Journal of Integrative Nursing and Palliative Care (JINPC)

Volume 7 | Issue 1 | Page 38-50

Original Article

Ethical Issues in Palliative Care for Patients with Chronic Diseases: A Systematic Review of Nursing Perspectives

Aisha Bello[1]*, Zainab Musa[1]

[1]*Department of Nursing and End-of-Life Care, Faculty of Health Sciences, University of Ibadan, Ibadan, Nigeria.*

Abstract

The global rise in chronic conditions requiring prolonged management underscores the urgent need for optimized palliative care. Although nursing professionals are central to delivering this care, they routinely face ethical dilemmas, complex clinical decisions, and occupational burnout. This systematic review synthesizes and groups international data regarding nurses' ethical viewpoints, dilemmas, and systemic interventions within both institutional hospital units and home-care environments. The analysis explicitly addresses three inquiries: (1) How do nurses ethically perceive the delivery of palliative services? (2) What specific moral dilemmas and decision-making barriers do they experience? (3) Which practical frameworks and protocols effectively promote ethically resilient care? Operating under the PRISMA 2020 methodological framework, a comprehensive literature search was executed across five databases (PubMed, Scopus, Web of Science, SID, and Magiran), along with gray literature from Google Scholar for investigations published from 2015 through 2025 in English or Persian. Peer-reviewed qualitative, quantitative, mixed-methods, and review papers tracking nursing-focused ethical conflicts in palliative environments were selected. Qualitative insights were extracted using inductive content analysis, quantitative data were gathered via descriptive synthesis, and mixed-methods profiles were integrated to harmonize conclusions across disparate research structures. Generated codes were systematically grouped into themes, organized into categories, and mapped into final overarching domains. 34 publications satisfied the established criteria, revealing four core areas of ethical friction: (1) Clinical decision-making and patient autonomy—focusing on disputes over life-prolonging measures, pharmacological and hydration protocols, palliative sedation, and friction between patient intent and familial or cultural paradigms; (2) Justice and resource allocation—highlighting deficient ethics training, severe workloads, minimal organizational backing, fractured interdisciplinary communication, and asset scarcity; (3) Beneficence and patient-centered care—comprising issues involving modern clinical technologies, informed consent, data protection, and structural stressors like ICU or emergency department conditions; (4) Non-maleficence and moral distress prevention—tracking moral distress, professional exhaustion, compromised moral fortitude, and legal vulnerabilities that alter clinical trajectories. Nursing personnel confront deep-seated moral obstacles when providing palliative services to individuals with chronic pathologies. Alleviating these burdens demands robust ethics coursework, formalized institutional policies, interprofessional alignment, and adaptive, setting-specific approaches that protect human dignity and mitigate moral distress. These conclusions offer empirical guidance for policy architects, clinical educators, and healthcare directors designing actionable frameworks across varied care delivery models.

Keywords: Chronic disease, Decision making, End-of-life care, Ethical issues, Moral distress, Nursing

Introduction

The global rise in chronic diseases requiring intricate, long-term therapeutic regimens underscores the paramount importance of sustainable healthcare delivery [1]. Palliative intervention stands as a cornerstone of this

Corresponding author: Aisha Bello
Address: Department of Nursing and End-of-Life Care, Faculty of Health Sciences, University of Ibadan, Ibadan, Nigeria.
E-mail: ✉ aisha.bello@gmail.com
Received: 09 October 2025; **Accepted:** 05 February 2026; **Published:** 30 June 2026

How to Cite This Article: Bello A, Musa Z. Ethical Issues in Palliative Care for Patients with Chronic Diseases: A Systematic Review of Nursing Perspectives. J Integr Nurs Palliat Care. 2026;7(1):38-50. https://doi.org/10.51847/jbe1AvOMQ3

framework, seeking to elevate patient well-being by mitigating physical, emotional, social, and spiritual trauma [2]. The World Health Organization defines this paradigm as “An approach that improves the quality of life of patients and their families facing problems associated with life-threatening illnesses, through the prevention and relief of suffering by early identification, precise assessment, and treatment of pain and other physical, psychosocial, and spiritual problems” [3].

Theoretical analyses frame palliative care as a holistic, preemptive, and multi-layered methodology. It prioritizes comprehensive patient assessment, active patient self-determination in clinical paths, familial engagement, interprofessional coordination, and the balanced application of scientific evidence alongside clinical intuition. Expected outcomes yield heightened quality of life, the preservation of personal dignity, and smoother patient adjustment to terminal illnesses [4-7].

Nurses serve as the primary engine of palliative care delivery, tasked with administering treatments, evaluating clinical shifts, bridging communication among multi-professional teams, and guiding families alongside their patients [8]. Accumulating evidence indicates that nurses managing chronic illness cohorts routinely encounter heavy moral friction, stressful decision-making impasses, and intense vocational anxiety.

An array of localized investigations mirrors these systemic pressures. Researchers observed that home-health nurses routinely grapple with clashes between patient self-determination and family dictates, threats to patient privacy, and difficulties navigating discordant cultural or religious beliefs [9]. Previous studies demonstrated that ethical hurdles surrounding pain management protocols and patient rights directly compromise the professional quality of life of nursing staff [10]. Other researchers detailed how Swedish nurses encounter moral distress and professional strain when addressing volatile choices regarding hydration therapy and terminal comfort care [11]. Similarly, studies have shown that Iranian nurses delivering palliative aid to end-stage heart failure populations face severe barriers regarding pain stabilization, psychological burnout, and volatile communication loops with patient relatives [12].

Nurses’ ethical considerations span choices regarding the continuation or cessation of aggressive, invasive therapies, the protection of patient self-governance, the preservation of confidentiality, and the reconciliation of conflicting priorities between patients and relatives [13-16]. In hospital units, these dynamics are frequently aggravated by extreme time pressures, resource deficits, and clinical instability; conversely, home-based practitioners must balance separate ethical duties toward the individual and the immediate household [17, 18]. Recent documentation confirms that nurses must simultaneously oversee complex clinical decisions, manage volatile symptoms, and provide emotional support to families while upholding ethical mandates—an operational reality that underscores the urgent need for structural support and ongoing professional training [19].

Despite the profound impact of these issues, the literature lacks an organized, comprehensive synthesis of nurses’ ethical insights in palliative chronic care across both inpatient and domiciliary settings. Historical research has largely focused on isolated clinical metrics, leaving gaps in our understanding of ethical pressures, institutional choices, and practical resolutions, thereby scattering existing knowledge and leaving the ethical anatomy of palliative nursing incomplete.

To address this deficit, this systematic review aggregates the available literature on nurses’ ethical positions, systemic challenges, and professional interventions in chronic palliative care environments. Specifically, this review aims to resolve three central research questions:

1. What ethical challenges do nurses face when providing palliative care to patients with chronic diseases in hospital and home settings?
2. How do nurses navigate these challenges regarding decision-making, professional interventions, and ethical practices?
3. What strategies and organizational supports have been recommended to facilitate ethically sound palliative care in these contexts?

Materials and Methods

Study design and inclusion criteria

This study was conducted as a systematic review to document and appraise the ethical perspectives of nursing staff providing palliative care to individuals with chronic illnesses in acute and home care settings. The review’s structural design was modeled strictly on the PRISMA 2020 criteria to ensure methodological clarity, study reproducibility, and scientific rigor **(Figure 1)** [20].

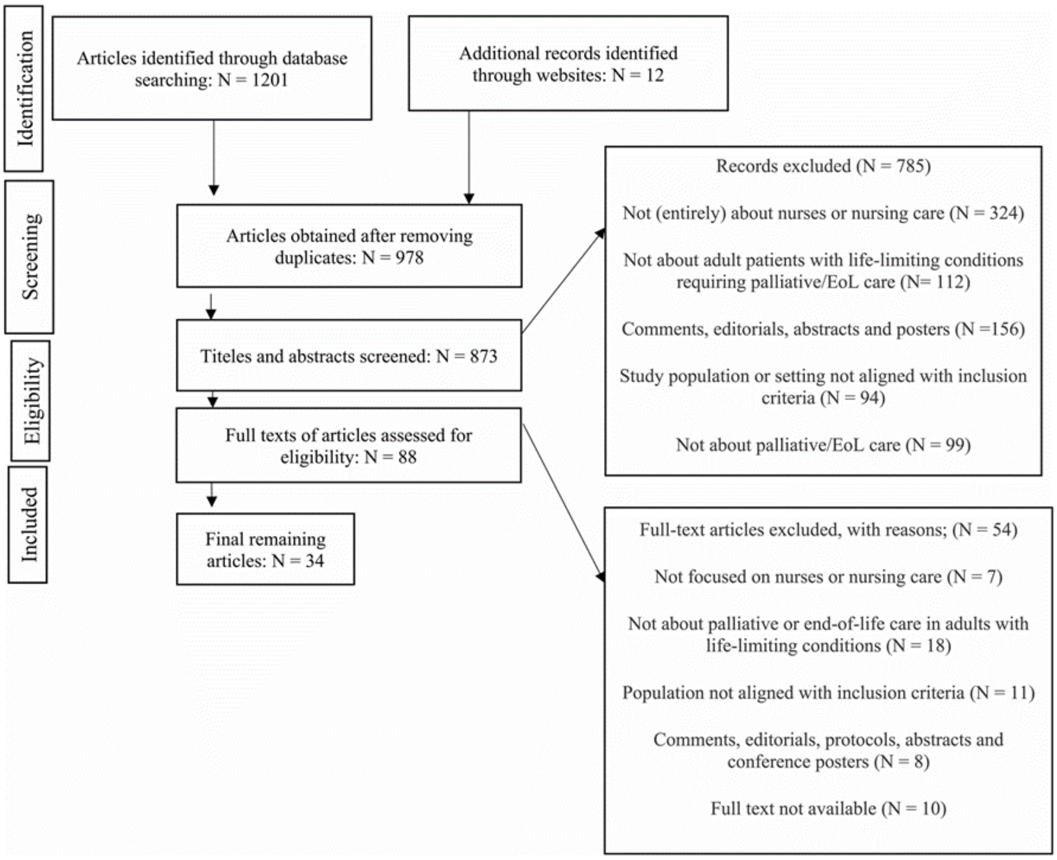

Figure 1. Prisma 2009 flow diagram

Inclusion criteria

Literature was selected for this review if it satisfied the following parameters:

1. Population: Professional nursing staff (including registered nurses, auxiliary nurses, or general nursing personnel) involved in administering palliative or end-of-life interventions to individuals diagnosed with chronic, advanced, or life-limiting conditions.
2. Focus: Concentrated on documenting ethical challenges, moral dilemmas, moral distress, or the dynamics of ethical decision-making within the realm of palliative care.
3. Study type: Open to qualitative, quantitative, mixed-methods, quasi-experimental, and experimental frameworks, alongside systematic and narrative reviews. Review articles were restricted strictly to those that had undergone peer review.
4. Keywords and conceptual scope: The thematic boundaries were intentionally expanded to prevent the omission of pertinent literature. Consequently, the core phrase “ethical challenge” was supplemented with related terms like “ethical dilemma,” “ethical issues,” “moral distress,” “moral conflict,” and “decision making.” Similarly, palliative care descriptors were expanded to include terms such as “serious illness,” “life-limiting illness,” and “progressive disease.”
5. Setting: Investigations situated within inpatient hospital units or home-care environments.
6. Access: Availability of the complete full-text manuscript written in either English or Persian.
7. Time Frame: Publications distributed between the years 2015 and 2025. Restricting the literature window to the preceding 10 years aligns with current recommendations for systematic review methodologies [21], thereby ensuring that the extracted data reflect modern healthcare infrastructures and contemporary ethical paradigms [22].

Exclusion criteria

Research papers were excluded from the analysis if they:

- Consisted of non-empirical reviews, editorial letters, conference proceedings, posters, or institutional reports lacking primary empirical data.
- Omitted specific evaluation of the ethical dimensions of palliative or end-of-life care models.
- Centered primarily on functional nursing performance parameters rather than underlying ethical complications.
- Lacked accessible full-text versions.

- Addressed legal, policy, or administrative frameworks exclusively, without establishing direct relevance to ethical issues in clinical nursing practice.

Search strategy

Electronic databases polled from 2015 through April 2025 comprised PubMed, Scopus, Web of Science, CINAHL (via EBSCO), SID, and Magiran. Furthermore, digital platforms were combed to capture relevant grey literature **(Table 1)**.

Table 1. Distribution of included studies by database and study design. From: Ethical perspectives in palliative care for chronic patients: a systematic review of nurses' experiences in home and hospital settings.

Information source	Total studies identified (n)	Distribution by research design (n)
PubMed	12	Qualitative studies: 6; Quantitative studies: 3; Mixed-methods studies: 1; Review articles: 2
Scopus	9	Qualitative studies: 4; Quantitative studies: 2; Mixed-methods studies: 1; Review articles: 2
Web of Science	5	Qualitative studies: 3; Quantitative studies: 1; Mixed-methods studies: 0; Review articles: 1
CINAHL	3	Qualitative studies: 2; Quantitative studies: 1; Mixed-methods studies: 0; Review articles: 0
Scientific Information Database (SID)	2	Qualitative studies: 2; Quantitative studies: 0; Mixed-methods studies: 0; Review articles: 0
Magiran	1	Qualitative studies: 1; Quantitative studies: 0; Mixed-methods studies: 0; Review articles: 0
Websites and Gray Literature Sources	2	Qualitative studies: 0; Quantitative studies: 0; Mixed-methods studies: 0; Review articles: 2

The literature retrieval process utilized an extensive matrix of keywords and equivalents distributed across three primary thematic pillars: (1) ethical concepts, (2) palliative care, and (3) nursing responsibilities. This process incorporated both standardized MeSH terminology and free-text search phrases. The exhaustive search syntax deployed for PubMed is detailed in Additional File 1, which also outlines the customized search sequences executed across the remaining databases.

The bibliographies of all selected papers and pertinent review articles were manually cross-checked to identify additional qualifying publications. Grey literature and web domains maintained by specialized palliative or nursing associations were also searched with targeted keywords (including nursing associations, palliative care organizations, and nursing ethics committees). Management and de-duplication of the retrieved citations were executed using EndNote version 26.

Study selection and data extraction

All compiled citations were independently reviewed by a pair of investigators (ZKHF and MZ) using the Covidence online workspace, which served as the primary platform for initial screening and data extraction [23]. The evaluation began with a preliminary screening of titles and abstracts; this phase yielded an unweighted Cohen's kappa coefficient of 0.90, indicating an almost perfect level of inter-rater agreement, consistent with Muldrew *et al.* [24] benchmarks. Subsequently, the complete texts of the remaining articles were scrutinized by the same two researchers, yielding a Cohen's kappa coefficient of 0.84, which is also categorized as almost perfect. Any analytical differences were settled through open discussion, mutual consensus, or, when necessary, mediation by FG.

The compiled dataset recorded bibliographic details, research design, country of origin, methodological framework, care environment, and documented ethical challenges. For the initial cohort of five papers, data extraction and validation were conducted independently by ZKHF and MZ; for all subsequent articles, data extraction was completed by FG and verified by SFK.

Quality assessment

The methodological integrity of the chosen studies was appraised using the checklist developed by Nikbakht Nasrabadi *et al.* [25], which establishes discrete evaluation metrics tailored to individual research designs:

- Quantitative studies: Evaluated via six specific items, including the clarity of the research question, study design, sample selection protocols, data collection methods, statistical analysis, and data reporting consistency.
- Qualitative studies: Evaluated via eleven items covering the clarity of the research question, the appropriateness of the qualitative framework, participant selection strategies, data collection and analysis procedures, transparency, findings validity, ethical considerations, study limitations, practical applicability, and report coherence.

- Quasi-experimental studies: Evaluated via eight items, including study design, participant allocation methods, control of confounding variables, data collection and analysis, internal and external validity, reporting standards, and practical applicability.
- Experimental studies: Evaluated via seven items encompassing study design, presence of a control group, randomization protocols, data collection and analysis, validity measures, and practical applicability.

Each item was assigned a binary score of 0 (criterion not met) or 1 (criterion met), which was then aggregated into a total score. Only studies satisfying the pre-established quality cut-offs were retained for final analysis. This quality assessment phase was carried out independently by two researchers (ZKHF and MZ), with any analytical discrepancies resolved through team discussions to ensure uniform application of criteria and study comparability **(Table 2)**.

Data analysis and synthesis

The process of evaluating and aggregating data was guided by the integrative review framework established by Omidi *et al*. [26], which accommodates the simultaneous analysis and synthesis of qualitative, quantitative, and mixed-methods research designs.

1. Qualitative studies:
    - Textual data were assessed using inductive content analysis and constant comparative methods, in accordance with the protocols of Peng *et al*. [27].
    - Initial conceptual codes were isolated and subsequently assembled into axial subcategories.
    - Central themes alongside supporting subthemes were systematically determined.
2. Quantitative and mixed-methods studies:
    - Empirical data were synthesized using descriptive and narrative approaches, following the methodology of Sadeghi *et al*. [28].
    - Every finding related to the ethical parameters of palliative healthcare was specifically flagged to facilitate its subsequent integration with the qualitative datasets.
3. Data Integration and Identification of Themes, Categories, and Domains:

The analytical framework relied on a transparent, layered structural hierarchy to arrange the collective findings. The most microscopic phase of data interpretation yielded specific themes, which represent concrete moral dilemmas or real-world experiences. Overlapping themes were then aggregated into broader, more conceptual categories. Ultimately, these categories were consolidated into the highest tier of conceptualization, termed overarching domains. This three-tiered structure (Themes $\rightarrow$ Categories $\rightarrow$ Domains) underpins the organization of data and serves as the foundation for the discussion section.

- Data harmonization: Extracted codes and observations from quantitative and mixed-methods publications were systematically contrasted with qualitative themes, allowing equivalent items to be organized into preliminary themes.
- Category development: Blended themes were mapped to broader analytical categories that reflect the diverse ethical challenges faced by nursing staff.
- Domain development: Categories were comprehensively synthesized into core conceptual domains, which included:
    1. Clinical decision-making and patient autonomy
    2. Justice and resource allocation
    3. Beneficence and patient-centered care
    4. Non-maleficence and prevention of moral distress
- Validation and Consensus: Quantitative insights were initially categorized by ethical dimension before being blended with qualitative themes. Two investigators independently verified the codes and analytical labels throughout every phase of this process, resolving any differing interpretations through collaborative deliberation and mutual consensus. A practical demonstration of this cross-comparison and alignment protocol is detailed in Additional File 2 [26, 29].

4. Final Reporting of Findings:
    - Consolidated data outcomes were cataloged in **Table 2** to preserve complete transparency, study replicability, and standard cross-study comparison.

Table 2. Quality assessment of included studies. From: Ethical perspectives in palliative care for chronic patients: a systematic review of nurses' experiences in home and hospital settings.

Number of studies (n)	Research design	Quality appraisal based on Gifford *et al.*	Overall assessment
6	Systematic reviews	High quality, meeting most appraisal criteria, with clearly described methodology and transparent search and synthesis procedures	Acceptable

16	Qualitative studies	High quality, characterized by well-defined sampling strategies, rigorous data collection and analysis procedures, and documented ethical considerations	Acceptable
4	Quantitative (cross-sectional) studies	High quality, featuring clearly specified study populations, validated measurement tools, and transparent analytical methods	Acceptable
2	Mixed-methods studies	High quality, demonstrating effective integration of qualitative and quantitative findings alongside transparent reporting practices	Acceptable
3	Literature or narrative reviews	High quality, employing systematic or structured review approaches, and providing coherent evidence synthesis	Acceptable
3	Survey studies / early reports	High quality, utilizing validated survey instruments and presenting findings in a clear and comprehensive manner	Acceptable

This progressive, transparent methodology ensures that research themes and structural categories are meticulously derived from diverse study designs and integrated into final core domains, thereby bolstering the validity and reproducibility of the overall results.

Results and Discussion

Study selection process

A total of 1,201 unique citations were identified through database searches, and an additional 12 records were obtained from specialized websites and grey literature sources. After deleting 487 duplicate records, 671 articles were vetted based on their titles and abstracts. The complete texts of 89 papers were subsequently evaluated for structural eligibility, ultimately leaving 34 articles that successfully satisfied all inclusion criteria **(Table 3)**.

Table 3. General characteristics of studies included in the review. From: Ethical perspectives in palliative care for chronic patients: a systematic review of nurses' experiences in home and hospital settings.

Reference	**Objective**	**Research design**	**Setting**	**Data collection/ Methodology**	**Participants**	**Ethical domain**	**Category**	**Main theme**
Adegbesan *et al.* [1]	Examine ethical concerns associated with implementing AI in palliative care	Concept analysis and review	International	Conceptual review and analysis	N/A	Beneficence and patient-focused care	Consent procedures and protection of personal data	Technological innovations and emerging digital tools
Akbarian-Rakeni *et al.* [2]	Explore nurses' views regarding ethical difficulties in end-of-life care	Qualitative study	Iran	Structured interview approach	16 nurses	Clinical decision-making and respect for autonomy	Disagreements in treatment-related decisions	Decisions concerning withdrawal of treatment
Alanazi *et al.* [3]	Identify obstacles affecting palliative care accessibility among older people	Systematic review	International	Systematic evidence review	28 studies	Justice and equitable resource distribution	Communication and coordination among teams	Absence of shared decision-making frameworks
Alodhialah *et al.* [4]	Investigate accessibility of palliative services for older adults	Qualitative study	Saudi Arabia	Individual interviews	22 nurses	Justice and allocation of resources	Insufficient education and organizational backing	Challenges arising from cultural and religious diversity
Arab *et al.* [5]	Explore nurses' experiences regarding ethical principles in home healthcare	Qualitative study	Iran	Interviews with content analysis	16 nurses	Clinical decision-making and patient autonomy	Preserving autonomy and dignity	Tension between patient preferences and family expectations; influence of cultural and religious values

Arash *et al.* [6]	Assess moral distress and clinical decision-making among ICU nurses	Descriptive analytical cross-sectional study	Iran	Survey questionnaire	198 nurses	Clinical decision-making and autonomy; Non-maleficence and prevention of moral distress	Decision-making conflicts; Psychological impact on nurses	Decisions about continuing, withholding, or limiting invasive treatment; Moral distress and ethical harm
Arends *et al.* [7]	Investigate moral distress associated with life-sustaining interventions	Mixed-methods study	Germany	Questionnaires and data analysis	15 nurses	Non-maleficence and prevention of moral distress; Clinical decision-making and autonomy	Psychological effects on nurses; Decision-making conflicts	Moral distress and ethical injury; Decisions regarding continuation or limitation of invasive care
Bosch *et al.* [8]	Examine ethical concerns experienced by nurses and volunteers	Qualitative study	Netherlands	Hermeneutic interview method	21 nurses	Clinical decision-making and autonomy; Non-maleficence and moral distress prevention	Maintaining autonomy and dignity; Psychological impact on nurses	Conflicts between patient and family wishes; Cultural pressures; Moral distress and ethical injury
Cheon *et al.* [9]	Identify ethical issues encountered by hospice and palliative care nurses	Survey study	USA	Questionnaire survey	861 nurses	Clinical decision-making and patient autonomy	Decision-making conflicts	Mandatory continuation of non-beneficial treatments
Friedrichsen *et al.* [10]	Explore ethical concerns related to thirst management in dying patients	Qualitative study	Sweden	Semi-structured interviews with thematic analysis	14 nurses	Clinical decision-making and patient autonomy	Conflicts in treatment decisions	Management of medications and fluids
Geng *et al.* [11]	Synthesize evidence on ethical dilemmas faced by palliative care nurses	Systematic review	International	Systematic review methodology	15 studies	Justice and resource allocation; Non-maleficence and prevention of moral distress	Team communication and coordination; Psychological effects on nurses	Communication barriers; Moral distress, and ethical injury
Ghavi *et al.* [12]	Explore ethical challenges and possible solutions	Qualitative study	Iran	Structured interviews	12 nurses	Non-maleficence and prevention of moral distress; Justice and resource allocation	Psychological impact on nurses; Limited education and organizational support	Moral distress, ethical injury, burnout, workload burden, and inadequate support
Gonzalez-Perez *et al.* [13]	Investigate perspectives on ethical conflicts	Qualitative study	Spain	Semi-structured interviews	12 nurses	Justice and equitable distribution of resources	Inadequate education and organizational support	Deficiencies in professional ethics training
Geuenich *et al.* [14]	Examine supervision practices, moral distress, and moral injury in palliative care	Qualitative study	Germany	Interviews and thematic analysis	20 nurses	Non-maleficence and prevention of moral distress	Psychological outcomes for nurses	Moral distress and ethical injury

Overall characteristics of included studies

Every selected publication focused exclusively on nursing personnel (comprising registered nurses, auxiliary nursing assistants, or general nursing staff) tasked with delivering palliative or end-of-life treatments. The 34 included papers represent standalone investigations published between 2015 and 2025 and are available in either English or Persian. Eight of these investigations were executed within Iran, while the remaining cohort originated from diverse international regions or global contexts.

Among these, 17 papers used qualitative methodologies, relying heavily on semi-structured or structured interview protocols and thematic or content analysis. Seven papers utilized quantitative methods, predominantly cross-sectional surveys, and another seven investigations deployed mixed-methods frameworks (combining interviews with questionnaires or matching descriptive designs with analytical components). The overall methodological integrity of the literature was deemed satisfactory according to the verification metrics of the Gifford *et al*. checklist [25]. The study cohorts consisted mostly of hospital-based, home-care, intensive care unit (ICU), or hospice nurses, who were predominantly female and possessed professional clinical experience ranging from 1 to 25 years.

Ethical challenges identified **(Table 4)**

Clinical decision-making and patient autonomy

- Category 1.1: Conflicts in Clinical Decisions
    - Theme: Continuation, withdrawal, or limitation of aggressive treatments — Clinical staff faced profound tension regarding the preservation, cessation, or restriction of invasive interventions, which triggered psychological strain and professional burnout [11, 19, 30].
    - Theme: Medication and fluid management — Clinical choices involving pharmacological regimens and artificial hydration often lacked structured protocols, forcing staff to balance patient symptom alleviation with established institutional metrics [11, 17].
    - Theme: Use of palliative sedation — The administration of palliative sedation was associated with significant complications, requiring seamless interprofessional alignment and strict adherence to medical ethics [10, 31].
- Category 1.2: Maintaining Patient Autonomy and Dignity
    - Theme: Conflicts between patient wishes and family expectations — Nursing professionals actively strove to protect patient self-determination when caught between the direct desires of the patient and the demands of relatives [9, 12, 32].
    - Theme: Cultural and religious differences — Divergent cultural values and spiritual orientations introduced intense ethical pressure within both home-care contexts and institutional hospital units [9, 33, 34].

Justice and resource allocation

- Category 2.1: Lack of Training and Organizational Support
    - Theme: Inadequate specialized ethics training — A deficiency in targeted bioethics education hindered effective moral decision-making and amplified rates of moral distress [21, 30, 31].
    - Theme: High workload and lack of institutional support — Excessive operational demands combined with deficient workplace backing accelerated systemic burnout and eroded professional moral fortitude [19, 24, 26].
- Category 2.2: Communication and Team Coordination Issues
    - Theme: Insufficient interdisciplinary collaboration — Deficient teamwork among multi-professional staff members resulted in fragmented clinical choices and intensified moral friction [1, 16, 18].
    - Theme: Resource and time constraints — Deficits in physical assets and available time generated substantial ethical strain, ultimately degrading the caliber of palliative care delivery [8, 17].
    - Theme: Absence of shared decision-making guidelines — The total absence of standardized, collaborative decision-making frameworks rendered clinical choices more arduous and susceptible to error [11, 18].

Beneficence and patient-centered care

- Category 3.1: Innovations and Emerging Technologies
    - Theme: Use of artificial intelligence and ethical risks — The deployment of AI utilities in palliative settings triggered complex ethical issues, specifically concerning informed consent pathways and data confidentiality [1].
- Category 3.2: Care Environment and Setting
    - Theme: Emergencies and time pressure — Acute clinical crises and compressed decision windows directly aggravated the moral distress experienced by nursing staff [6, 12, 19, 26].
    - Theme: ICU care and treatment conflicts — Intensive care unit practitioners navigated sharp contradictions when trying to balance aggressive curative interventions against comfort-oriented palliative measures [6, 26, 27].

Non-maleficence and moral distress prevention

- Category 4.1: Psychological Consequences for Nurses
  - Theme: Moral distress and ethical injury — Phenomena relating to moral distress and profound ethical injury were highly prevalent across the nursing cohorts [6, 11, 14, 35].
  - Theme: Burnout — The compounding effects of ethical dilemmas and intense workload pressures triggered widespread vocational burnout [23, 31].
  - Theme: Reduced moral courage — Deficient institutional advocacy paired with excessive daily workflows compromised the clinical moral courage of practicing nurses [34].
- Category 4.2: Legal and Regulatory Challenges
  - Theme: Fear of legal responsibility and conflicts between patient and team preferences — Regulatory ambiguities surrounding end-of-life legislation and apprehensions regarding personal legal liability occasionally blocked proper clinical choices and escalated moral stress, highlighting an acute need for structured organizational protections [1, 6, 32].

Table 4. Hierarchy of nurses' ethical challenges in palliative care: domains, categories, and themes. From: Ethical perspectives in palliative care for chronic patients: a systematic review of nurses' experiences in home and hospital settings.

Domain	Category	Subtheme
1. Clinical decision-making and patient autonomy	1.1 Conflicts in clinical decision-making	Decisions regarding the continuation, discontinuation, or restriction of invasive interventions
		Challenges related to medication administration and fluid management
		Ethical considerations surrounding palliative sedation
	1.2 Protection of patient autonomy and dignity	Disagreements between patients' preferences and family members' expectations
		Cultural and religious influences are creating pressure on decision-making processes
2. Justice and allocation of resources	2.1 Insufficient education and organizational support	Deficiencies in specialized ethics education and professional training
		Excessive workload and inadequate support from healthcare institutions
	2.2 Communication and interdisciplinary coordination challenges	Limited collaboration among healthcare professionals
		Constraints related to available resources and time
		Lack of formal guidelines for collaborative decision-making
3. Beneficence and patient-focused care	3.1 Emerging innovations and technological developments	Application of artificial intelligence and associated ethical concerns
		Issues related to informed consent procedures and protection of personal data
	3.2 Care context and treatment setting	Time constraints and challenges encountered in emergencies
		Conflicts associated with intensive care unit (ICU) treatment and care decisions
4. Non-maleficence and prevention of moral distress	4.1 Psychological effects on nurses	Experiences of moral distress and moral injury
		Occupational and emotional burnout
		Decline in moral and ethical courage
	4.2 Legal and regulatory concerns	Anxiety regarding potential legal responsibility or liability
		Disagreements between patient preferences and the perspectives of the healthcare team

Barriers and facilitators of ethical care

The primary obstructions and catalysts surrounding ethical care delivery were linked fundamentally to dynamics within nurse-patient, nurse-team, and nurse-organization interactions. Clinical models rooted in mutual trust, dignified interpersonal relationships, patient-centered priorities, and clinical care adaptability actively catalyze ethical practice. Conversely, absolute deficits in clinical knowledge, severe time deficits, and inadequate institutional support served as primary systemic barriers [2, 12, 30].

Practical recommendations

Proposed interventions centered on delivering structured ethics coursework, prioritizing patient-centered clinical methodologies, optimizing interprofessional communication pipelines, expanding institutional administrative support mechanisms, and adjusting resource distribution models. Actionable strategies underscored the value of scenario-based learning models, proactive advance care planning, refining familial communication approaches, and ensuring open access to specialized palliative care resources [4, 11].

By aggregating data from 34 separate investigations across institutional and domiciliary sectors, this systematic review offers a comprehensive, multifaceted evaluation of the moral friction experienced by nursing staff delivering palliative services to individuals with chronic conditions. The synthesized evidence directly resolves the three primary research questions regarding nursing standpoints, moral dilemmas, and actionable protocols. The findings are structured around a core architecture of eight analytical categories distributed across four global domains: clinical decision-making and patient autonomy; justice and resource allocation; beneficence and patient-centered care; and non-maleficence and the prevention of moral distress. Together, these conceptual domains yield a unified framework for deciphering the intricate nature of ethics within palliative environments.

Within the domain of clinical decision-making and patient autonomy, the extracted data demonstrate that nurses routinely navigate complex scenarios regarding the initiation, continuation, or cessation of invasive, life-prolonging therapies, the management of pharmacological and hydration therapies, and the implementation of palliative sedation protocols. These occurrences, classified under the category “clinical decision-making conflicts,” represent some of the most pervasive professional challenges. This high frequency arises because nursing staff must constantly arbitrate competing pressures between their independent clinical expertise, the explicit preferences of the patient, and the desires of the immediate family [11, 17, 26, 27]. These underlying dilemmas are further amplified in high-velocity environments such as intensive care units and emergency rooms, where rapid clinical decisions carry profound ethical weight [17, 19]. Correspondingly, the category “preserving autonomy and patient dignity” illuminates how discrepancies between patient choices and familial demands—particularly when shaped by deeply rooted cultural or spiritual traditions—exert a decisive influence on clinical ethical decisions [9, 12, 30]. These dynamics underscore that nursing staff’s ethical calculations are continually shaped by an interactive matrix of professional obligations, cultural paradigms, and psychological variables.

The domains of justice and resource allocation reveal a clear consensus across the reviewed literature that deficient bioethics coursework and minimal institutional infrastructure constitute profound impediments to ethical clinical practice. Insights from the category “lack of training and organizational support” indicate that a large proportion of nursing professionals feel systematically unprepared to manage moral friction due to a lack of targeted education regarding terminal care decisions, ethical conflicts, and corresponding statutory frameworks [19, 22, 21, 31]. This educational gap directly drives clinical ambiguity, practitioner hesitation, and eroded professional self-efficacy. Furthermore, data within the “communication and teamwork challenges” category indicate that severe time constraints, deficient interprofessional synergy, and material resource deficits impede the implementation of ethically sound decisions, thereby undermining equity in healthcare delivery [14, 18, 30]. These collective outcomes indicate that a major portion of ethical hurdles stems not from individual practitioner deficits, but rather from systemic, institutional vulnerabilities.

The domain of beneficence and patient-centered care interrogates how evolving clinical technologies and localized workspace dynamics reshape ethical practice models. Documentation within the category “innovation and emerging technologies” indicates that incorporating algorithmic and AI-driven tools into palliative care introduces novel ethical risks, particularly surrounding the preservation of informed consent, patient data confidentiality, and systemic technological bias [1]. Nursing professionals are forced to balance the operational advantages of technical tools in optimizing care metrics with the latent moral liabilities associated with their deployment. Additionally, the category “care environment and clinical conditions” emphasizes how acute time deficits, high-acuity patient profiles, and intensive care environments disrupt not only the mechanics of ethical decision-making but also the structural feasibility of executing patient-centered care [6, 26, 27]. These insights reveal that the manifestation of beneficence in palliative care depends not merely on individual nursing competencies but also heavily on the physical and environmental architecture.

Within the domain of non-maleficence and the prevention of moral distress, the emotional, psychological, and regulatory ramifications of ethical friction become highly prominent. The category “psychological impacts on nurses” demonstrates that ongoing exposure to unresolved ethical conflicts frequently induces moral distress, deep-seated ethical [13, 14, 22-24, 32]. Compounding these emotional burdens, the category “legal and regulatory challenges” indicates that ambiguous statutory frameworks regarding end-of-life care, apprehensions about personal liability, and fear of litigation can lead to excessive clinical caution and disrupt appropriate symptom management [15, 32, 34]. These observations highlight the critical necessity for transparent legal structures and protective organizational regulations.

From a global, cross-cultural perspective, the assessment of these 34 studies reveals that while nursing cohorts across nations encounter parallel ethical challenges, their severity and specific characteristics vary according to societal expectations, legal systems, and healthcare models. In Middle Eastern environments, collective family involvement and cultural paradigms significantly dictate clinical decision-making conflicts; conversely, in European and Australian settings, standardized administrative documentation and statutory liabilities assume greater prominence [26, 29]. This divergence underscores the value of designing culturally attuned ethical interventions calibrated to local healthcare landscapes.

Several critical knowledge gaps were identified through this systematic evaluation:

- Very few investigations have empirically measured the true efficacy of specific educational modules or institutional support systems designed to mitigate moral distress, despite a universal acknowledgment of their importance.
- The current empirical literature remains skewed toward inpatient hospital settings, leaving home-based palliative care models significantly underexamined.
- Research tracking the ethical dimensions of advanced clinical technologies remains scarce, despite their rapid integration into routine palliative infrastructure.
- While multiple publications acknowledge the influence of legal and policy frameworks, few have deployed empirical methodologies to examine their direct, practical impact on real-time ethical choices.

Beyond merely cataloging systemic obstacles, this review synthesizes an array of actionable methodologies highlighted across the source literature to address the third research question. These solutions include implementing structured, case-based ethics coursework, creating unified interprofessional guidelines for clinical choices, improving multi-professional communication channels, building institutional counseling networks to alleviate moral distress, and formulating culturally responsive institutional policies. Furthermore, clarifying and updating statutory frameworks regarding end-of-life responsibilities could enhance clinical confidence and reduce overly defensive, cautious healthcare delivery.

Ultimately, this review confirms that the ethical challenges faced by nursing staff arise from an intricate, overlapping matrix of ethical knowledge deficits, organizational constraints, cultural forces, statutory barriers, and psychological strains. A primary value of this evaluation lies in its synthesis of empirical evidence across highly diverse medical settings and geographic boundaries, yielding an all-encompassing, layered depiction of the contemporary palliative care landscape. These consolidated insights can directly guide the execution of targeted educational curricula, organizational supports, and legislative reforms intended to bolster ethical palliative nursing practice.

A primary merit of this systematic review is its dedicated evaluation of the direct accounts of nursing professionals regarding ethical barriers, moral distress, and clinical experiences within chronic disease palliative care. By structuring the identification and synthesis of themes, categories, and domains, this review provides a highly organized taxonomy of contemporary moral issues. The deployment of broad inclusion criteria yielded a large pool of literature representing highly diverse nursing perspectives. Furthermore, combining qualitative, quantitative, and mixed-methods research designs facilitated the integration of disparate conceptual viewpoints across distinct healthcare environments.

Conversely, certain limitations must be acknowledged:

- Broad variability persists in the baseline definitions and operational terminology used to describe palliative and end-of-life care across the literature, which may have led to studies evaluating related but distinct clinical focus areas.
- A subset of the qualitative observations relies heavily on participants' subjective perceptions and personal histories rather than on objective, empirical metrics.
- The literature search was restricted exclusively to papers published in English or Persian, potentially omitting relevant empirical datasets published in alternative languages.
- A small number of the included papers lacked comprehensive methodological reporting, potentially masking underlying variations in research rigor.

Conclusion

The evidence compiled in this systematic review indicates that nursing professionals delivering palliative care to individuals with chronic illnesses regularly confront multifaceted ethical challenges that can compromise both the quality of healthcare delivery and their psychological well-being. These core hurdles encompass complex clinical decision-making loops, the preservation of patient self-determination and human dignity, systemic deficiencies in institutional support and ethics education, fractured interprofessional communication, emotional exhaustion, statutory ambiguities, and the physical constraints of advanced technology and specific clinical settings.

Cultivating robust organizational support infrastructures, providing continuous professional bioethics coursework, and establishing transparent, collaborative clinical decision-making models are essential to minimizing moral distress and preventing vocational burnout among nursing staff. Additionally, optimizing interpersonal communication skills within multi-professional teams, remaining attentive to cultural and spiritual diversity, and offering actionable clinical guidance during acute emergency crises represent critical steps forward.

Future empirical research should prioritize the formulation and objective evaluation of targeted interventions that translate abstract ethical frameworks into actionable, real-world clinical tools across diverse palliative care settings. Specifically, measuring the direct efficacy of targeted ethics education, evaluating systemic strategies to reduce moral distress, and identifying frameworks to maximize interdisciplinary harmony will be essential to advancing both patient care quality and the psychological well-being of the nursing workforce.

Acknowledgments: None

Conflict of interest: None

Financial support: None

Ethics statement: None

References

1. Adegbesan A, Akingbola A, Ojo O, Jessica OU, Alao UH, Shagaya U, et al. Ethical challenges in the integration of artificial intelligence in palliative care. J Med Surg Public Health. 2024;4:100158.
2. Akbarian-Rokni M, Mardani-Hamooleh M, Abbasi M, Seyedfatemi N, Pezaro S. Nurses' perceptions of the challenges involved in providing of end-of-life care to people with heart failure: a context-based study. BMC Palliat Care. 2023;22(1):180.
3. Alanazi MA, Shaban MM, Ramadan OME, Zaky ME, Mohammed HH, Amer FGM, et al. Navigating end-of-life decision-making in nursing: a systematic review of ethical challenges and palliative care practices. BMC Nurs. 2024;23(1):467.
4. Alodhialah AM, Almutairi M. Exploring palliative care access among older adults in Saudi Arabia: implications for nursing practice. BMC Nurs. 2025;24(1):1098.
5. Arab M, Shahriari M, Keshavarzian A, Abbaszadeh A, Keshvari M. Nurses' experiences of the ethical values of home care nursing: A qualitative study. Int J Nurs Sci. 2022;9(3):364–72.
6. Arash A, Mahmoodi-Shan G, Mehravar F, Sabzi Z, Mancheri H. Clinical decision making and moral distress among intensive care units nurses in Iran. BMC Psychol. 2024;12(1):692.
7. Arends SA, Steenbergen M, Thodé M, Francke AL, Jongerden IP. Moral distress among nurses involved in life-prolonging treatments in patients with a short life expectancy: a qualitative interview study. Patient Educ Couns. 2022;105(7):2531–6.
8. Bosch GVD, Schaik MV, Pasman HR, Janssens R, Widdershoven G, Metselaar S. Moral Challenges of Nurses and Volunteers in Dutch Palliative Care. A Qualitative Study. J Palliat Care. 2023;38(3):364–71.
9. Cheon J, Coyle N, Wiegand DL, Welsh S. Ethical issues experienced by hospice and palliative nurses. J Hospice Palliat Nurs. 2015;17(1):7–13.
10. Friedrichsen M, Lythell C, Milovanovic M, Waldréus N, Thulesius H, Jaarsma T, et al. Nurses' experiences of ethical challenges concerning thirst in dying patients in specialist palliative care: a qualitative study. BMC Palliat Care. 2024;23(1):192.
11. Geng S, Zhang L, Zhang Q, Wu Y. Ethical dilemmas for palliative care nurses: systematic review. BMJ Support Palliat Care. 2024.
12. Ghavi A, Valizadeh L, Powers K, Zamanzadeh V. Professional ethical challenges and suggested strategies in nursing: a qualitative study. J Med Ethics Hist Med. 2024;17:10.
13. Gonzalez-Perez M, Sanchez-Romero S, Ruiz-Fernandez MD, Ibanez-Masero O, Ventura-Miranda MI, Ortega-Galan AM. Qualitative study on nursing students' perspective on ethical conflicts at the end of life: We are not prepared. Nurse Educ Today. 2025;149:106671.
14. Geuenich P, Schlömer L, Owusu-Boakye S, Stanze H, Supervision. Moral Distress and Moral Injury Within Palliative Care—A Qualitative Study. Int J Environ Res Public Health. 2025;22(7):1156.
15. Heggestad AKT, Magelssen M, Pedersen R, Gjerberg E. Ethical challenges in home-based care: A systematic literature review. Nurs Ethics. 2021;28(5):628–44.
16. Heshmatifar Far N, Manzari ZS, Heydari A. Barriers and challenges of team working in palliative care of the elderly: an integrated review. Navid No. 2024;27(91):53–67.
17. Ibrahim AM, Abdel-Aziz HR, Zaghamir DEF, Elneblawi NH, Elhoty MAE-RE, Kamal Sweelam R, et al. Ethics and moral empathy in end-of-life palliative care. Palliat Support Care. 2025;23:e108.
18. İlhan H, Çınarlı T, Şener A. Difficulties Experienced by Palliative Care Nurses in Emergency Care Practices: A Qualitative Study. Online Turkish J Health Sci. 2024;9(4):357–64.

19. Kochems K, de Graaf E, Hesselmann GM, Ausems MJE, Teunissen S. Healthcare professionals' perceived barriers in providing palliative care in primary care and nursing homes: a survey study. Palliat Care Soc Pract. 2023;17:26323524231216994.
20. Luk JK, Chan FH. End-of-life care for advanced dementia patients in residential care home—a Hong Kong perspective. Annals Palliat Med. 2018;7(3):35964–364.
21. Mehrolhassani MH. Challenges of palliative care: A systematic review. J Health Adm. 2021;24(3):9–21.
22. Moazam E, Moazam E, Abassi M. Ethical aspects of end-of-life care and end-stage disease: A review article. J Isfahan Med School. 2020;38(584):528–36.
23. Muldrew Née Preshaw DH, McLaughlin D, Brazil K. Ethical issues experienced during palliative care provision in nursing homes. Nurs Ethics. 2019;26(6):1848–60.
24. Muldrew DHL, Kaasalainen S, McLaughlin D, Brazil K. Ethical issues in nursing home palliative care: a cross-national survey. BMJ Support Palliat Care. 2020;10(3):e29.
25. Nikbakht Nasrabadi A, Wibisono AH, Allen KA, Yaghoobzadeh A, Bit-Lian Y. Exploring the experiences of nurses' moral distress in long-term care of older adults: a phenomenological study. BMC Nurs. 2021;20(1):156.
26. Omidi M, Abdi A, Rezaei M. A qualitative study on ICU nurses' perceptions of palliative care. BMC Nurs. 2025;24(1):521.
27. Peng M, Guan Q, Zhu X. Moral distress, attitude toward death, and palliative care core competencies among ICU nurses: a cross-sectional study. BMC Palliat Care. 2025;24(1):16.
28. Sadeghi N, Hesami SA, Sadeghi M, Sadeghi S. Nurses' Experiences of Palliative Care in the Neonatal Intensive Care Unit: A Qualitative Study. Avicenna J Nurs Midwifery Care. 2021;29(4):302–13.
29. Schofield G, Dittborn M, Huxtable R, Brangan E, Selman LE. Real-world ethics in palliative care: a systematic review of the ethical challenges reported by specialist palliative care practitioners in their clinical practice. Palliat Med. 2021;35(2):315–34.
30. Svendsen SJ, Grov EK, Staats K. Home care nurses' ethical compass in palliative decision-making processes. Geriatr Nurs. 2025;65:103561.
31. Udeh NN, Idemili Aronu N, Ezeome ER. A qualitative study of the ethical issues encountered at end-of-life care at a university teaching hospital in Nigeria. J Med Ethics. 2026;52(4):239-44. doi:10.1136/jme-2024-110101
32. Willmott L, White B, Yates P, Mitchell G, Currow DC, Gerber K, et al. Nurses' knowledge of law at the end of life and implications for practice: A qualitative study. Palliat Med. 2020;34(4):524–32.
33. Wong EL-Y, Kiang N, Chung RY-N, Lau J, Chau PY-K, Wong SY-S, et al. Quality of palliative and end-of-life care in Hong Kong: Perspectives of healthcare providers. Int J Environ Res Public Health. 2020;17(14):5130.
34. Yildirim D, Kocatepe V, Türkmenoğlu A. Moral courage of palliative care nurses and affecting factors. BMC Palliat Care. 2025;24(1):179.
35. Silva MHA, Dantas THdM, Araúújo ACdM, Dantas DdS, Dantas MIdA, de Lucena BCM, et al. Content analysis of assessment tools used in post-stroke rehabilitation: A scoping review with linkage to the international classification of functioning. Int J Environ Res Public Health. 2025;22(8):1277.