that "framing its progression [is] central to understanding the problem in its entirety."[53] They define *moral distress* similarly to Jameton's account, describing it as occurring when "an individual believes he or she knows the right thing to do, but institutional or other constraints make it difficult to do what is right."[54] Just as Epstein and Hamric, Dean et al. also propose that if an episode of moral distress is not resolved with sufficient processing, *moral residue* is left behind, which they define as "the unresolved emotional and psychological conflicts attendant to episodes of distress, [making] subsequent incidents of moral dilemma or moral distress less tolerable."[55] Dean, Talbot, and Caplan define "moral injury" as the deepest experience of built-up moral suffering:

> Moral injury implies an erosion of a person's moral framework as the result of a single egregious violation or persistent, repeated moral distresses. The accumulation of these incidents could drive clinicians to question their perceptions of medicine as a safe, benevolent profession and the belief that those working in it are trustworthy.[56]

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[52] Kristine Olson, "Physician's Occupational Distress: Burnout or Moral Injury?," *Mayo Clinic Proceedings* 99, no. 12 (December 1, 2024): 1860, https://doi.org/10.1016/j.mayocp.2024.10.014.

[53] Wendy Dean, Simon G. Talbot, and Arthur Caplan, "Clarifying the Language of Clinician Distress," *JAMA* 323, no. 10 (March 10, 2020): 923, https://doi.org/10.1001/jama.2019.21576.

[54] Ibid.

[55] Ibid.

[56] Ibid.

The difference in impact between a single "egregious" event and multiple repeated events influencing moral injury likely varies by individual physician, but it warrants further research and explanation. In the physician literature, definitions of moral injury consistently and explicitly identify the healthcare system as the source of constraints that hinder physicians from providing the best possible patient care, with their perspective of moral suffering being predominantly constraint-dependent compared to other forms, like uncertainty or luck. The progression from moral distress to moral injury, as outlined particularly by Dean, Talbot, and Caplan, underscores how unresolved ethical conflicts can lead to lasting psychological and emotional harm. By framing moral injury as the cumulative effect of repeated moral distresses, these definitions enable a perspective shift from individual resilience to systemic accountability.

1.5 Symptoms of Moral Suffering in Medicine

In an article encouraging the inclusion of moral injury in discussions about physician well-being, Marek S. Kopacz et al. highlight the psychological and emotional symptoms that can arise from moral injury:

> The morbidity encapsulated in moral injury reflects the challenge of reconciling the gap between what happened and what should have happened, especially in highly stressful, high-stakes circumstances. For some physicians, this gap might challenge their own values and norms, giving way to painful emotions such as shame, guilt, self-condemnation, feelings of betrayal, difficulty trusting, and difficulty forgiving. In cases where this gap becomes exceptionally trying, symptoms of moral injury might also lead to self-destructive behaviours.[57]

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[57] Marek S. Kopacz, Donna Ames, and Harold G. Koenig, "It's Time to Talk about Physician Burnout and Moral Injury," *The Lancet Psychiatry* 6, no. 11 (November 1, 2019): E28, https://doi.org/10.1016/S2215-0366(19)30385-2.

A growing body of research, including the work of Kopacz et al., highlights the profound psychological and emotional toll of moral injury on physicians. However, since moral injury is still a relatively new term in healthcare, and even newer in describing physician experiences, the symptoms identified for physicians are largely drawn from research on moral injury in military veterans. This highlights the need for more research specific to physicians' workplace environments, professional roles, and responsibilities. In their "Physician Wellness Hub," the Canadian Medical Association (CMA) lists the following symptoms of moral injury important for physicians to know: "guilt, anger and betrayal, feelings of worthlessness, helplessness and powerlessness, loss of identity and role, loss of trust in oneself and in others, self-isolation, reduced empathy, and negative beliefs about oneself."[58] Notably, the CMA does not categorize symptoms as core or secondary, as the article researching the aftermath of Patient Safety Incidents does.

While research on moral injury in physicians is still developing, most existing evidence comes from qualitative studies, including physician narratives and interviews. For example, Dr. Jason Prior shares a personal narrative illustrating how moral injury can reshape a physician's emotional state and behavior over time, manifesting in distressing symptoms:

> Gradually, I changed. Lashing out at colleagues, friends, and family became routine, and I couldn't understand why. A mixture of anxiety and anger consumed me—I grew more distant, and those around me trod carefully, hoping not to set me off. Each night I only wanted to forget my days and move on, but I never could.[59]

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[58] "Moral Injury: What It Is and How to Respond to It," Canadian Medical Association, accessed April 1, 2025, https://www.cma.ca/physician-wellness-hub/content/moral-injury-what-it-and-how-respond-it.

[59] Jason Prior, "Halfway Around The World, Echoes Of Physician Moral Injury," *Health Affairs* 41, no. 5 (May 1, 2022): 770, https://doi.org/10.1377/hlthaff.2021.01621.

Narratives like Dr. Prior's are crucial in helping other physicians recognize and assess the potential symptoms they may be experiencing that mirror his self-described moral injury. To advance the reliable assessment of moral injury among healthcare professionals and support more quantitative research, a study was conducted to develop and evaluate the psychometric properties of a measurement tool designed to identify clinically significant moral injury in healthcare professionals.[60] This measurement tool is a 10-item scale called the "Moral Injury Symptom Scale-Healthcare Professionals version" (MISS-HP) that measures ten theoretically grounded dimensions of moral injury assessing "betrayal, guilt, shame, moral concerns, religious struggle, loss of religious/spiritual faith, loss of meaning/purpose, difficulty forgiving, loss of trust, and self-condemnation."[61] As awareness of moral injury in physicians grows, the development of reliable assessment tools, such as the MISS-HP, represents a critical step toward better understanding the prevalence of moral injury and its specific symptoms.

1.6 An Analysis of the Moral Suffering Discourse in Nursing and Medicine

As explored in this chapter, among nurses and physicians, the prominent terminology employed to characterize their experiences of moral suffering are the terms *moral distress* and *moral injury*. The discourse on moral suffering has a longer history in nursing than in medicine, beginning in 1984 when clinical ethicist Andrew Jameton

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[60] Sneha Mantri et al., "Identifying Moral Injury in Healthcare Professionals: The Moral Injury Symptom Scale-HP," *Journal of Religion and Health* 59, no. 5 (2020): 2323, https://doi.org/10.1007/s10943-020-01065-w.

[61] Ibid.

introduced the original concept and definition of moral distress as experienced by nurses in hospital settings. Nurses including Judith Wilkinson and Cynda Rushton have since contributed extensively to literature on the term. Over time, the concept of moral distress continued to be refined, notably by Stephen M. Campbell, Connie M. Ulrich, and Christine Grady, who offered a broader definition.

In contrast, discussions of physician well-being historically focused on *burnout* rather than any form of deep moral suffering, as expressed by Subha Perni in a 2017 *AMA Journal of Ethics* issue focused on moral distress among physicians and medical students. A significant shift occurred in 2018 when Wendy Dean and Simon G. Talbot published an article in STAT advocating for *moral injury*—a term borrowed from the experiences of war veterans—as an alternative and a more appropriate descriptor for physicians' diminished well-being than *burnout*. Almost simultaneously, moral injury gained prominence in nursing, particularly through the work of nurse-bioethicist Cynda Rushton.

When the definitions and symptoms of moral distress and moral injury are examined within the contexts of nursing and medicine, as done in this chapter, the experiences of both groups often overlap. However, they have historically been labeled differently, with moral distress dominating the nursing literature and moral injury more recently taking precedence in the literature on physicians. This shift is likely part of an effort to move away from the focus on burnout, which, as Dean and Talbot argue, emphasizes individual resilience rather than addressing the systemic business interests that shape the healthcare environment.

At first glance, the terms appear nearly indistinguishable. Both *moral distress* and *moral injury* describe a clinician experiencing an inability to act in alignment with their morals, values, and professional codes of ethics, resulting in a profound impact on their professional and moral integrity—concepts which were introduced in this chapter and will be explored further in Chapter 4. However, moral distress and moral injury are increasingly being viewed and discussed as forms of what I call *moral suffering*—similar to how constraint-based moral distress differs from uncertainty-based moral distress yet falls under the same umbrella— and existing on a continuum of severity, as proposed by Elizabeth Gingell Epstein and Anne Baile Hamric in their Crescendo Effect model.

The primary criticism of the newer term, moral injury, questions whether it is necessary to use it within the context of healthcare at all.[62] However, the shift toward viewing moral suffering as a continuum of severity represents progress in validating the necessity of the term while also addressing language ambiguities in the literature examining the experiences and symptoms across nursing and medicine. Continuing to gain conceptual clarity, as both the fields of nursing and medicine have done and are now converging in opinion, is crucial for effectively understanding the nuanced experiences encompassed by moral suffering. Additionally, validating tools to screen for symptoms of moral suffering, such as the MDT, MDS, and MISS-HP, and encouraging the development of empirical research is crucial for further understanding the symptoms of moral suffering in nurses and physicians, as well as other healthcare professionals.

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[62] Anto Čartolovni et al., "Moral Injury in Healthcare Professionals: A Scoping Review and Discussion," *Nursing Ethics* 28, no. 5 (August 1, 2021): 598, https://doi.org/10.1177/0969733020966776.

Notably, the prominent definitions of both moral injury and moral distress incorporate the concept of *constraint*. Bioethicist Georgina Morley et al. explain that there is "little ambiguity about how to understand 'constraint,'" simply defining it as a "barrier to acting as one would want."[63] While other types of moral distress, as encompassed by Campbell et al. in their broad definition, exist, research in nursing and medicine investigating the causes of moral suffering still primarily focuses on a variety of constraints. To encapsulate the constraints identified in the nursing and medicine literature, I expand the definition of *constraint* in this thesis to refer to a dominant force of higher authority, either through direct or indirect influence, within a clinician's workplace environment that prevents them from acting in alignment with their core professional and moral values. A *cause*, on the other hand, refers to events or factors that may lead to moral suffering, such as institutional priorities or profit-driven models, and is distinct from the constraining force itself. The next chapter of this thesis will explore the causes and constraints of moral suffering among nurses and physicians, providing a deeper analysis of how they shape the experiences and well-being of these clinicians.

1.7 Conclusion

This chapter has explored the evolving discourse on moral suffering among nurses and physicians, with a particular focus on moral distress and moral injury. The overlap between these two forms of moral suffering, and the inclusion of concepts such as moral residue and constraint, suggests that these experiences may not be entirely

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[63] Georgina Morley et al., "What Is 'Moral Distress'? A Narrative Synthesis of the Literature," *Nursing Ethics* 26, no. 3 (May 1, 2019): 655, https://doi.org/10.1177/0969733017724354.

separate but are interconnected, forming a spectrum of moral suffering. As the discourse continues to evolve, it is essential to gain further conceptual clarity, particularly in how moral suffering is defined and measured across nursing, medicine, and other healthcare professions that provide direct patient care. By providing an expanded definition of *constraint*, this chapter has established a foundation for understanding the barriers that prevent clinicians from acting in alignment with their moral and professional values. Moving forward, the next chapter will explore the causes and constraints of moral suffering among nurses and physicians.

Chapter 2:

Moral Suffering and Constraints Present in Nursing and Medicine

2.1 Introduction

The third step in the AACN's resource for recognizing and addressing symptoms of moral distress is identifying potential causes and constraints. The AACN explains that "specific situations trigger moral distress. Typically, there is a defining element that constrains or stops you from acting. This constraint may be related to internal or external factors (such as work environment or organizational pressures)."[64] Once again, the concept of *constraint*, central to traditional definitions of moral distress, emerges as a key factor that prevents clinicians from acting in alignment with their morals and values. In this chapter, I will examine the various constraints that contribute to the development of moral suffering among nurses and physicians.

2.2 Constraints in Nursing

The AACN classifies the causes and constraints of moral distress among nurses into three categories: the self, the unit, and the organization.[65] Similarly, in a review of the characteristics of moral distress from nurses' perspectives, Mohannad Aljabery et al. categorized constraints based on their causes at three levels, which aligns well with the definitions of *cause* and *constraint* presented at the end of Chapter 1: "the individual level, which includes factors related to the nurse, patient, and patient's family; the team level, which provides for factors related to the team or unit involved in the morally

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[64] American Association of Critical-Care Nurses, "Recognize and Address Moral Distress," 4.
[65] Ibid.

distressing situation; and the system level, which includes institutional and policy factors."[66] As will be examined in this section, other research in the nursing literature aligns with the AACN's classification and Aljabery et al.'s compilation of causes and constraints at the individual, work environment, and system levels.

2.2.1 Individual-Level Constraints

The AACN categorizes the following situations under the "self" category as potential causes of moral distress: performing care perceived as futile, implementing unnecessary treatments, providing end-of-life care, witnessing needless patient suffering/inadequate pain relief, and providing false hope to patients.[67] In the AACN framework, the "self" category appears to refer to individual-level factors that contribute to moral distress, specifically related to the nurse's personal actions, responsibilities, and ethical conflicts in direct patient care. Furthermore, according to Aljabery et al., at the individual-level, nurse-related constraints include "a lack of competency, training, and preparedness; role ambiguity; lack of professional autonomy; role conflict; and compromised integrity."[68] The terms "self" and "individual" in the context of constraint do not suggest that the moral distress arises solely from the nurse's personal values or capabilities, but rather that it also stems from the ethical tensions nurses may encounter in their specific healthcare roles due to dominant external forces.

At the bedside, a nurse plays a unique direct patient-care role within the healthcare team, spending the most time with patients and having a distinct experience

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[66] Mohannad Aljabery et al., "Characteristics of Moral Distress from Nurses' Perspectives: An Integrative Review," *International Journal of Nursing Sciences* 11, no. 5 (November 1, 2024): 582, https://doi.org/10.1016/j.ijnss.2024.10.005.

[67] American Association of Critical-Care Nurses, "Recognize and Address Moral Distress," 4.

[68] Aljabery et al., "Characteristics of Moral Distress from Nurses' Perspectives," 582.

that shapes their potential development of moral distress and moral injury. For example, in the United States, many bedside nurses hold licensure as Registered Nurses (RNs). According to the U.S. Bureau of Labor Statistics, the role of an RN is to "provide and coordinate patient care, educate patients and the public about various health conditions, and provide advice and emotional support to patients and their families… Most registered nurses work as part of a team with physicians and other healthcare specialists."[69] Moreover, bedside nurses "provide holistic nursing, which encompasses physical, emotional, and psychological support. They often serve as the first point of contact for patients and their families, acting as patient advocates to ensure patient voices are heard and patient rights are protected."[70] Due to their direct involvement in patient care and the relationships they develop with patients, bedside nurses navigate ethical dilemmas that can conflict with their personal and professional values on a regular basis.

Research in the nursing literature has shown that nurses often encounter ethically challenging situations that both contribute to moral distress and position them as key figures in the early identification of ethical conflicts in patient care. Research by Carol Pavlish et al. examined nurses' descriptions of these challenges, identifying risk factors and early indicators of ethical conflicts in clinical settings. Their study found that "nurses in all clinical settings encounter ethical issues that frequently lead to moral distress…Nurses are in a key position to recognize vulnerable patients and advocate for clearly stated treatment goals, effective team communication, and empathic attention to

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[69] "Registered Nurses," Bureau of Labor Statistics, accessed April 1, 2025, https://www.bls.gov/ooh/healthcare/registered-nurses.htm#tab-2.

[70] "What Is Bedside Nursing? Covalon Blog," Covalon, January 20, 2025, https://covalon.com/blog/what-is-bedside-nursing-global/.

patient suffering."[71] This finding aligns with the inherent impact of prolonged patient interactions, which deepen nurses' awareness and exposure to ethical challenges. Because nurses spend extensive time at the bedside and engage closely with both patients and families, they often find themselves navigating ethical tensions and balancing their professional responsibilities with ethical concerns. In doing so, prioritizing patient-centered care can become increasingly difficult.

While participating in morally distressing events is challenging, lacking the preparedness to respond effectively poses an additional challenge. On moral distress among nurses, Belinda Mandrell et al. explain that "many nurses express concerns about inadequate resources and a lack of ethical education when making difficult decisions regarding life-sustaining treatments, end-of-life care, and complex family dynamics."[72] Ethical training can provide nurses with guidance on the "right" course of action in certain situations. Aljabery et al. highlight a key distinction between confident and unconfident nurses:

> Self-doubt reflects a lack of confidence and may be labeled an internal constraint; nurses may become reluctant or uncertain about participating and sharing their opinions even if they know the right action. In contrast, confident and competent nurses are more specific and willing to share, participate, and act according to the correct moral judgment. [73]

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[71] Carol Pavlish et al., "Early Indicators and Risk Factors for Ethical Issues in Clinical Practice," *Journal of Nursing Scholarship: An Official Publication of Sigma Theta Tau International Honor Society of Nursing* 43, no. 1 (March 2011): 13, https://doi.org/10.1111/j.1547-5069.2010.01380.x.

[72] Belinda Mandrell et al., "Moral Distress and Moral Stress Among Nurses Facing Challenges in a Health Care System Under Pressure," *The American Journal of Bioethics* 24, no. 12 (December 1, 2024): 48, https://doi.org/10.1080/15265161.2024.2417992.

[73] Aljabery et al., "Characteristics of Moral Distress from Nurses' Perspectives," 581.

It is important to recognize that experience and training can enhance a nurse's confidence and competence over time, which is why nurses express a need for ethical decision-making training. However, while this growth enables nurses to assert their values more effectively, it does not necessarily eliminate moral distress. When nurses remain unable to act in alignment with their moral judgment—despite their confidence—the constraint is no longer a reflection of the individual's capabilities but rather a systemic or external barrier beyond their control. Thus, while self-confidence and ethical preparedness may be seen as a lack of capability, moral distress often arises when nurses are powerless to act despite knowing the right course of action.

2.2.2 Work Environment Constraints

The AACN categorizes the following situations under the "unit" category as potential causes and constraints of moral distress: inadequate staffing, ineffective communication, working with incompetent colleague(s), bullying, and lack of a healthy work environment.[74] In the AACN framework, the "unit" refers to the nurse's multi-role healthcare team and the workplace culture in which they operate. Similarly, according to Aljabery et al., at the team-level, constraints include "improper communication, unhealthy work environments, lack of collaboration, working with incompetent colleagues, obstinacy in treatment planning, bullying, powerlessness, lack of professional autonomy, and lack of involvement in the decision-making process."[75] Adverse situations arising from the "unit" or healthcare team within a nurse's work environment can constrain nurses and contribute to the development of moral suffering.

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[74] American Association of Critical-Care Nurses, "Recognize and Address Moral Distress," 4.
[75] Aljabery et al., "Characteristics of Moral Distress from Nurses' Perspectives," 582.

Extensive research links moral distress among nurses to feelings of powerlessness, poor communication, and limited or discouraged involvement in decision-making processes due to medical hierarchies. Pavlish et al. found that "misunderstandings and conflicts were compounded by poor communication. Moreover, nurses and physicians failed to understand each other's ethical consternations… all 14 moral distress situations involved distressing conflict… 7 described conflict within the healthcare team."[76] In a review of moral distress in medicine, Alexandra Kherbache et al. found that "nurses experience significantly higher levels of moral distress than physicians… Due to the ubiquitous medical hierarchy, nurses' authority is limited, and they are more likely to experience moral distress because of their subordinate position."[77] Mandrell et al.'s findings integrate poor communication with the hierarchical structure of healthcare, highlighting how nurses—despite their extensive time with patients—often have their insights constrained by other higher authorities including healthcare administrators:

> Nurses often occupy a lower position within the medical hierarchy, limiting their ability to advocate for improvements in working conditions and patient care. This lack of authority exacerbates feelings of moral distress, as nurses may feel their insights and concerns go unrecognized. Despite their extensive experience and knowledge of patient care challenges, they often navigate a system that prioritizes administrative decisions over clinical input.[78]

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[76] Pavlish et al., "Early Indicators and Risk Factors for Ethical Issues in Clinical Practice," 19.

[77] Alexandra Kherbache, Evelyne Mertens, and Yvonne Denier, "Moral Distress in Medicine: An Ethical Analysis," *Journal of Health Psychology* 27, no. 8 (July 1, 2022): 1972, https://doi.org/10.1177/13591053211014586.

[78] Mandrell et al., "Moral Distress and Moral Stress Among Nurses Facing Challenges in a Health Care System Under Pressure," 49.

In a study on nurses working in children's units and pediatric intensive care wards in Iran, results revealed a direct inverse relationship between professional autonomy and moral distress.[79] Similarly, in another study focused on emergency nurses in Iran, researchers found that lack of autonomy "hinders nurses from functioning effectively and efficiently in practice and even can lead to moral distress. Increasing professional independence and the use of experienced nurses as mentors in emergency settings to support younger nurses can help with the reduction of moral distress."[80] This finding further reinforces the significant influence of the work environment on the potential to develop moral distress. A supportive and collaborative workplace—where nurses are empowered with autonomy and mentorship—is more likely to alleviate moral distress, whereas a restrictive or hierarchical environment may intensify it. In a study of critical care nurses at two hospitals in the United Kingdom, a lack of shared decision-making is found to be a constraint causing moral distress:

> Shared decision-making involving all members of the multi-disciplinary team is the ideal standard by which treatment decisions should be made in the NHS [National Health Service]. However, because the responsibility for decisions ultimately lies with the doctor, they make the final decisions, which means even when nurses (or other members of the team) disagree, their opinion can be overridden, leaving them feeling ignored and disregarded.[81]

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[79] Zahra Sarkoohijabalbarezi, Arash Ghodousi, and Elham Davaridolatabadi, "The Relationship between Professional Autonomy and Moral Distress among Nurses Working in Children's Units and Pediatric Intensive Care Wards," *International Journal of Nursing Sciences* 4, no. 2 (January 31, 2017): 117, https://doi.org/10.1016/j.ijnss.2017.01.007.

[80] Mohsen Abdolmaleki et al., "Relationship between Autonomy and Moral Distress in Emergency Nurses," *Indian Journal of Medical Ethics* 4, no. 1 (2019): 20, https://doi.org/10.20529/IJME.2018.076.

[81] Georgina Morley, Caroline Bradbury-Jones, and Jonathan Ives, "What Is 'Moral Distress' in Nursing? A Feminist Empirical Bioethics Study," *Nursing Ethics* 27, no. 5 (August 2020): 1306, https://doi.org/10.1177/0969733019874492.

The research presented in this section underscores the critical role of the work environment in shaping moral distress among nurses. Constraints such as poor communication, lack of professional autonomy, hierarchical decision-making, and insufficient collaboration create conditions in which nurses feel powerless and unheard. When nurses are excluded from shared decision-making or unable to advocate for patient care effectively, their moral distress intensifies. Conversely, work environments that prioritize collaboration, mentorship, and professional independence can help mitigate these challenges.

2.2.3 Institutional and Systemic Constraints

The AACN categorizes the following situations under the "organization" category as potential causes of moral distress: “inadequate staffing, lack of resources, pressures to decrease costs, hospital policies, hierarchy of power, ineffective communication, and financial limitations.”[82] According to Aljabery et al., at the system-level, nurse-related constraints include “the healthcare system and the healthcare delivery system… a lack of resources, increased workload, a shortage of staff, and a lack of administration and manager support.”[83] When hospitals (institutions) and the healthcare system fail to adequately support nurses, moral distress can escalate, leaving nurses unable to provide the quality of care they believe is ethically necessary.

A study on moral distress among Thai nurses identified a lack of organizational support as a sub-theme within the broader theme of powerlessness. Researchers found that “insufficient resources such as medical equipment, available beds, and staffing,

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[82] American Association of Critical-Care Nurses, “Recognize and Address Moral Distress,” 4.
[83] Aljabery et al., “Characteristics of Moral Distress from Nurses’ Perspectives,” 582.

were problematic organization-level causes of moral distress. Participants raised concerns to administrators, but they felt their voices were unheard."[84] In the United Kingdom, data published by the Nursing and Midwifery Council (NMC) showed that more nurses and midwives left the profession than those who joined it, and "two of the most cited reasons for leaving the register were working conditions – specifically poor staffing levels and high workloads – and disillusionment with the quality of care that nurses reported feeling able to provide."[85]

During the COVID-19 pandemic, nurses' work overload was found to reflect poorly on the quality of care and prevented nurses from acting in alignment with their values. On work overload during the pandemic in Brazil, Santos et al. found that it proved to be a "powerful source of experiences of moral distress due to excessive working hours during vaccination, double working hours, a troubled relationship due to pressure from managers and the population and physical and mental exhaustion, which prevented nurses from act according to their judgment."[86]

At the institutional and healthcare system level, most nurses are confined to their direct patient-care roles, leaving them voiceless and powerless to influence the broader systemic changes that shape the healthcare environment they work within. Despite being responsible and accountable for the quality of patient care, nurses often find

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[84] Chuleeporn Prompahakul et al., "Moral Distress among Nurses: A Mixed-Methods Study," *Nursing Ethics* 28, no. 7–8 (November 1, 2021): 1174, https://doi.org/10.1177/0969733021996028.

[85] Morley, Bradbury-Jones, and Ives, "What Is 'Moral Distress' in Nursing?," 1298.

[86] Thallison Carlos Campos Santos et al., "Nurses' Workload during the COVID-19 Pandemic: Potential for Experiences of Moral Distress," *Revista Brasileira de Enfermagem* 77, no. Suppl 4 (n.d.): 1, https://doi.org/10.1590/0034-7167-2023-0200.

themselves excluded from the policy-making processes that directly impact their practice. Kim Lützén et al. highlight this disconnect, stating:

> Nurses are held to be responsible and accountable for the quality of care they provide; yet they are rarely involved in the health care policy making that structures their practice. For example, a policy that increases the number of patient admissions to a ward has effects on nursing practice over which nurses have little control. The second reason is that health care policies are generally orientated towards the 'utilitarian' good or the maximum of benefit, while nursing care is often orientated towards the individual good. Health care policy is usually based on the balance between cost and effectiveness of health care services and treatment for groups or a whole population. In contrast, providing nursing care is based on prioritizing care among the needs of individual patients.[87]

Lützén et al.'s observation underscores the systemic imbalance that contributes to moral distress among nurses. While nurses are expected to uphold high ethical and professional standards, they often have little say in the policies that determine staffing levels, resource allocation, and patient care priorities. The utilitarian approach of healthcare policy—focused on maximizing benefits for the largest number of people—frequently conflicts with the individualized, patient-centered values that are the foundation of nursing care. This systemic issue highlights the need for greater nurse representation in policy-making to align institutional decisions with both the ethical and practical realities of patient care.

2.3 Constraints in Medicine

Unlike the extensive research on moral distress among nurses—which can be effectively categorized into individual, work environment, and systemic constraints—the

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[87] Kim Lützén et al., "Moral Stress: Synthesis of a Concept," *Nursing Ethics* 10, no. 3 (May 1, 2003): 312–13, https://doi.org/10.1191/0969733003ne608oa.

literature on physicians' moral suffering predominantly attributes the phenomenon to systemic issues. This suggests that while individual and workplace dynamics may play a role, larger systemic forces that constrain physicians likely have the greatest impact on the potential to develop moral suffering.

In an article on distinguishing between the terms *moral injury* and *burnout*, physician Sara Sheikhbahaei et al. argued that in medicine, the two "main culprits" (causes) of moral injury can be understood as "(a) a divergence of purpose between the institution and physicians, and (b) a compulsive bureaucracy: a divergence of purpose or imposing doctrines and ideologies (eg, social, cultural, political) that are often contrary or irrelevant to those held by caregivers."[88] These two causes provide a valuable framework for understanding the constraints physicians face. Accordingly, this section will examine constraints through the lens of Sheikhbahaei et al.*'s divergence of purpose* and *compulsive bureaucracy*.

2.3.1 The Constraint of Divergence of Purpose

According to the U.S. Bureau of Labor Statistics, the role of physicians and surgeons is to "diagnose and treat injuries or illnesses and address health maintenance. Physicians examine patients; take medical histories; prescribe medications; and order, perform, and interpret diagnostic tests. They often counsel patients on diet, hygiene, and preventive healthcare."[89] Among the translations of the 2,500-year-old Hippocratic Oath historically taken by physicians is the following line: "I will follow that system of

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[88] Sara Sheikhbahaei, Tushar Garg, and Christos Georgiades, "Physician Burnout versus Moral Injury and the Importance of Distinguishing Them," *RadioGraphics* 43, no. 2 (February 1, 2023): 1, https://doi.org/10.1148/rg.220182.

[89] "Physicians and Surgeons," Bureau of Labor Statistics, accessed April 1, 2025, https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm.

regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous."[90] In 2017, the World Medical Association (WMA) adopted a revised *Declaration of Geneva*, "The Physician's Pledge," as the modern successor to the Hippocratic Oath. The beginning of the Physician's Pledge contains the following lines: As a member of the medical profession: I solemnly pledge to dedicate my life to the service of humanity; the health and well-being of my patient will be my first consideration."[91]

The role and moral purpose of physicians are intertwined, and while individual motivations for entering the profession may vary, the core moral purpose of the profession remains constant: to prioritize and promote the well-being of patients. This commitment is reflected in the standard role and responsibilities of the physician as well as in traditional ethical oaths and professional codes. However, as journalist Eyal Press argues in his article "The Moral Crisis of America's Doctors" for *The New York Times*, the expectations placed on physicians have shifted in ways that undermine their traditional role and purpose:

> In recent years, despite the esteem associated with their profession, many physicians have found themselves subjected to practices more commonly associated with manual laborers in auto plants and Amazon warehouses, like having their productivity tracked on an hourly basis and being pressured by management to work faster.[92]

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[90] Robert H. Shmerling, "First, Do No Harm," Harvard Health, October 13, 2015, https://www.health.harvard.edu/blog/first-do-no-harm-201510138421.

[91] "World Medical Association Declaration of Geneva," *African Health Sciences* 17, no. 4 (December 2017): 1203, https://doi.org/10.4314/ahs.v17i4.30.

[92] Eyal Press, "The Moral Crisis of America's Doctors," *The New York Times*, June 15, 2023, sec. Magazine, https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html.

Physicians take an oath to prioritize patient care and follow ethical codes, yet institutional pressures such as profit-driven models and insurance restrictions may lead them to compromise their moral and professional values. For example, in a case report examining the intersection of physician moral injury and patient healthcare experience, Erika Erlandson et al. explain that physicians face a heightened risk of moral injury "when insurance companies steer medical decisions by restricting payment, effectively taking decisions about the course of diagnosis and treatment out of physicians' hands."[93] Erlandson et al. raise a critical question about the conflict between patient-centered care and financially driven healthcare systems: "How can physicians practice patient-centered medicine in a business model that allows payers to negate doctors' decision-making authority and delay medically necessary treatment?"[94]

Wendy Dean, a co-author of the case report with Erlandson, poses a similar question in an article aiming to reframe clinician distress from burnout to moral injury: "Moral injury is the consequence of the ever-present double binds in health care: Do we take care of our patient, the hospital, the insurer, the EMR, the health care system, or our productivity metrics first?"[95] These perspectives illustrate a fundamental divergence of purpose between physicians and the institutions that control healthcare delivery. As argued by Sheikhbahaei et al., "institutional priorities have diverged from those of physicians, and they are nearly exclusively molded by financial considerations."[96] This

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[93] Erika Erlandson, Carrie Ramirez, and Wendy Dean, "Medicine Shouldn't Be This Hard: The Intersection of Physician Moral Injury and Patient Healthcare Experience in Pediatric Complex Care," *Journal of Pediatric Rehabilitation Medicine* 16, no. 3 (n.d.): 443, https://doi.org/10.3233/PRM-230027.

[94] Ibid.

[95] Dean, Talbot, and Dean, "Reframing Clinician Distress," 401.

[96] Sheikhbahaei, Garg, and Georgiades, "Physician Burnout versus Moral Injury and the Importance of Distinguishing Them," 1.

misalignment between clinical ethics and institutional priorities exemplifies a key cause of moral injury, as physicians are repeatedly placed in situations where their ability to act in the best interest of their patients is constrained by the business-centric external forces beyond their control. The *divergence of purpose* aligns with the expanded definition of *constraint* I provided that incorporates indirect influences, where no singular authority figure may be responsible for the constraint. Instead, the healthcare system, insurance companies, and healthcare policies act as authoritarian barriers, limiting a physician's actions within the workplace and impeding their ability to act in alignment with their personal and professional values.

2.3.2 The Constraint of Compulsive Bureaucracy

On bureaucracy as a potential cause of moral injury, Sheikhbahaei et al. offer the following commentary:

> The system underpins the gradual transfer of power from those who deliver health care (physicians) to those who administer it (bureaucrats). It protectively isolates the bureaucrats from the direct reach of physicians, until finally it transforms physicians into "bank tellers" policed by an impersonal, confusingly structured, unapproachable bureaucratic machinery.[97]

An example of the figurative "bureaucratic machinery" is the Electronic Health Record (EHR) or Electronic Medical Record (EMR), a digital system that stores and manages a patient's medical history. While intended to improve efficiency and streamline access to patient records, the EHR has become a frequent source of frustration for physicians. Excessive documentation requirements and administrative

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[97] Sheikhbahaei, Garg, and Georgiades, "Physician Burnout versus Moral Injury and the Importance of Distinguishing Them," 2.

burdens often hinder meaningful patient interactions and contribute to feelings of detachment and the development of moral suffering. Wendy Dean's 2023 book, *If I Betray These Words*, explores the experiences of healthcare professionals struggling with moral injury, with much of Chapter 3, "Losing Connection," focusing on the impact of the Electronic Medical Record (EMR).

Dean describes the moment Dr. Don Kovacs accepted the resignation of nurse practitioner Mary Franco, who expressed to him "'I can't do this anymore. How can my patients trust me if my eyes are glued to the screen? This isn't the way I want to practice,'" a sentiment with which Dr. Kovacs agreed.[98] In addition to the divided focus between documenting in the EMR and building meaningful patient relationships, appointments at Dr. Kovacs' practice became limited after a large health system acquired them: "Appointments were limited to twenty minutes as the health system drove the practice to almost 'double their productivity'– the term adopted from assembly lines for how many patients they could move through the office and therefore how much revenue they could generate each month."[99] Sheikhbahaei et al.'s comparison of physicians to "bank tellers" within the bureaucratic machinery is exemplified by the pervasiveness of the EMR, which can demoralize physicians and other healthcare professionals, ultimately contributing to moral suffering over time.

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[98] Wendy Dean, *If I Betray These Words : Moral Injury in Medicine and Why It's so Hard for Clinicians to Put Patients First* (Lebanon, New Hampshire: Steerforth Press, 2023), 61.

[99] Dean, *If I Betray These Words*, 62.

In *If I Betray These Words*, Dean describes an example of healthcare administrators and corporations prioritizing institutional interests over the commitments of physicians dedicated to patient care:

> Management teams, almost always headed by business experts with MBAs, are taught to scour the balance sheet for overlooked efficiencies…Onex Partners [an investment management firm] owned more than 80 percent in voting shares in EmCare [a staffing company] when the staffing company got in trouble for pressuring doctors in HMA hospitals to document patients as sicker than they were to justify a higher billing code and better reimbursement, a practice known as upcoding."[100]

The practice of upcoding not only compromises medical integrity but also places physicians in ethically and legally challenging positions, forcing them to choose between adhering to corporate directives or maintaining their professional and moral obligations. Such financially motivated interference in medical decision-making exemplifies how *compulsive bureaucracy* and profit-driven policies can lead to moral injury, as physicians are repeatedly placed in situations where their ethical standards conflict with institutional demands. This systemic issue contributes to widespread disillusionment and the potential for moral suffering, acting as an indirect constraint on physicians, similar to the broader *divergence of purpose* Sheikhbahaei et al. describe.

2.4 An Analysis of Constraints in Nursing and Medicine

Nurses and physicians similarly encounter ethical dilemmas that force them to choose between upholding their professional commitments or complying with demands from authority. For nurses, this often involves administering treatments they perceive as futile, witnessing patient suffering with inadequate means to intervene, and being

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[100] Dean, *If I Betray These Words*, 233.

excluded from decisions that directly impact patient care. Physicians face similar challenges, particularly when insurance restrictions, hospital policies, and productivity quotas dictate their clinical decisions. In both cases, *moral suffering*—a fundamental misalignment between their medical or nursing training, their personal values, and the realities of modern healthcare systems—arises from *constraint*.

Despite these similarities, the root causes and constraints of moral suffering in nursing and medicine differ based on their roles and the structures governing their work. The key distinction that arises from this thesis is that nurses' moral suffering is often rooted in interpersonal and workplace-level constraints, while physicians' moral suffering tends to stem from institutional and systemic constraints. This distinction contributes to a deeper understanding of the different sources of moral suffering across clinicians in healthcare, which is essential for designing targeted interventions rather than one-size-fits-all solutions. Nurses often face hierarchical decision-making structures where they must comply with physician and administrative directives, whereas physicians often struggle against insurance companies, corporate healthcare models, and bureaucratic policies that limit their ability to practice medicine ethically.

Ultimately, both nurses and physicians experience moral suffering when their professional values conflict with expectations from authorities of higher power and influence. Whether through hospital policies, financial priorities, or administrative inefficiencies, these constraints erode their sense of purpose, diminish their professional fulfillment, and contribute to diminished well-being. More research on the causes and constraints of moral suffering among healthcare professionals is needed, namely among physicians. Without meaningful changes, the disconnect between clinicians' values and

institutional expectations will continue to fuel moral suffering, ultimately threatening the well-being of both clinicians and the quality of patient care.

2.5 Conclusion

This chapter has examined the various causes and constraints contributing to moral suffering among nurses and physicians, focusing on the ways constraints shape their professional and moral experiences. For nurses, constraints at the individual, work environment, and systemic levels were explored, revealing how factors such as lack of autonomy, poor communication, and inadequate resources can prevent them from aligning their actions with their ethical values. In contrast, for physicians, the analysis focused primarily on institutional and systemic constraints, including the divergence of purpose between physicians and healthcare institutions as well as the bureaucratic pressures that hinder their ability to prioritize patient-centered care.

Chapter 3:

Interventions to Alleviate Moral Suffering in Nursing and Medicine

3.1 Introduction

In this chapter, I examine interventions aimed at addressing moral suffering among nurses and physicians, drawing from both the recommended strategies in the literature and those implemented in practice. This chapter will distinguish between interventions for nurses, which primarily address individual and institutional factors, and those for physicians, which require broader systemic changes. Frameworks such as the AACN's 4A's, Cynda Rushton's concept of *moral resilience*, and Wendy Dean's Relational Repair Model will be presented as guides for the development of these interventions. Real-world examples of interventions at the individual, interprofessional, and institutional levels are then reviewed to gauge alignment and effectiveness in alleviating moral suffering. While some interventions show promise, this chapter highlights the ongoing challenges in addressing moral suffering, particularly the need for systemic reforms. Ultimately, the interventions explored in this chapter deepen the understanding of how such efforts attempt to alleviate moral suffering and emphasize the need for continued research and institutional commitment to addressing the systemic constraints that sustain it.

3.2 The Discourse on Moral Suffering Interventions in Nursing

Before discussing implemented interventions for addressing moral suffering among nurses and their outcomes, this section will present prominent frameworks and recommendations designed to guide the development of such interventions. One of the

frameworks discussed here is provided by the AACN, while the other, focused on *moral resilience*, was created by nurse-bioethicist Cynda Hylton Rushton. Before the AACN published its toolkit for recognizing and addressing moral distress, as referenced in Chapters 1 and 2, the organization introduced the 2004 *4A's to Rise Above Moral Distress* framework: Ask, Affirm, Assess, and Act.[101] In their review of the contributing factors and outcomes of moral distress in nursing, Adam S. Burston and Anthony G. Tuckett identify recommended interventions within the nursing literature aimed at addressing nurses' moral distress, categorizing them into two sub-themes: individualistic and collaborative approaches.[102]

To address moral distress using the 4A's framework, the AACN prefaces that "the change process occurs in stages and is cyclic in nature, meaning that the stages in the cycle may need to be repeated before there is success."[103] The first step of the framework is to "ask," with the goal of becoming more aware that moral distress is present: "Am I feeling distressed or showing signs of suffering? Is the source of my distress work related? Am I observing symptoms of distress within my team?"[104] The next step is for nurses to "affirm" their moral distress by validating their feelings and perceptions with others, aiming to commit to self-care and actively address moral distress.[105] The third step is to "assess" the sources of distress—whether personal or environmental—and its

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[101] American Association of Critical-Care Nurses, "The 4A's to Rise Above Moral Distress," n.d., https://www.emergingrnleader.com/wp-content/uploads/2012/06/4As_to_Rise_Above_Moral_Distress.pdf.

[102] Adam S Burston and Anthony G Tuckett, "Moral Distress in Nursing: Contributing Factors, Outcomes and Interventions," *Nursing Ethics* 20, no. 3 (May 1, 2013): 320, https://doi.org/10.1177/0969733012462049.

[103] "The 4A's to Rise Above Moral Distress," 2.

[104] Ibid.

[105] Ibid.

severity, while evaluating readiness to act by weighing risks and benefits, to prepare an action plan."[106] The final step is to "act," which involves implementing strategies to initiate and sustain desired changes while anticipating and managing setbacks, with the goal of preserving integrity and authenticity.[107] While the 4A's framework may appear to be an intervention itself, it instead serves as a guiding tool for institutions and organizations to develop measurable strategies to mitigate moral distress.

Similarly, Cynda Rushton's concept of moral resilience serves as a theoretical framework for guiding the development of interventions. Cynda Rushton's research on *moral resilience* defines it as a means to transform, rather than eliminate, moral suffering. Moral resilience will be explored further in relation to integrity in Chapter 4. She explains the concept as follows:

> Moral resilience focuses on "(1) the moral aspects of human experience, (2) the moral complexity of decisions, obligations and relationships, and (3) the inevitable moral challenges that ignite conscience, confusion, and moral distress. Moral resilience is fundamentally grounded in personal, professional, or collective integrity.[108]

Rushton also helps guide the understanding of moral resilience away from misinterpretation. For example, she explains that the term has the potential to be used in ways that do not align with its true meaning, and this pattern can "cause leaders to view addressing moral adversity and moral suffering solely as an individual responsibility that requires more education or training to withstand the workplace

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[106] Ibid.
[107] Ibid.
[108] Cynda Hylton Rushton, "Transforming Moral Suffering by Cultivating Moral Resilience and Ethical Practice," *American Journal of Critical Care* 32, no. 4 (July 1, 2023): 240, https://doi.org/10.4037/ajcc2023207.

pressures, ignoring the broader systemic factors that contribute to moral suffering and erode well-being."[109] The concept of moral resilience thus can provide the structure and language necessary to develop and implement interventions that address both individual and systemic contributors to moral suffering.

In their 2013 review article, Burston and Tuckett argued that the factors leading to moral distress affect the self, others, and the healthcare system, necessitating both individualistic and collaborative approaches.[110] In their review, Burston and Tuckett explain that an individualistic approach to addressing moral distress emphasizes education, communication, and self-reflection. They support this approach by citing that a "positive correlation between ethics education and the moral action of nurses has been demonstrated" in the literature.[111] Targeted recommendations include seeking support, such as morally sensitive counseling or chaplaincy services, and engaging in critical self-reflection to enhance personal growth and coping skills.[112] Burston and Tuckett also highlight more "radical" individualistic interventions, such as nurses lobbying for resource funding, engaging in political action, or being prepared to leave the profession altogether.[113] Notably, these radical interventions underscore the severity of moral distress and the extent to which systemic issues can push nurses to consider extreme measures. While these interventions may empower nurses to advocate for change, they also signal a failure of the healthcare system to adequately support its workforce. If not supported by advocacy from higher-level stakeholders (such as

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[109] Rushton, "Transforming Moral Suffering by Cultivating Moral Resilience and Ethical Practice," 245.
[110] Burston and Tuckett, "Moral Distress in Nursing," 320.
[111] Ibid.
[112] Ibid.
[113] Ibid.

healthcare administrators), radical individualistic interventions may place an even greater burden on clinicians, adding to their primary responsibility of patient care.

Regarding a collaborative approach, Burston and Tuckett write that "an inoculation to moral distress is collective action."[114] A collaborative approach to addressing moral distress emphasizes interprofessional education and the creation of supportive environments. Overlapping with the individual approach, ethics education remains a central recommendation, with relevant interventions including interprofessional forums, ethics rounds, staff meetings, and peer-led discussions.[115] Additionally, mentorship is a critical component of collective action, and administrators are encouraged to identify and support those experiencing high levels of moral distress with mentors or role models who can provide guidance.[116] Burston and Tuckett also argue that "collective action in the form of practical guidance and discussion forums for sharing of concerns must extend to the patients and their family."[117] Engaging all stakeholders in discussions about care goals may help alleviate distress for nurses by ensuring a coordinated plan that considers the needs and perspectives of all involved. Ultimately, fostering a supportive and inclusive culture that respects nurses' ethical concerns is key to mitigating moral distress at the institutional level.

As examined in this section, researchers studying moral suffering in nursing recommend multi-level interventions focused on individual nurses, interprofessional collaboration, and institutional policy changes. Based on the recognized causes,

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[114] Ibid.
[115] Ibid.
[116] Ibid.
[117] Ibid.

constraints, and symptoms of moral distress among nurses, researchers most often recommend ethics training as an intervention to better equip nurses for challenging situations. Ethics training interventions highlight the importance of equipping nurses with ethical decision-making skills, fostering a supportive workplace culture, and ensuring strong organizational backing to empower nurses to voice concerns without fear of retaliation. Additionally, communication-centered interventions are recommended to foster a more supportive professional environment that engages nurses, other healthcare professionals, and administrative leadership at the institutional level. Notably, institutional-level interventions would require action from hospital leadership, as nurses alone typically lack the authority to implement institutional policy changes.

3.3 Implemented Moral Suffering Interventions for Nurses

The AACN and Cynda Rushton, along with other professional organizations and leading nursing experts, have developed frameworks to guide stakeholders in addressing moral distress among nurses. Broader research on various aspects of moral distress in nursing has also led to proposed interventions at the individual, work environment, and institutional levels. This section explores examples of real-world interventions implemented to address moral distress among nurses, assessing their level of implementation, the symptoms and constraints they targeted, and their effectiveness in alleviating moral distress.

In a two-part mixed-methods study, Jeanie Sauerland et al. analyzed moral distress levels, moral residue, and ethical climate perceptions among registered nurses, first in adult acute and critical care settings, and then among pediatric and neonatal

nurses. Drawing from pre- and post-study findings, discussions within the Nursing Ethics Council (NEC), strategies from the literature, and recommendations from professional organizations such as the AACN and the American Nurses Association (ANA), the authors proposed a multi-level intervention framework centered on continuing ethics education and ethical skills development.[118] The multi-level intervention encompassed three levels: the individual, the intraprofessional and interprofessional environment, and hospital policies.

Individual-level interventions serve to equip individual nurses with the skills and resources to recognize, process, and address moral distress. For example, this includes "Ethics 101" presentations, which explain key ethics terms and various theories—such as principle-based, care, and virtue ethics—allowing participants to discuss and apply approaches to "everyday ethical situations involving care providers, patients/family members, and supervisory personnel."[119] Ethics trainings, such as "Ethics 101," can help address both the cognitive and emotional symptoms of moral distress, including confusion about what constitutes an ethical dilemma, feelings of helplessness or frustration, and experiences of anxiety or guilt. Sauerland et al. also analyzed the creation of a "Center for Caring," which would address affective and somatic responses to moral distress through strategies such as stress management techniques, coping skills, and additional options like "reflexology, hypnotherapy, and music therapy [and] an annual retreat…with varied types of holistic care such as journaling, yoga, and equine

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[118] Jeanie Sauerland et al., "Assessing and Addressing Moral Distress and Ethical Climate Part II: Neonatal and Pediatric Perspectives," *Dimensions of Critical Care Nursing* 34, no. 1 (February 2015): 43, https://doi.org/10.1097/DCC.0000000000000083.

[119] Sauerland et al., "Assessing and Addressing Moral Distress and Ethical Climate Part II," 44.

therapy."[120] These ad hoc interventions may help address the psychological and physical symptoms of moral distress among nurses, but they do not specifically target the constraints that contribute to the issue itself, as discussed in Chapter 2.

Intraprofessional and interprofessional interventions would serve to improve communication and ethical decision-making across different hospital teams. For example, Sauerland et al. analyze interprofessional ethics conferences, which unite nurses, physicians, social workers, and hospital leaders to discuss complex cases and ethical challenges to foster a "moral community" where nurses and other providers can learn to engage with one another and collaborate effectively.[121] These interventions would address key constraints of moral distress among nurses, including poor communication, hierarchical power dynamics, and a sense of being unsupported by leadership.

At the institutional and policy-level, the goal is to strengthen hospital policies to support ethical practice and reduce systemic causes of moral distress. Sauerland et al. include examples of interventions at this level, such as safe staffing policies with nurse-patient ratios that are conducive to adequate care, a reinforced code of professional conduct to set expectations for ethical behavior, and policies addressing lateral violence and bullying to reduce nurse-to-nurse conflicts and hierarchical intimidation.[122] These interventions would address the emotional and psychological symptoms of moral distress, such as anxiety and stress, while also mitigating power imbalances and

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[120] Ibid.
[121] Ibid.
[122] Ibid, 43.

hierarchical intimidation—systemic constraints that contribute to the development of moral suffering among nurses.

Regarding the outcomes of Sauerland et al.'s multi-level moral distress and ethical climate interventions, the authors note that anecdotal feedback indicates nurses became "increasingly able to identify situations with ethical content and are more comfortable making formal ethics consults."[123] However, other measures to assess the moral distress levels of nurses who participated in the interventions were not conducted. Instead, the success of implementing the interventions within the academic medical center appeared to be the focus. Future research to evaluate the impact of these interventions on the experiences of nurses is warranted.

A 2013 study by Zahra Molazem et al. evaluated the effectiveness of education based on the AACN's 2004 4A's framework in reducing moral distress among Iranian CCU nurses. The study involved 60 nurses, with 30 participating in an educational workshop on moral distress and the 4A's framework delivered by an instructor with expertise in nursing ethics, while the remaining 30 served as a control group and did not receive the intervention.[124] The intervention consisted of two four-hour sessions over two weeks, during which nurses participated in discussions, case studies, and role-playing exercises to internalize the 4A's strategies. The MDS was administered before the intervention and then again one- and two months post-intervention. According to the study's results, moral distress scores in the intervention group significantly decreased one month after the intervention and declined further after two months,

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[123] Ibid, 45.

[124] Zahra Molazem et al., "Effect of Education Based on the '4A Model' on the Iranian Nurses' Moral Distress in CCU Wards," *Journal of Medical Ethics and History of Medicine* 6 (April 6, 2013): 1.

whereas the control group experienced an initial increase in moral distress, which then remained high. By introducing the 4A's framework, this intervention aimed to empower nurses to recognize their moral distress, develop a deeper awareness of its causes, and learn effective coping strategies. This intervention, however, did not seem to target any specific constraints that contribute to moral distress.

Another example of an education-based intervention to address moral distress is the Mindful Ethical Practice and Resilience Academy (MEPRA) led by Cynda Rushton. MEPRA is an experiential educational program developed "to nurture a culture of mindfulness, ethical competence, and resilience among frontline nurses."[125] The program consists of six experiential workshops of four hours each, and "10 minutes of daily technology-enabled, guided mindfulness practices (breathing, loving-kindness, difficult emotions, letting go) and reflective questions to reinforce content and engage prosocial attitudes and emotions."[126] The MEPRA curriculum consisted of six experiential workshops, each focusing on the following elements:

> [1] Moral compass, mindfulness, resilience plan; [2] autonomic nervous system activation, self-regulation, moral sensitivity; [3] empathy, perspective taking, assumptions, bias, communication; [4] ethical competence, moral adversity, self-stewardship; [5] high-fidelity simulation: integration session; and [6] moral resilience, culture of ethical practice.[127]

To assess the effectiveness of the MEPRA program, 192 nurses across two hospitals in a large academic system completed the program, with a control group of 223 nurses at one of the hospitals not receiving the intervention. The study's findings revealed that the

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[125] Cynda Hylton Rushton et al., "Mindful Ethical Practice and Resilience Academy: Equipping Nurses to Address Ethical Challenges," *American Journal of Critical Care* 30, no. 1 (January 1, 2021): e3, https://doi.org/10.4037/ajcc2021359.

[126] Ibid.

[127] Ibid.

MEPRA curriculum "increased participants' ethical confidence, ethical competence, resilience, work engagement, and mindful attention and awareness. MEPRA also decreased reported symptoms of depression and anger and turnover intention."[128] However, there was no significant difference in moral distress levels after MEPRA participation, necessitating further research to understand the relationship between moral distress and moral resilience.[129]

A distinctive interprofessional-level intervention to address moral distress among Intensive-Care Unit (ICU) nurses is a social worker-facilitated protocol called "Reflective Debriefing" implemented by Emily D. Browning and Jourdan S. Cruz. This protocol involved regular case studies and moral distress debriefings facilitated by a social worker, which included "an educational component in moral distress, moral efficacy, and common end-of-life issues in the ICU. The aim of the protocol, a 10-question guided intervention for engaging in reflective practice, was to build ethics voice among staff as well as to help them process emotions related to moral distress."[130] Sessions lasted for 45-60 minutes, with 5-10 nurses attending most of the sessions, and moral distress levels were assessed using the Moral Distress Scale-Revised (MDS-R) at the beginning and end of a six-month period.[131]

The findings of this study were based on six nurses who were assessed at both intervals and attended at least one Reflective Debriefing session. Notably, Browning and

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[128] Ibid, e6
[129] Ibid, e8.
[130] Emily D. Browning and Jourdan S. Cruz, "Reflective Debriefing: A Social Work Intervention Addressing Moral Distress among ICU Nurses," *Journal of Social Work in End-of-Life & Palliative Care*, January 2, 2018, 49.
[131] Browning and Cruz, "Reflective Debriefing," 54.

Cruz found a reduction in moral distress scores too small to be considered significant among this group.[132] Although moral distress scores may not have significantly reduced in this small sample size, findings also revealed that "nurses reported that they felt supported and affirmed just by the fact that debriefings were offered, corroborating the hypothesis that organizational support may help to mitigate the effects of moral distress."[133]

The real-world implementation of interventions to mitigate moral distress among nurses has yielded mixed but promising results. Education-based approaches, such as the AACN's 4A's framework workshop and MEPRA, have demonstrated improvements in ethical competence, resilience, and work engagement, though their direct impact on reducing moral distress remains inconclusive. Interprofessional interventions, like Reflective Debriefing sessions, provide nurses with emotional support and affirmation, even though they also do not significantly reduce measured moral distress scores. These findings suggest that while individual and institutional support mechanisms are valuable, no single intervention fully resolves moral distress. Further research is needed to refine existing interventions, develop and evaluate new strategies, and assess their long-term effectiveness in reducing moral distress and enhancing nurse well-being.

3.4 The Discourse on Moral Suffering Interventions in Medicine

In her article "Moral Injury: Healthcare Systems in Need of Relational Repair," Wendy Dean revisits *moral injury* as a conceptual framework with inherent practical implications. In the article, Dean describes the framework of moral injury as a model

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[132] Ibid, 65.
[133] Ibid.

that highlights the relational and moral dimensions of physician distress.[134] This framework distinguishes moral injury from other forms of distress, particularly burnout, by highlighting betrayal by a legitimate authority in high-stakes situations, resulting in profound ethical conflict and moral compromise—an experience fundamental to the definition of moral injury in healthcare. Dean highlights the need for systemic solutions, explaining as follows:

> The framework of moral injury adds a relational and moral dimension to the discussion of distress in healthcare, the absence of which may explain why results from interventions addressing burnout have been less robust than hoped. Interventions for moral injury require a collaborative approach among clinicians, administrators, hospital systems, payors, regulators and legislators to interrupt conflicting incentives and allegiances, which erode trust between stakeholders.[135]

The conceptual framework of moral injury among physicians asserts that it arises when systemic pressures—such as business decisions, policies, and regulations—force them to compromise their professional ethics and commitment to patient care. This creates a profound sense of internal conflict, leading to distress, disillusionment, and a loss of trust in healthcare institutions. Dean highlights that existing burnout interventions—such as improving workflow efficiency—fail to address the core relational breakdown that defines moral injury.[136] Instead, she argues that solutions must focus on repairing trust between healthcare workers and institutions, recognizing and addressing systemic constraints, and fostering a workplace culture that prioritizes ethical practice and clinician well-being.

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[134] Wendy Dean, "Moral Injury - Healthcare Systems in Need of Relational Repair," *Physician Leadership Journal* 10, no. 3 (June 2023): 46.

[135] Ibid, 48.

[136] Ibid, 47.

Wendy Dean is not alone in emphasizing that addressing moral injury requires systemic change. Central to the framework of moral injury is the idea that responsibility lies with institutions and healthcare systems. An international e-Delphi study exploring morally healthy organizations highlights the critical role of systemic factors in shaping employee well-being and overall organizational performance. The authors point out a persistent misalignment in current approaches, stating:

> Despite extensive research demonstrating that employee wellbeing and overall organizational performance are heavily influenced by systemic factors like culture, commitment to values, and leadership behavior, wellbeing initiatives continue to prioritize individual interventions. The failure to consider systemic factors perpetuates poor organizational health and mischaracterizes the causes of occupational distress and poor patient experiences.[137]

Despite growing evidence linking employee well-being and organizational performance to these systemic factors, individual-focused interventions remain the priority. The study emphasizes that systemic factors—such as just culture, transparent decision-making, and ongoing monitoring of moral injury—are essential for promoting a healthier work environment. On physician burnout versus moral injury, Sheikhbahaei et al. make a powerful assertion: "Accusing physicians who are morally injured of being burned out is the equivalent of labeling shell-shocked soldiers who are returning from war as 'cowards.'"[138]

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[137] Deborah Morris et al., "Guidance for Creating Morally Healthy Organizations That Remediate the Experience of Moral Injury in Health Care: Findings From an International e-Delphi Study," *Journal of Occupational and Environmental Medicine* 67, no. 3 (March 2025): 181, https://doi.org/10.1097/JOM.0000000000003285.

[138] Sheikhbahaei, Garg, and Georgiades, "Physician Burnout versus Moral Injury and the Importance of Distinguishing Them," 3.

In advocating for "bolder steps" to eliminate burnout and moral injury, Mark Linzer and Sara Poplau similarly emphasize that the responsibility lies with those in positions of authority above physicians to implement widespread systemic changes, insisting that their proposals "will require leaders to show commitment and devote resources; in return, these actions can reduce trauma and despair among those who devote their lives to caring for others. It is now time to care for them."[139] These perspectives on moral injury collectively underscore the urgent need for systemic reforms that uphold ethical practice, ensure institutional accountability, and safeguard the well-being of physicians and other healthcare professionals.

Interventions recommended at the institutional level require collaboration and coordinated action from multiple stakeholders, including hospital administrators, executives, and physicians themselves. The British Medical Association's (BMA) review of moral distress and moral injury among doctors in the United Kingdom includes a category of "structural solutions" aimed at mitigating risk, with the following recommendations: Adequate funding and resourcing; Increase staffing; Empower doctors; Develop an open and sharing workplace culture; Provide support for employees; and Streamline National Health Service (NHS) bureaucracy.[140] Multiple scholars have advocated for improving workplace culture, empowering physicians, and reforming bureaucracy, aligning with the British Medical Association's

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[139] Mark Linzer and Sara Poplau, "Eliminating Burnout and Moral Injury: Bolder Steps Required.," *eClinicalMedicine* 39 (September 1, 2021): 1, https://doi.org/10.1016/j.eclinm.2021.101090.

[140] British Medical Association, "Moral Distress and Moral Injury: Recognising and Tackling It for UK Doctors," June 2021, 3, https://www.bma.org.uk/media/4209/bma-moral-distress-injury-survey-report-june-2021.pdf.

recommendations in their review. For example, Sheikhbahaei et al. recommend interventions that realign priorities and eliminate “bureaumania”:

> Institutions should educate administrators to the ethos of patient care. Administrative machinery should work to facilitate physician clinical practice and not become the conduit of it… Those who deliver health care should be shielded from unnecessary tasks. This can be achieved by delegating to them some bureaucratic oversight and by exposing bureaucrats to the daily clinical experience and how it is affected by bureaucratic tasks.[141]

Similarly, Wendy Dean and Simon Talbot also encourage physicians to invite hospital administrators to shadow them in their daily work, allowing them to witness firsthand the challenges of the healthcare system and, as Sheikhbahaei et al. describe, to "understand the ethos of patient care.” Dean and Talbot argue that “only when we understand the other party’s perspective can we truly begin to empathize and communicate meaningfully. That profound understanding is the place where commonality and compromises are found.”[142] Additionally, Dean and Talbot highlight that as resources become scarce, clinicians are often forced into competition rather than collaboration.[143] Doctors compete for referrals, nurses compete with physicians, and these dynamics highlight the need to rebuild a sense of community and collaboration not only between clinicians and administrators but also among clinicians themselves.

When moral injury occurs, Dean asserts that repair is essential alongside mitigation efforts, which are closely tied to enhancing workplace culture. On repairing moral injury, Dean writes that it requires “re-establishing, or establishing for the first

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[141] Sheikhbahaei, Garg, and Georgiades, “Physician Burnout versus Moral Injury and the Importance of Distinguishing Them,” 3.

[142] Dean, Talbot, and Dean, “Reframing Clinician Distress,” 400.

[143] Ibid, 402

time, a trusting and trustworthy relationship between the workforce and the institution, which is the foundation of a resilient organization."[144] To repair moral injury, Dean outlines seven steps to an intervention that would help a healthcare organization create a better and just culture. These steps involve renewing the healthcare organization's commitment to mutual respect and shared goals, taking responsibility and sharing accountability, and prioritizing transparency and learning from mistakes.[145] Additionally, they focus on rebuilding trust with the broader community the organization serves.[146]

At the systemic level, interventions focus on reforming the actions and policies of health insurance companies and healthcare systems. In a case report, Erlandson et al. argue that "health insurance policy should not interfere with physician decision-making, and necessary medical treatment must be available to patients without significant barriers… health systems must recommit to aligning their values with the patient, rather than profit, as their priority."[147] Additionally, reducing the excessive administrative burdens within the EMR system would enable physicians to focus more on meaningful patient connections. Aligning healthcare values with patient needs rather than corporate interests is essential for restoring trust, reducing clinician moral suffering, and ensuring equitable access to medical treatment.

Robert P. Lennon et al. also urge professional associations to incorporate protections against morally injurious events into their codes of ethics, ensuring that

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[144] Dean, "Moral Injury - Healthcare Systems in Need of Relational Repair," 47.
[145] Ibid, 47-48.
[146] Ibid.
[147] Erlandson, Ramirez, and Dean, "Medicine Shouldn't Be This Hard," 446.

healthcare organizations are obligated to uphold these standards for physicians.[148] Lennon et al. advocate for revising ethical codes, arguing that "if enough physicians identify these moral injuries and petition a governing medical body, that body might include in its code of ethics limitations on practice to avoid these injuries. Organisations that hire physicians would then be obligated to allow the physician to adhere to the revised ethical code which would in turn protect against PMIEs [Potentially Morally Injurious Events]."[149] When ethical codes are not enough to address widespread moral injury, the authors advocate for petitioning the government to add protections under the law, such as through the Occupational Safety and Health Administration (OSHA).[150]

At the individual level, interventions are also recommended to help physicians proactively mitigate the effects of moral injury, though their ability to implement these strategies is often limited by workplace constraints. The BMA suggests physicians take the following steps: Talk about moral distress and moral injury; Develop support networks; Speak out (when possible); Seek advice; Develop a self-care plan.[151] Philip Day et al. recommend multiple individual-level coping strategies to help physicians navigate and recover from morally distressing experiences, including: seeking support from administrators, sharing and processing trauma with loved ones, maintaining

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[148] Robert P. Lennon, Philip G. Day, and Janelle Marra, "Recognizing Moral Injury: Toward Legal Intervention for Physician Burnout," *Hastings Center Report* 50, no. 3 (2020): 81, https://doi.org/10.1002/hast.1146.

[149] Ibid.

[150] Philip Day et al., "Physician Moral Injury in the Context of Moral, Ethical and Legal Codes," *Journal of Medical Ethics* 48, no. 10 (October 2022): 746, https://doi.org/10.1136/medethics-2021-107225.

[151] British Medical Association, "Moral Distress and Moral Injury," 3.

emotional support networks, reframing their experience from victimhood to survivorship, using humor, and building confidence in their ability to cope.[152]

As examined in this section, and building on the moral injury framework, the literature overwhelmingly emphasizes systemic interventions at both the institutional and healthcare system-wide levels to address physician moral suffering, while cautioning against placing disproportionate responsibility on physicians and healthcare professionals. However, some recommendations take a multi-faceted approach, incorporating individual-level interventions incorporating coping mechanisms to help physicians support themselves.

3.5 Implemented Moral Suffering Interventions for Physicians

One tested intervention aimed at mitigating moral suffering, examined in this section, includes physicians in its sample population but adopts an interprofessional approach. The overall lack of research measuring moral suffering levels and the historical emphasis on physician burnout contributes to the scarcity of studies on interventions specifically designed to address moral suffering among physicians, in contrast to the more abundant research focused solely on nurses.

A 2017 study by Lucia Wocial et al. aimed to evaluate the impact of PEACE (Pediatric Ethics and Communication Excellence) Rounds, a structured ethics and communication intervention in a pediatric intensive care unit (PICU).[153] The

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[152] Philip Day et al., "Physician Moral Injury in the Context of Moral, Ethical and Legal Codes," 746.

[153] Lucia Wocial et al., "Pediatric Ethics and Communication Excellence (PEACE) Rounds: Decreasing Moral Distress and Patient Length of Stay in the PICU," *HEC Forum* 29, no. 1 (March 2017): 75, https://doi.org/10.1007/s10730-016-9313-0.

intervention sought to reduce moral distress among physicians and nurses, improve patient outcomes by decreasing the length of stay in the PICU, and facilitate ethical discussions and decision-making regarding realistic care goals for long-term PICU patients.[154] Overall participation in the intervention included 10 physicians and 32 nurses who completed both pre- and post-intervention surveys, as well as 60 PICU patients. Outcomes were measured using the MDT and the MDS-R.

The PEACE Rounds intervention involved a weekly interprofessional team meeting conducted over a 12-month period. Weekly PEACE Rounds were led by an ethicist and senior intensivist who led discussions about goals of care for patients hospitalized in the PICU for more than 10 days. Wocial et al. described the meeting dynamics and the collaborative role between the ethicist and intensivist:

> The senior intensivist helped focus the discussion on broad goals of treatment. The ethicist used probing questions to uncover situational risk factors for and early indicators of ethical conflict. The ethicist intentionally called on quiet members of the team, particularly non-physicians to invite them to share their perspective, particularly when value-based discord was evident during discussions. Additionally, the ethicist provided just in time education and coaching using mnemonics such as NURSE (responding to emotion), ADAPT (discussing prognosis) and REMAP (transitions in goals of care) to illustrate effective communication techniques to use when engaging decision makers in sensitive discussions… When there was a perception of incongruence between predicted medical outcome and family expectations, a care conference was scheduled in the same week between the bedside medical team and family members.[155]

One of the most notable aspects of this intervention is its commitment to inclusivity and team-based decision-making. The ethicist intentionally invites quieter members of the

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[154] Ibid, 75-76.
[155] Ibid, 78.

team, particularly non-physicians, to contribute to the discussion. This ensures that a diverse range of perspectives are heard and helps to mitigate the effects of hierarchies that often exist in medical settings. By valuing input from all team members, PEACE Rounds promotes a shared sense of responsibility and moral agency, reinforcing a collaborative and psychologically safe work environment where ethical concerns can be openly addressed.

Findings from the study showed that physicians benefited from improved communication with colleagues and families, which may help address moral distress in the long-term.[156] However, despite these benefits, the authors were disappointed that PEACE Rounds did not significantly reduce overall moral distress scores for physicians.[157] Nevertheless, the success of PEACE Rounds is evident, as the program has continued to grow and expand within the PICU.[158] The structured nature of PEACE Rounds ensures that ethical reflection and communication become ingrained in the ICU's daily practice, working to keep improving both clinician well-being and patient care outcomes in the long-term.

3.6 Comparing Moral Suffering Interventions in Nursing and Medicine

The recommended interventions for addressing moral suffering among nurses and physicians align with the implemented interventions examined in this chapter. However, significant gaps remain in both research and execution, preventing the full implementation and testing of all recommended interventions. Many proposed

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[156] Ibid, 87.
[157] Ibid, 88.
[158] Ibid.

interventions focus on ethics education, communication-centered strategies, and systemic reforms, and these approaches have been reflected in real-world implementation to varying degrees of success. However, while ethics training and communication-based interventions have been tested among both nurses and physicians, institutional and system-wide interventions remain underdeveloped and inconsistently implemented, particularly among physicians.

Table 1 provides a summary of the five interventions examined in this chapter to address moral suffering. Four out of the five interventions can be classified as having a *cognitive* focus (all except for Molazem et al.'s Educational Workshop on Moral Distress). These interventions focus on the mental processes involved in recognizing and understanding ethical dilemmas, improving decision-making, and clarifying values. The aim is to enhance moral awareness and provide clarity in distinguishing right from wrong. All five interventions also can be classified as having a *behavioral* focus, addressing the emotional and affective responses to decisions, particularly after they have been made. These interventions help clinicians cope with emotional distress post-decision and support moral resilience.

Moreover, all five interventions aimed to alleviate emotional and psychological symptoms of moral suffering in their respective ways, while only three interventions (Sauerland et al., Browning and Cruz, and Wocial et al.) attempted to address constraints, such as hierarchical power dynamics, poor interprofessional communication, and lack of ethics training, respectively. Additionally, as discussed in Chapter 2, it is essential to recognize that there is no one-size-fits-all solution, as constraints differ across clinician groups. Therefore, interventions should ideally be

designed and evaluated with a focus on one clinician group at a time. Interventions implemented by institutions or researchers must also be thoroughly tested to assess their effectiveness, enabling continued improvement.

The primary distinction between the nursing and medicine professions is their focus on addressing moral suffering—medicine advocates for broader healthcare system reforms, while nursing emphasizes institutional-level changes. Despite this difference in emphasis, their interventions still intersect at the individual level, highlighting shared strategies for mitigating moral suffering that would involve ethics education and training. Overall, nurses have more tested interventions available, though these interventions remain largely individual-focused rather than systemic. Physicians, on the other hand, require systemic-level changes, yet few structured interventions have been successfully implemented at this level.

Healthcare system-wide constraints, such as profit-driven decision-making, have been acknowledged in policy recommendations advocating for aligning healthcare priorities with patient needs rather than financial goals. Similarly, legal and regulatory pressures impacting physician autonomy have led to recommended interventions for reforming EMR requirements, insurance reimbursement policies, and administrative oversight, though these changes remain largely unimplemented. Cultural resistance to systemic change in healthcare organizations presents a significant challenge. Many interventions depend on institutional cooperation, which can explain the lack of interventions implemented at the institutional-level.

Studies based on the AACN's 4A's framework and Cynda Rushton's Moral Resilience framework, such as MEPRA and Reflective Debriefing, have demonstrated

that ethics training and structured discussions can support nurses in processing moral distress. However, these interventions have not consistently led to a significant reduction in distress levels. Similarly, for physicians, the recommended systemic solutions—including reducing administrative burdens, fostering just workplace cultures, and realigning institutional priorities per Wendy Dean's Relational Repair model—have not been widely implemented in a controlled, research-based manner. While PEACE Rounds provided a structured ethics and communication intervention for physicians and nurses in a pediatric ICU, and it led to improved communication and ethical discussions, it still did not significantly reduce moral distress scores among physicians. This suggests that while ethics training and communication-based interventions offer partial relief, they do not fully resolve the deeper systemic issues that contribute to moral suffering.

While both recommended and implemented interventions for nurses and physicians share common elements—particularly ethics training and communication strategies—their effectiveness in fully addressing moral suffering is hindered by the lack of tested systemic reforms. Nursing has experienced more structured and tested interventions, but many remain individual-focused, while physicians require broader institutional change, which remains largely untested. The findings suggest that for interventions to be truly effective, they must move beyond individual and interprofessional strategies and focus on institutional accountability, healthcare system-wide policy changes, and cultural shifts that prioritize ethical practice and clinician well-being.

Table 1. Moral Suffering Interventions in Nursing and Medicine

Intervention	Target Level	Clinician	Focus	Target Relief
Multi-Level Moral Distress and Ethical Climate Interventions *Sauerland et al. 2015*	Individual/ Inter-professional/ Institutional	Nurse	Cognitive and Behavioral	**Symptoms**: Emotional, Psychological **Constraints**: Hierarchical Power Dynamics, Poor Inter-professional Communication
Educational Workshop on Moral Distress *Molazem et al. 2013*	Individual	Nurse	Behavioral	**Symptoms**: Emotional, Psychological
Mindful Ethical Practice and Resilience Academy (MEPRA) *Rushton et al. 2021*	Individual	Nurse	Cognitive and Behavioral	**Symptoms**: Emotional, Psychological
Reflective Debriefing *Browning & Cruz 2018*	Individual/ Inter-professional	Nurse	Cognitive and Behavioral	**Symptoms**: Emotional, Psychological **Constraints**: Lack of Ethics Training, Poor Inter-professional Communication
Pediatric Ethics and Communication Excellence (PEACE) Rounds *Wocial et al. 2017*	Individual/ Inter-professional	Physician, Nurse	Cognitive and Behavioral	**Symptoms**: Emotional, Psychological **Constraints:** Lack of Ethics Training, Poor Inter-professional Communication

3.7 Conclusion

The findings in this chapter reveal that while recommended moral suffering interventions frequently acknowledge the need for systemic change, the majority of implemented interventions still focus on individual or small-scale institutional strategies, with little progress in addressing larger structural barriers. The current landscape of interventions suggests that further progress in alleviating moral suffering will require institutional and systemic accountability. This includes policy changes that prioritize ethical practice over bureaucratic efficiency, healthcare leadership that actively supports ethical decision-making, and workplace cultures that foster trust and collaboration rather than competition and patient-care compromise. Without these changes, the cycle of moral distress and moral injury will persist, leaving nurses and physicians to bear the emotional and ethical burden of a system that has yet to fully recognize its responsibility in preventing moral suffering.

Chapter 4:

Examining Moral Suffering through the Lens of Virtue Ethics

4.1 Introduction

This chapter explores the philosophical foundations of virtue ethics and connects them to the moral demands placed on nurses and physicians through professional codes, ethical standards, and institutional expectations. I also expand the definition of moral suffering introduced in Chapter 1 to include the erosion of professional identity and *integrity*—arguing that at its core, moral suffering stems from the inability to act with integrity, even as institutions continue to expect it. By examining moral suffering through the lens of virtue ethics, this chapter contributes to ongoing efforts to shift the conversation away from individual resilience alone and toward systemic accountability for creating the moral conditions necessary for ethical clinical practice.

4.2 The Role of Virtue in Nursing and Medicine

This section explores how virtue ethics provides a meaningful framework for understanding ethical practice in healthcare, particularly in the professions of medicine and nursing. Drawing from Aristotelian philosophy and the work of scholars such as Edmund Pellegrino, David Thomasma, Felipe E. Vizcarrondo, and Rosalind Hursthouse, I examine how moral character—especially virtues like compassion and integrity—guides clinicians toward their professional *telos* or moral purpose. In addition to outlining the theoretical foundations of virtue ethics, this section analyzes how contemporary professional codes and competencies implicitly rely on virtue-based expectations. Through examples and close readings of ethical standards, I demonstrate

that professionalism in healthcare is not only principlist in structure but also deeply rooted in the cultivation of moral character.

Virtue ethics is a philosophical theory rooted in Aristotelian thought. In the simplest sense, a *virtue* is a morally good character trait in a person. According to physician-ethicist Felipe E. Vizcarrondo's interpretation of Aristotle's work, *virtue* is defined by Aristotle as "competence in the pursuit of excellence. For Aristotle the virtuous man is principled, and his ultimate *telos* [aim] is to become a man of excellence… Man's virtue is linked with action. Virtue is acquired by doing virtuous acts; and enhanced by repetition of virtuous acts."[159] Virtue ethics focuses on the virtues or "moral character" of the person performing an act, making it different from other ethical theories like *deontology*, which emphasizes duties and rules that an act adheres to, and *utilitarianism*, which emphasizes the consequences of actions.

A criticism of virtue ethics is that it does not provide a person with moral guidance, providing a circular speculation rather than a specification that a person can use to guide them to an ethical action.[160] However, because a person is striving for a virtuous moral character—or, as Aristotle would say, "excellence"—they inherently desire to be good. This internal pursuit naturally guides them to act in alignment with their virtues, which they perceive as right. Their ability to discern what is virtuous develops over time through the practice of virtues and the accumulation of experience. On moral motivation, Rosalind Hursthouse asserts that "acting virtuously, in the very

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[159] Felipe E. Vizcarrondo, "The Return of Virtue to Ethical Medical Decision Making," *The Linacre Quarterly* 79, no. 1 (February 2012): 73, https://doi.org/10.1179/002436312803571519.

[160] Rosalind Hursthouse, *On Virtue Ethics* (Oxford, UNITED KINGDOM: Oxford University Press, Incorporated, 2000), 30.

way the virtuous agent acts, namely from virtue, is sufficient for being 'morally motivated' or acting 'from (a sense of) duty.'"[161] A virtuous person's ultimate *telos* is the cultivation of their moral character, which they cultivate by applying their virtues across various situations.

Over time, a person's virtues can become better moral guidance for their actions. Aristotle recognized this notion, which is why he developed the idea of *phronesis* (practical wisdom). The concept of *phronesis* is complicated and can be interpreted in various ways. Kristján Kristjánsson et al. write that a neo-Aristotelian perspective would suggest that "virtues are the habitual actions that make it possible to live a good or *eudaimonic* life, and *phronesis* is the wisdom an individual recruits to recognize what virtues are appropriate to a specific situation so that action conduces to that good life."[162] If one agrees with this perspective, one can see that over time, a virtuous agent will gain more experience and better apply their virtues in different situations.

In healthcare, the professions of medicine and nursing are inherently moral practices in which clinicians—both nurses and physicians—rely not only on formally taught bioethical principles but also on their virtues to guide their actions in the healthcare setting. According to Andrew JT George et al., the *telos* of medicine "might be summarised as 'to help people flourish by enabling them to optimise their health.'"[163] Aristotle's "virtuous" doctor or nurse—one of morally good character who strives for

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[161] Hursthouse, *On Virtue Ethics*, 142.

[162] Kristján Kristjánsson et al., "Phronesis (Practical Wisdom) as a Type of Contextual Integrative Thinking," *Review of General Psychology* 25, no. 3 (September 1, 2021): 241–42, https://doi.org/10.1177/10892680211023063.

[163] Andrew JT George, Catherine E Urch, and Alan Cribb, "A Virtuous Framework for Professional Reflection," *Future Healthcare Journal* 10, no. 1 (March 1, 2023): 78, https://doi.org/10.7861/fhj.2022-0121.

excellence—would consistently act in ways that prioritize their patient's well-being. The virtuous physician and nurse prioritize their patient's well-being above all else. Thus, a nurse or physician who protects a patient from undue harm exemplifies virtuous action and moral excellence.

In the modern day, the four principles of biomedical ethics outlined by Tom L. Beauchamp and James F. Childress—autonomy, beneficence, nonmaleficence, and justice—serve as the foundation for ethical decision-making in clinical practice. At the same time, the good doctor or nurse will act in alignment with their *telos* of acting in favor of their patient's wellbeing; prioritizing the benefit of the patient shapes the development of their moral character. The physician and nurse's *telos* is a personal moral pursuit, but also one presented as duties which they pledged in their respective oaths, the most common being the Hippocratic Oath or the Nurse's Pledge. Clinicians in medicine and nursing are united by a shared moral purpose and a commitment to patient well-being, with an inherent expectation to act virtuously. Virtues such as compassion, trust, and integrity are foundational to many healthcare professionals' moral character which they then apply to their profession. In healthcare, particularly in nursing and medicine, I argue that a physician and nurse's virtues are not only necessary but also an expected complement to the bioethical principles that form the foundation of ethical decision-making in clinical practice. Physicians and nurses are expected to embody moral character traits—such as compassion and integrity—and these traits are reflected in the ethical codes and standards of professionalism discussed next.

The four principles of biomedical ethics also form the basis of formal codes of conduct, wherein *professionalism* is often included as a competency, and ultimately, an expectation. Although rooted in principlism, the codes of conduct discussed in this section implicitly highlight virtues that physicians and nurses must embody to maintain ethical practice and professionalism. As Pellegrino and Thomasma assert, "Medicine, or more properly healing, is a practical enterprise requiring a fusion of technical competence and moral judgment."[164] Although healthcare institutions may not always explicitly explain how clinicians should develop moral character, they implicitly recognize that professionalism and ethical practice require more than just rule-following and adherence to principles. The professions of nursing and medicine expect nurses and physicians to act in alignment with "good" moral character, which is why institutional codes often implicitly incorporate virtues.

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) introduced six "core competencies" it expected of physician residents and fellows, one of which is professionalism. To exhibit professionalism, "Residents must demonstrate a commitment to carrying out professional responsibilities [and] adherence to ethical principles…Residents are expected to: demonstrate respect, compassion, and integrity [and] responsiveness to the needs of patients and society that supersedes self-interest…"[165] The ACGME professionalism competency requires physicians to demonstrate compassion, respect, and integrity—core virtues of moral character. Similarly, the 2021 American Association of Colleges of Nursing (AACN) "Essentials of

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[164] Pellegrino and Thomasma, *The Virtues in Medical Practice*, 86.

[165] Lynne M. Kirk, "Professionalism in Medicine: Definitions and Considerations for Teaching," *Proceedings (Baylor University. Medical Center)* 20, no. 1 (January 2007): 13.

Nursing" standards also emphasize professionalism and incorporate virtues in its description.[166] According to the AACN definition, *professionalism* "encompasses the development of a nursing identity embracing the values of integrity, altruism, inclusivity, compassion, courage, humility, advocacy, caring, autonomy, humanity, and social justice."[167] In this code, professionalism is defined by a list of virtues. This definition reinforces the idea that professionalism in nursing is deeply rooted in moral character and ethical commitment.

The American Medical Association's (AMA) *Code of Medical Ethics* integrates principles of biomedical ethics with virtues into a unified framework. The AMA explains: "The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient…The following *Principles* adopted by the [AMA] are not laws, but standards of conduct that define the essentials of honorable behavior for the physician…[Principle 1] A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.[168] Compassion, in particular, is a virtue that defines the "honorable" or "good" physician. To act ethically, the AMA emphasizes that physicians must possess both practical competence and strong moral judgment.

The virtues outlined by the ACGME, AACN, and AMA align with several virtues examined by Pellegrino and Thomasma in their 1993 book, *The Virtues in Medical*

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[166] Although they share the same abbreviation, the American Association of Colleges of Nursing (AACN) discussed in this section should not be confused with the American Association of Critical-Care Nurses.

[167] American Association of Colleges of Nursing, "The Essentials Domain 9: Professionalism," accessed April 1, 2025, https://www.aacnnursing.org/essentials/tool-kit/domains-concepts/professionalism.

[168] American Medical Association, "Principles of Medical Ethics," accessed April 1, 2025, https://code-medical-ethics.ama-assn.org/principles.

Practice. Compassion and integrity are the virtues most prominently reflected in the codes, aligning with two of the eight that Pellegrino and Thomasma examine in their work. Regarding *compassion*, they write that the "call for compassion goes directly to the central concern of [their] book: the character of the physician… It summates the whole of the character, virtues, and vices of physicians and nurses. Compassion is the character trait that shapes the cognitive aspect of healing to fit the unique predicament of *this* patient."[169] The virtue of compassion highlights the significance of virtue ethics in healthcare professionalism, reinforcing Pellegrino and Thomasma's argument that a physician's and nurse's character is fundamental to ethical practice. Their assertion that compassion "summates the whole of the character" highlights its role in bridging clinical knowledge with patient-centered care.

An example of a physician acting with compassion is one treating a terminally ill cancer patient who is experiencing severe pain and emotional distress. Instead of focusing solely on managing symptoms through medication, the doctor takes the time to sit with the patient, listen attentively to their fears, and provide reassurance. They engage in shared decision-making, ensuring the patient's values and preferences guide their care plan. The doctor also coordinates with palliative care specialists and the patient's family to provide holistic support, demonstrating that compassion goes beyond clinical expertise—it involves genuine empathy, understanding, and a commitment to the patient's overall well-being.

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[169] Pellegrino and Thomasma, *The Virtues in Medical Practice*, 79.

Virtue ethics invites reflection on the moral purpose—or *telos*—of nursing and medicine, considers the character traits necessary to achieve that purpose, and integrates both ethical reasoning and *phronesis* or practical wisdom. It is no coincidence that virtues—such as compassion—also appear in healthcare codes of ethics and professional conduct. The examples of codes presented in this section illustrate that professionalism in medicine and nursing, while formally grounded in principlism, is also implicitly virtue-based. These frameworks assume that a "good doctor" or "good nurse" not only acts ethically but possesses a well-formed moral character. Whether explicitly stated or implicitly embedded, virtues help shape the expectations placed on healthcare professionals.

4.3 Moral Suffering and the Erosion of Professional Identity and Integrity

Across multiple definitions of *moral suffering*—including moral distress and moral injury—examined in Chapter 1 of this thesis, a common thread emerges: the violation of a clinician's *integrity* often constitutes the core transgression when they are unable to act in alignment with their moral purpose of prioritizing patient well-being and their professional competency. As examined in the previous section, scholars such as Pellegrino and Thomasma emphasize a range of virtues essential to clinical practice, including the importance of *compassion*, and professional codes also highlight several key moral traits. However, I argue that *integrity* is the foundational and all-encompassing virtue of medicine and nursing—one under which other virtues, such as compassion, are nested. *Integrity* not only unifies the moral communities of nursing and medicine but also encapsulates the virtues that define ethical professionalism. As

such, professional identity and integrity become synonymous within the practices of both nursing and medicine.

The inherent presence of morality in medicine and nursing aligns with Pellegrino and Thomasma's assertion that medicine is a *moral community*, a concept that has been central throughout this thesis. In their work, Pellegrino and Thomasma argue that medicine—and, by extension, nursing—is a moral endeavor grounded in three main pillars: "(1) the nature of illness, (2) the nonproprietary nature of medical knowledge, and (3) the nature and circumstances of a professional oath"[170] Regarding the first pillar, illness places patients in a state of vulnerability, which in turn creates a professional and moral responsibility for physicians and nurses to provide care. This inherent dependency requires a foundation of trust—that physicians and nurses will apply their medical expertise to promote the patient's well-being and not cause them harm. Regarding the "nonproprietary nature of medical knowledge," physicians and nurses possess technical competence developed through rigorous training—expertise that is not private property, but a responsibility carried for the benefit of those who are ill. Lastly, physicians and nurses are expected to uphold professional commitments through oaths such as the Hippocratic Oath and the Nurse's Pledge. These three pillars, inherent to medicine—and, as I argue, to nursing as well—form the foundation of professional identity and moral integrity. When nurses and physicians are unable to practice in alignment with these pillars due to *constraints*, as defined in Chapter 1, moral suffering arises.

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[170] Ibid, 35.

On the virtue of *integrity*, Pellegrino and Thomasma write that a person with integrity "…is almost predictable about the responses to specific situations [and] he or she can integrate all the virtues into a whole and can prudentially judge the relative importance in each situation…in reaching a decision to act."[171] They further assert that the "moral claim to autonomy rests on the deeper moral claim of all humans to integrity of the person."[172] When healthcare institutions include *integrity* as a defining virtue of professionalism, they acknowledge—though without elaboration—its role in maintaining ethical consistency, reinforcing the idea that a physician's moral wholeness is integral to their ability to act justly, compassionately, and responsibly in patient care. A physician or nurse with integrity will consistently align their actions with ethical principles, such as protecting the autonomy of their patient or upholding fairness.

For example, a nurse acting with integrity would advocate for a patient who is being discharged prematurely due to hospital policy, despite knowing the patient is not medically stable. Recognizing their ethical responsibility, the nurse voices their concerns to the attending physician and hospital administration, even if it means challenging authority. They ensure the patient receives appropriate care, whether that means delaying discharge or arranging follow-up care. By prioritizing the patient's well-being over institutional pressures, the nurse exemplifies professionalism and integrity, reflecting a strong moral character. The virtue of integrity bridges ethical principles and professional standards; Lisa M. Haddad and Robin A. Heiger emphasize that "Nurses should know the Code of Ethics within their profession and be aware and recognize their

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[171] Ibid, 127.
[172] Ibid.

own integrity and moral character."[173] Nurses—and physicians—are expected to actively uphold ethical commitments, even in difficult situations, to ensure patient-centered care and maintain trust in the profession.

However, contrary to what the previous example illustrates, it is not always possible for a nurse or physician to successfully persuade others to prioritize patient well-being over institutional, financial, or policy-driven concerns. While nurses and physicians are expected to act with integrity, they are not always able to carry out morally right actions in practice. On professionalism in medicine, physician John Saultz writes:

> At its root, professionalism is based on a series of promises made by members of a profession to the society in which they live…In the case of medicine, these promises can be found in the oaths taken by physicians dating back to Hippocrates. When graduating medical students adopt such an oath, they claim to share the virtues on which the profession is based. Fundamental to the pledge of altruism is that physicians serve patients, not medical groups, health systems, universities, or health plans. Today, this notion is being questioned as more and more physicians are employed, not by patients, but by business entities such as hospitals or integrated health systems.[174]

The business-oriented healthcare system Saultz describes is one that other scholars, such as Dean and Talbot, consistently point to as causes of moral suffering. The integrity that shapes a clinician's moral character is eroded by authorities operating beyond the realm of direct patient care. Pellegrino and Thomasma articulated the harm this shift causes to the medical community: "Physicians [and nurses] who resist are morally abandoned to defend themselves, without encouragement or support from their

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[173] Lisa M. Haddad and Robin A. Geiger, "Nursing Ethical Considerations," in *StatPearls* (Treasure Island (FL): StatPearls Publishing, 2023), http://www.ncbi.nlm.nih.gov/books/NBK526054/.

[174] John Saultz, "Professional Virtue," *Family Medicine* 48, no. 7 (2016): 509–10.

profession. Only the most courageous raise their voices, and at great risk of retribution… The enormous moral power that resides in the community of medicine is left unused."[175]

Persistent *constraints*—such as administrative pressures, systemic inefficiencies, and conflicting institutional values—can successfully obstruct a clinician's ability to act in alignment with what they believe is morally right. As defined in Chapter 1 and examined throughout this thesis, I further argue that constraints contribute to moral suffering by gradually eroding clinicians' virtues and impeding the development of their moral character. Thus, here I expand the definition of *moral suffering* to explicitly incorporate the effect on a clinician's *moral integrity*:

> In addition to being an adverse moral experience of varying severity, moral suffering in nursing and medicine also represents the gradual erosion of a clinician's professional identity and moral integrity. It stems from the ongoing tension between a clinician's aspirational moral character and the dominant forces that either support or hinder the embodiment of the virtues essential to their practice—virtues rooted in integrity that healthcare institutions themselves expect clinicians to uphold.

Pellegrino and Thomasma argue that, for centuries, the "shared source of morality" in medicine has been the character of the physician, a notion that I also extend to the character of the nurse.[176] Since medicine and nursing are moral endeavors shaped by their clinicians, the moral character of the physician and nurse naturally influences their decisions as professionals within their work environment. Persistent constraints contributing to moral suffering ultimately erode virtues and stunt the moral character development of nurses and physicians. Moral suffering, then, stands in direct opposition

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[175] Pellegrino and Thomasma, *The Virtues in Medical Practice*, 26.
[176] Ibid, 3.

to professional identity formation and alignment with one's moral values, beliefs, and clinical competency.

The interventions examined in Chapter 3—centered on ethics education and communication—have been implemented and tested among both nurses and physicians, though predominantly among nurses. However, institutional and system-wide interventions remain underdeveloped and inconsistently implemented, particularly in addressing moral suffering among physicians. Ultimately, for a nurse or physician to act with integrity and meaningfully prevent or mitigate the development of moral suffering, they must be empowered and supported in aligning their clinical competence with their moral purpose of prioritizing patient well-being over external pressures.

In essence, acting in alignment with one's virtues involves not only recognizing the right course of action and having the ability to carry it out, but also maintaining a stable sense of self as a professional committed to integrity. As discussed in Chapter 3, addressing moral suffering requires more than fostering individual resilience—it calls for institutional support grounded in both *cognitive* and *behavioral* approaches. This includes cultivating environments that encourage ethical reflection, reinforce moral identity, and—most importantly—eliminate the business-centric barriers that prevent clinicians from acting in alignment with their values and the professional oaths they have taken and promise to uphold.

4.4 Conclusion

This chapter has argued that moral suffering in healthcare cannot be fully addressed without explicitly acknowledging the central role of virtues—particularly the all-encompassing virtue of *integrity*—in clinical practice. By examining the

philosophical foundations of virtue ethics and their expression in professional codes and expectations, it becomes clear that nursing and medicine are not only technical professions but inherently moral ones. When clinicians are unable to act in alignment with their moral character due to constraints, their professional identity and moral integrity are gradually eroded, giving rise to moral suffering. Addressing this issue requires more than individual resilience; it calls for institutional and systemic accountability. Only by engaging these institutional and systemic authorities can nurses and physicians be empowered to act with integrity and fulfill the moral purpose of their professions: prioritizing patient well-being.

Conclusion

This thesis has explored the complex phenomenon of moral suffering in nursing and medicine. Building on the work of nurse-bioethicist Cynda Hylton Rushton, in this thesis, I used the term *moral suffering* as an overarching concept to encompass the varying severities of adverse moral anguish. As examined in Chapter 1, moral suffering has long been studied within the context of nursing, particularly under the term *moral distress*. Recently, discussions surrounding *moral injury* have emerged in relation to physicians, often as an alternative to *burnout*. Moreover, conceptual frameworks in the nursing and medicine literature have evolved to recognize that moral distress can escalate into moral injury, implying that moral suffering exists along a continuum of severity.

Both physicians and nurses work within healthcare environments where dominant forces create constraints conducive to moral suffering at various levels. The first main argument of this thesis is that what differentiates the experience of moral suffering between physicians and nurses is the nature of the constraints they face. In Chapter 2, I argue that nurses often experience moral suffering as a result of hierarchical structures, institutional policies, and resource limitations that prevent them from delivering the quality of care they believe is ethically necessary. Meanwhile, physicians are constrained by systemic and bureaucratic pressures and may experience moral suffering due to conflicts between patient advocacy and administrative demands or through the business-oriented priorities of the modern-day healthcare system. Understanding these distinctions is critical for developing effective interventions that

acknowledge the unique challenges faced by each profession while reinforcing the shared moral purpose at the core of both nursing and medicine.

In 2019, Wendy Dean and Simon Talbot wrote the following: "When an individual falls ill, her or his clinician looks for the cause of the problem and its corresponding medical solution. We need to approach moral injury in the same way, knowing full well that the solutions aren't medical but are social, economic, and political."[177] As examined in Chapter 3, Dean and Talbot's perspective underscores a fundamental challenge in addressing moral suffering: while individual-level interventions can provide short-term relief, they do not resolve the systemic, institutional, and cultural factors that create and perpetuate moral suffering. This thesis agrees with the growing discourse that moral suffering is not merely an individual burden but a systemic issue that demands institutional and systemic reform.

In Chapter 4, I examined moral suffering through the lens of virtue ethics, arguing that the erosion of professional identity and integrity lies at its core. Acting with *integrity*—the all-encompassing virtue I argue is central to both nursing and medicine—is essential for clinicians to fulfill their moral purpose of prioritizing patient well-being. However, when persistent constraints prevent nurses and physicians from acting in alignment with their values, moral suffering arises and integrity is impacted. Ultimately, the issue of moral suffering requires more than resilience-building or ethics training; it demands healthcare environments actively support the cultivation and expression of

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[177] Wendy Dean and Simon G. Talbot, "Moral Injury and Burnout in Medicine: A Year of Lessons Learned," *STAT* (blog), July 26, 2019, https://www.statnews.com/2019/07/26/moral-injury-burnout-medicine-lessons-learned/.

moral integrity by eliminating the barriers that prevent nurses and physicians from fulfilling their moral purpose.

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