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Nurses' Experiences of Moral Distress and Palliative Care Difficulties in Hospital Settings

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Abstract

To identify the difficulties encountered by nursing staff delivering palliative care to inpatients, and to assess the intensity of their stress of conscience during the provision of this care. In this cross-sectional, descriptive investigation, 143 nurses delivering palliative care in the intensive care and oncology departments of a university hospital were enrolled. Data collection instruments comprised the Nurses Descriptive Characteristics Form, the Palliative Care Difficulties Scale, and the Stress of Conscience Questionnaire. Data analysis was executed utilizing arithmetic means, Cronbach's alpha, Independent Samples t-tests, Analysis of Variance (ANOVA), Mann-Whitney U tests, Kruskal-Wallis tests, and Spearman's rank correlation. The subjects' average age was 31.26 ± 6.88 years. Regarding the conceptual definition of conscience, 25.9% of the cohort equated it with "compassion", whereas 21.0% characterized it as "empathy". Mean scores recorded from the Stress of Conscience Questionnaire and the Palliative Care Difficulties Scale were 86.8 ± 48.7 and 42.6 ± 8.3, respectively. No statistically significant correlation was observed between the global scores of the Palliative Care Difficulties Scale and the Stress of Conscience Questionnaire ($P > 0.05$). Conversely, statistically significant relationships were identified between the participants' Palliative Care Difficulties Scale scores and variables including sex and clinical department ($P \leq 0.05$). The findings indicate that nurses engaged in palliative care require targeted support, and that female sex, alongside postgraduate education, exerts a favorable influence on conscience. These results suggest that undergraduate and graduate nursing curricula should place greater emphasis on ethical dilemmas in palliative care. Nurses delivering palliative care in oncology and intensive care settings routinely confront diverse ethical dilemmas and experience moral distress while striving to maintain effective communication with patients and ensure continuity of care. Bolstering support for these professionals through national and international policy frameworks will enhance the overall quality of patient care.

Keywords: Palliative care, Stress of conscience, Care difficulty, Ethical issues, Nurse

Introduction

Conscience acts not merely as an internal alarm notifying us that our individual and professional values, core beliefs, ethics, or clinical standards are jeopardized by surrounding problems and conditions [1]. Still, it also reinforces the delivery of nursing care rooted in ethical principles [2]. Because the nursing profession involves intimate, continuous contact with patients to optimize their quality of life, notions such as conscience, the stress of conscience, and conscientious objection are sometimes interpreted as at variance with professional nursing roles [3, 4]. Nonetheless, given that nursing's primary focus is human well-being, these concepts must be integrated into the discourse on professional ethical values.

Stress of conscience has been operationalized by Glasberg *et al*. [5] as the distress stemming from a troubled conscience, which manifests when an individual suppresses their internal moral voice or when their personal conscience clashes with internal desires, other individuals, or societal expectations. Within clinical practice, stress of conscience emerges when nursing staff are blocked from practicing in harmony with their moral compass, when

they face ethically distressing situations [6] and systemic limitations that impinge upon their moral judgment, when they are compelled to act against their internal values [3, 7], or when they cannot resolve an ongoing ethical dilemma [8]. Factors triggering stress of conscience in long-term clinical settings encompass interpersonal friction, difficulties prioritizing tasks, compromising on optimal care standards, being pressured to administer interventions they deem inappropriate, institutional healthcare constraints that limit care duration, insufficient time to address patient needs, and spillover from personal life into professional obligations [6, 8, 9]. This form of stress is intimately tied to nurses' recognition that they cannot uphold their own ethical standards during patient interactions, and it is significantly exacerbated by barriers to delivering high-quality care and safeguarding patients from harm [8].

As an evaluative process for judging one's own thoughts and behaviors, conscience serves as an asset that helps nurses preserve their ethical integrity and provide proper patient care [10]. Consequently, conscience establishes the foundation for ethically sound nursing practice [11].

Clinical strategies designed to prevent or mitigate pain and suffering via early identification, precise assessment, and the management of physical, psychosocial, or spiritual distress are categorized under the umbrella of palliative care [12]. Palliative care, a crucial component of nursing practice, is a process in which conscience serves as a powerful determinant in decision-making that serves the patient's best interests [13].

Nurses frequently face obstacles throughout the management of patients undergoing palliative care. Specifically in palliative care settings, initiating dialogues about end-of-life trajectories and the dying process is highly challenging. Prior research involving palliative care nurses highlights that obstacles to care delivery include difficulties interpreting patient reactions to dying, communication breakdowns, breaking distressing news, and providing insufficient information to families [14, 15]. These complications surface with greater frequency in intensive care units and among populations managing chronic, advanced malignancies. Throughout this trajectory, nurses may endure stress of conscience as they navigate complex choices intended to maximize patient welfare [14].

A previous study noted that stress of conscience occurs frequently among healthcare professionals, fluctuates based on demographic characteristics, and correlates with burnout, occupational stress, the clinical environment, moral sensitivity, and care quality [6]. Because it heightens nursing staff's ethical sensitivity during care delivery, the stress of conscience is a critical variable. Currently, literature examining nurses' perceived palliative care difficulties alongside their stress of conscience concurrently remains scarce. This investigation aims to evaluate the levels of stress of conscience among nurses practicing in palliative and intensive care environments, to analyze the association between stress of conscience and perceptions of palliative care, and to determine whether variations in stress of conscience occur across different sociodemographic and occupational profiles. Concurrently, this study seeks to clarify how nurses conceptualize conscience and palliative care.

Research questions:

1. What level of conscience-related stress is experienced by nursing staff assigned to palliative and intensive care environments?
2. Does a meaningful correlation exist between nurses' experiences of conscience stress and how they perceive the delivery of palliative care?
3. Do background characteristics (such as gender, clinical unit, academic credentials, and length of service in the current department) lead to significant variations in nurses' levels of conscience stress?
4. How do sociodemographic and professional parameters (such as gender, assigned unit, and departmental tenure) affect nurses' overall outlook on palliative care?
5. What are the subjective viewpoints of nursing professionals regarding the definitive concepts of conscience and palliative care?

Materials and Methods

Design and methods

This research employed a descriptive, cross-sectional design to capture data from a cohort of 143 eligible nurses between January and June of 2023. Data collection was conducted at a university hospital in Turkey's Mediterranean region.

The target population encompassed the entire nursing workforce delivering end-of-life and supportive care within intensive care and oncology wards, noting that the institution does not feature an independent clinic officially designated as a "palliative care unit." Inclusion criteria required nurses to be actively stationed in these departments, fully briefed on the research objectives, willing to participate voluntarily, and able to complete the entire survey packet.

Conversely, personnel were excluded if they submitted incomplete forms, opted out mid-study, or were away on scheduled annual leave during the assessment window. Within this clinical context, the nursing role centers on managing patient symptoms, providing emotional and psychosocial reassurance, educating families, coordinating

multidisciplinary interventions, and optimizing patient comfort while upholding ethical principles and rigorous medical charting.
Data were collected through in-person interviews using structured questionnaires and established psychometric instruments. The participants filled out the forms under the researcher's direct guidance, taking roughly 15 minutes to complete.

Setting and sample
The available study population comprised 143 active nurses working within the intensive care and oncology wards of the designated hospital who were not currently away on sick leave or vacation.
To establish the sample size, calculations were performed using Epi Info™ StatCalc. Setting the confidence level at 99.99% and the Type I error rate at 5%, the minimum threshold for statistical power was determined to be 131 participants [16]. Since every eligible professional within the institutional framework agreed to join, the final analyzed sample totaled 143 nurses.

Data collection tools and methods
Nurses' descriptive characteristics form
Constructed by the authors based on prior literature, this 11-item demographic survey evaluates baseline characteristics (e.g., age and gender) and personal viewpoints on supportive care and conscience-driven stress [17, 18].

Palliative Care Difficulties Scale (PCDS)
Originally authored by Nakazawa *et al*. [19], the PCDS was adapted and psychometrically validated for Turkish clinical cohorts by Akdeniz Kudubeş *et al*. [20]. This instrument features 15 items scored on a 5-point Likert scale stretching from 1 (Never) to 5 (Always) to reflect the severity of obstacles encountered during care. Total scores range from 15 to 75. The structural design isolates five discrete core areas: multidisciplinary team communication, interactions with patients and families, availability of expert backing, symptom management, and care coordination. Higher cumulative values point to a greater burden of care difficulties. The internal consistency, measured via Cronbach's alpha, was 0.81 in the validation study by Akdeniz Kudubeş *et al*. [20] and reached 0.84 within our current sample [20].

Stress of Conscience Questionnaire (SCQ)
Designed by Glasberg *et al*. [5], the SCQ was adapted and validated for Turkish contexts by Aksoy *et al*. [18]. It contains nine items structured around a 6-point Likert scale. Every query requires two distinct responses, labeled Category A and Category B. Category A monitors situational frequency, asking how often a clinical scenario occurs on a scale from 0 (Never) to 5 (Every day). Category B evaluates the psychological impact, measuring how much that specific scenario burdens the respondent's moral compass, ranging from 0 (No, it does not trouble my conscience at all) to 5 (Yes, it troubles my conscience greatly). Individual item scores are derived by multiplying the frequency rating by the distress rating, and the products are summed to yield a global score (up to 225). Higher scores indicate more severe internal moral friction. The instrument's Cronbach's alpha was 0.74 in the Aksoy *et al*. [18] validation study and 0.88 in this investigation.
The research team administered these measurement packets directly to consenting nurses working in the oncology and intensive care units of University Hospital X. The total time required to complete the packet was approximately 12 min.

Data analysis
Quantitative analyses were conducted using SPSS Statistics 27 (IBM SPSS Statistics 27), employing descriptive statistics and frequencies to describe the baseline data. The normality of continuous data streams was verified using the Kolmogorov–Smirnov test and visual chart reviews. For data meeting parametric criteria, an "Independent Samples t-test" (t-test) was used to contrast the averages of two independent groups. In comparison, a one-way "ANOVA" (F-table value) was used for comparisons across three or more groups. If significant differences surfaced among three or more groups, a post-hoc Tukey test was performed, factoring in the homogeneity of variance.
Data distributions that deviated from normality were evaluated using non-parametric alternatives. Under these parameters, the "Mann-Whitney U" test (Z-table value) compared pairs of independent groups, and the "Kruskal-Wallis H" test (\chi^2-table value) compared three or more independent groups. Post-hoc pairs within multi-group comparisons were scrutinized using a Bonferroni adjustment. To identify the strength and direction of associations between non-normally distributed continuous scores, Spearman's rank correlation coefficient was employed.
A threshold of $P \leq 0.05$ was maintained across all tests to determine statistical significance.

Ethical and research approvals

In compliance with domestic ethical regulations, approval was granted by an institutional ethics review board (Decision Number: KAEK XXX, Decision Date: November 9, 2022). Administrative clearance to execute the investigation was obtained from the executive management of the participating hospital. Before initiating data collection, prospective subjects received a comprehensive explanation regarding the study's purpose in accordance with the Declaration of Helsinki, after which they provided written informed consent. Participants were explicitly informed that involvement was entirely voluntary, and that all responses would be kept strictly confidential and processed solely as scientific data.

Results and Discussion

The sample's mean age was 31.26 ± 6.88 years. Demographic distribution showed that 79.7% (n = 114) were female, 67.8% (n = 97) were stationed in intensive care units, 64.3% (n = 92) held a bachelor's degree, 53.8% (n = 77) lacked specific training in palliative care, 76.2% (n = 109) maintained a 40-hour workweek, and 58% (n = 83) were not considering leaving the nursing profession. The subjects' mean durations of service within their current department and the broader profession were 1.32 ± 0.47 and 9.08 ± 7.06 years, respectively.
The participants' mean SCQ score was 86.8 ± 48.7, whereas their mean PCDS score was 42.6 ± 8.3. No statistically significant correlation was observed between the cumulative scores of the PCDS and the SCQ ($P > 0.05$).
Table 1 details the subjects' initial cognitive associations regarding the concepts of conscience and palliative care. Conscience was most frequently linked to compassion (25.9%) and empathy (21.0%). Palliative care was primarily associated with effective or holistic care (28.7%), followed by death (14.7%) and end-of-life care (14.0%) **(Table 1)**.

Table 1. Participants' first associations with conscience and palliative care concepts. From: Challenges faced by nurses and their stress of conscience levels in providing palliative care: a cross-sectional descriptive study.

Concept	Response theme	Frequency (n)	Percentage (%)
Conscience	Compassionate attitude	37	25.9
	Empathic understanding	30	21.0
	Moral principle	11	7.7
	Sense of pity	11	7.7
	Internal moral guidance	8	5.6
	Mental tranquility	7	4.9
	Acting appropriately	6	4.2
	Emotional sensitivity	7	4.9
	Benevolent intention	5	3.5
	Miscellaneous responses*	21	14.6
Palliative Care	Comprehensive and effective care	41	28.7
	Association with death	21	14.7
	Care at the end of life	20	14.0
	Care for older adults	17	11.9
	Promotion of well-being	8	5.6
	Other responses**	34	25.1

*Other (Conscience): mother, nurse, self, humanity, elderly, child
Other (Palliative Care): chronic disease and pain, comfortable death, etc.
The mean SCQ score was recorded at 86.8 ± 48.7, and the mean PCDS score was 42.6 ± 8.3. Analysis confirmed the absence of a statistically significant relationship between cumulative SCQ and PCDS measurements ($P > 0.05$).

Table 2 highlights the comparison of mean PCDS and SCQ scores across various demographic and professional characteristics. To evaluate non-normally distributed data, the Mann-Whitney U test (Z-table value) was applied for two independent groups, while the Kruskal-Wallis H test $\chi 2$-table value) was used to compare three or more independent groups. Statistically significant differences emerged in PCDS scores by sex ($Z = -2.946$; $P = 0.003$), clinical department ($t = 2.195$; $P = 0.030$), and departmental length of service ($\chi 2 = 8.362$; $P = 0.039$). Post-hoc pairwise comparisons using Bonferroni correction demonstrated that this variance was driven by a contrast between staff with a departmental tenure of ≤ 1 year and those with tenures of 2–5, 6–9, or ≥ 10 years. No statistically significant differences were found in relation to age groups or total professional experience for either scale **(Table 2)**($P > 0.05$).

Table 2. Comparison of the mean scores participants obtained on the palliative care difficulties and stress of conscience questionnaire, by some of their characteristics. From: Challenges faced by nurses and their stress of conscience levels in providing palliative care: a cross-sectional descriptive study.

Participant characteristics (n = 143)	N	PCDS (Mean ± SD)	PCDS median [IQR]	SCQ mean ± SD	SCQ median [IQR]
Age category (years)					
≤ 25	30	42.17 ± 8.54	44.5 [8.0]	99.53 ± 57.66	100.0 [73.5]
26–30	51	41.37 ± 9.27	42.0 [11.0]	81.82 ± 47.47	72.0 [74.0]
31–35	30	45.43 ± 8.01	45.5 [12.5]	91.97 ± 42.73	97.0 [44.8]
> 35	32	42.38 ± 6.12	43.0 [9.0]	77.84 ± 46.04	89.0 [68.8]
Test statistic		$\chi^2 = 3.530$		F = 1.342	
P-value		P = 0.317		P = 0.263	
Sex					
Female	114	43.78 ± 7.35	45.0 [10.0]	90.16 ± 48.56	90.5 [61.5]
Male	29	38.04 ± 10.16	40.0 [11.0]	73.48 ± 47.93	84.0 [87.5]
Test statistic		Z = −2.946		Z = −1.303	
P-value		P = 0.003		P = 0.193	
Clinical department					
Intensive Care Unit	97	43.65 ± 7.49	45.0 [10.0]	87.29 ± 51.02	91.0 [72.0]
Oncology Unit	46	40.43 ± 9.49	42.0 [11.0]	85.69 ± 44.02	86.0 [56.0]
Test statistic		t = 2.195		t = 0.182	
p-value		P = 0.030		P = 0.856	
Years of service in the current department					
≤ 1 year (1)	11	34.73 ± 9.78	39.0 [17.0]	100.63 ± 53.67	115.0 [99.0]
2–5 years (2)	66	43.19 ± 6.67	43.5 [8.5]	94.25 ± 50.47	95.5 [54.3]
6–9 years (3)	25	42.00 ± 11.27	46.0 [11.0]	71.12 ± 40.41	70.0 [54.0]
≥ 10 years (4)	41	44.17 ± 7.14	45.0 [11.0]	80.56 ± 47.47	88.0 [62.5]
Test statistic		$\chi^2 = 8.362$		$\chi^2 = 5.666$	
p-value		P = 0.039		P = 0.129	
Post-hoc comparison		[1–2,3,4]		—	
Years of professional experience					
≤ 1 year (1)	10	38.00 ± 10.25	42.5 [11.0]	83.00 ± 67.62	109.5 [136.0]
2–5 years (2)	43	41.81 ± 7.32	41.0 [10.0]	104.96 ± 55.24	102.0 [88.0]
6–9 years (3)	36	43.77 ± 10.20	46.0 [9.8]	82.22 ± 35.79	94.5 [67.3]
≥ 10 years (4)	54	43.33 ± 7.00	44.0 [10.0]	76.24 ± 43.96	81.0 [56.5]
Test statistic		$\chi^2 = 6.374$		$\chi^2 = 6.485$	
P-value		P = 0.095		P = 0.090	

n: Number of participants, $\bar{x}$ ± SD =Arithmetic mean ± Standard Deviation; Independent Sample-t test = t; One-way ANOVA = F; Kruskal–Wallis H test = χ^2; Mann–Whitney U test = Z

Table 3 shows the comparison of overall PCDS and SCQ mean scores based on selected participant features. A statistically significant difference in cumulative SCQ scores was identified across educational status categories (F = 5.018; P = 0.002). Post-hoc Tukey pairwise comparisons, accounting for heteroscedasticity, indicated a significant difference between individuals holding a high school or associate degree and those with postgraduate credentials. Conversely, no statistically significant variances were detected in SCQ or PCDS scores relative to other descriptive attributes, including history of palliative care training, clinical caregiving approach, weekly working hours, or intentions to resign **(Table 3)**(P > 0.05).

Table 3. Comparison of the mean scores participants obtained on the overall palliative care difficulties and stress of conscience questionnaire, by some of their characteristics. From: Challenges faced by nurses and their stress of conscience levels in providing palliative care: a cross-sectional descriptive study.

Participant characteristics (N = 143)	n	PCDS (Mean ± SD)	PCDS median [IQR]	SCQ mean ± SD	SCQ median [IQR]

Educational attainment					
High school graduate (1)	23	44.00 ± 9.28	47.0 [10.0]	73.30 ± 29.60	87.0 [48.0]
Associate degree (2)	15	41.13 ± 8.36	44.0 [7.0]	60.80 ± 39.15	70.0 [63.0]
Bachelor's degree (3)	92	42.29 ± 8.39	42.0 [10.8]	89.09 ± 51.78	93.0 [69.8]
Postgraduate degree (4)	13	44.15 ± 5.51	44.0 [11.5]	124.15 ± 40.36	115.0 [63.5]
Test statistic		$\chi^2 = 3.223$		F = 5.018	
p-value		p = 0.359		p = 0.002	
Post-hoc comparison		—		[1,2–4]	
Palliative care training received					
Yes	66	42.23 ± 8.40	—	88.24 ± 42.81	93.0 [50.0]
No	77	42.94 ± 8.23	—	85.52 ± 53.54	88.0 [75.0]
Test statistic		Z = −0.298		t = 0.338	
p-value		p = 0.766		p = 0.736	
Approach to care delivery					
Patient-focused care	62	42.45 ± 9.45	44.5 [11.3]	77.58 ± 44.94	80.0 [71.0]
Patient- and task-focused care	79	42.63 ± 7.39	43.0 [8.0]	94.94 ± 50.72	95.0 [63.0]
Test statistic		Z = −0.414		Z = −1.780	
p-value		p = 0.679		p = 0.075	
Weekly working hours					
40 hours	109	43.49 ± 7.19	44.0 [9.0]	90.51 ± 49.67	91.0 [68.5]
45 hours	34	39.79 ± 10.77	43.0 [12.0]	74.79 ± 44.18	86.0 [65.0]
Test statistic		Z = −1.408		Z = −1.470	
p-value		p = 0.159		p = 0.141	
Intention to leave current position					
Yes	28	40.61 ± 7.95	40.0 [9.5]	100.86 ± 40.12	108.0 [48.5]
No	83	42.87 ± 7.75	44.0 [10.0]	82.43 ± 46.22	87.0 [65.0]
Undecided	32	43.72 ± 9.78	45.0 [11.0]	85.72 ± 59.95	78.5 [83.5]
Test statistic		$\chi^2 = 3.382$		F = 1.517	
P-value		p = 0.184		p = 0.223	

n Number of participants, $\bar{x}$ ± SD : Arithmetic mean±Standard Deviation; Independent Sample-t test = t; One-way ANOVA = F; Kruskal–WallisH test = χ^2; Mann–Whitney U test = Z.

Table 4 displays the three items reflecting the highest agreement and the three items reflecting the lowest agreement extracted from both the PCDS and the SCQ **(Table 4)**.

Table 4. Three statements with the highest agreement and three statements with the lowest agreement in the PCDS and SCQ. From: Challenges faced by nurses and their stress of conscience levels in providing palliative care: a cross-sectional descriptive study.

Scale/Item (n = 143)	N	Mean	SD
Palliative care difficulties scale (PCDS)			
Items receiving the highest levels of agreement			
Communication regarding symptom management within multidisciplinary teams is challenging.	75	3.68	1.09
Insufficient information is available concerning the management of cancer-related pain.	42	3.15	1.09
Exchanging information between hospital services and home-care providers is difficult.	33	2.97	1.03
Items receiving the lowest levels of agreement			
Obtaining support from specialist professionals for symptom management is difficult.	92	2.36	0.81
There is no specialist available for consultation regarding symptom control.	72	2.48	0.97
Responding to patients who express anxiety is difficult.	24	2.63	0.99
Stress of conscience questionnaire (SCQ) – Part A			
Items with the highest endorsement scores			
Does your healthcare work leave you with insufficient energy to spend time with your family as much as you would like?	33	3.55	1.52
How frequently do time pressures prevent you from delivering the care that patients require?	29	3.18	1.70
How often are you confronted with conflicting demands in your work environment?	48	2.76	1.52

Items with the lowest endorsement scores			
Have you ever withdrawn from patients or family members who required assistance or support?	19	1.40	1.61
Have you observed patients being verbally insulted and/or physically harmed?	22	1.45	1.63
Do you ever lower your expectations for high-quality care?	29	2.08	1.72
Stress of conscience questionnaire (SCQ) – Part B			
Items generating the greatest moral distress			
Does a lack of sufficient energy for family because of healthcare work cause you moral distress?	31	4.08	1.35
Does experiencing time limitations when providing necessary patient care cause you moral distress?	26	3.78	1.65
Does dealing with conflicting requests in the workplace cause you moral distress?	32	3.76	1.59
Items generating the least moral distress			
Does distancing yourself from patients or relatives who need support cause you moral distress?	15	2.30	2.02
Does witnessing patients being insulted and/or harmed cause you moral distress?	13	2.61	2.16
Does lowering your expectations for good-quality caregiving cause you moral distress?	16	2.66	2.08

Abbreviations: n = Number of participants, M = Mean, SD = Standard deviation, min = Minimum, max = Maximum.

In this study, nurses tasked with administering palliative care conceptualized conscience through terms such as "compassion," "empathy," "moral value," "sense of pity," and"inner voice," while defining palliative care as"effective or holistic care," "death," "end-of-life care," "elderly care," and "well-being." Existing literature similarly describes clinicians viewing conscience as a "compass" that steers clinical choices [10, 17], as well as an authority, an alert signal, a duty, and an internal sensitivity [21]. Cleary and Lees [1] characterize conscience as an affective origin that encompasses acting on professional intuition, recognizing clinical limits, and responding to patient vulnerability. Jodaki *et al*. [10] suggest that conscience channels an individual's emotional and cognitive processing during complex events, aiding in distinguishing right from wrong and motivating nursing staff to deliver ethically sound care. In an investigation of nurses in a dedicated palliative unit, the practice was defined as "communication," "the delivery of pain-free, trouble-free care and education to individuals in their final phase of life," "facilitating a peaceful and comfortable terminal period," and "supportive care" [22]. Consistent with the present study and historical data, conscience is defined diversely but remains an internal stimulus for making optimal decisions for patients in line with professional ethics. In definitions of palliative care, the core focus centers on terminal-stage care, optimizing quality of life, and preventing pain or distress. Within this environment, conscience serves as a critical driver that sharpens nurses' moral sensitivity during decision-making.

Regarding palliative care challenges, the priority issues identified by participants included communication barriers within the interdisciplinary team, gaps in information on cancer pain management, and obstacles to information sharing between institutional and home care networks. Conversely, subjects reported lower scores on items detailing the use of specialist consultation to manage symptoms or difficulties in responding to an anxious patient. In an investigation of Turkish nurses caring for dying patients, failing to alleviate a patient's pain emerged as a primary challenge [23]. Demir [14] notes that the palliative trajectory begins for patients and families at the time of a life-threatening diagnosis and progresses dynamically in response to evolving needs. The nurse-patient relationship is emphasized as a foundational mechanism for sustaining care quality, preserving ethical values, and making decisions that protect patient welfare [24]. Ethical struggles reported by palliative care nurses frequently include staff shortages, deficits in administrative or medical support, friction in collaboration with colleagues or families, and difficulties in addressing disparate needs across varied patient groups [24].

Inquiries involving intensive care and palliative care staff demonstrate that compromised institutional infrastructure, largely due to understaffing, complicates care delivery and results in suboptimal care standards [22, 25]. Related literature documents that conflicting directives issued by nursing supervisors or physicians [26], a lack of communication between clinicians and relatives, occupational stress, and the absence of protocols for end-of-life management complicate palliative interventions [25]. These findings highlight that palliative care challenges are multidimensional, arising from team dynamics, resource constraints, and patients and families alike. Minimizing these barriers is essential for palliative units because it improves nursing performance and upgrades care quality.

In this investigation, the factors generating the highest levels of stress of conscience and associated moral distress among participants included severe occupational exhaustion that depleted the energy needed for their own families, insufficient time to provide necessary patient care, and handling non-work-related demands. In contrast, the lowest levels of moral distress were tied to maintaining close connections with patients and families, not witnessing patient abuse or insults, and not downgrading personal standards of good care. When ethical dilemmas emerge, conscience can guide nurses to maintain high-quality, value-driven care [3, 8, 10, 27, 28]. Multiple studies note that nurses view conscience as a balancing mechanism between personal values and professional obligations, emphasizing the need for institutional, regional, and national frameworks to mitigate the stress of conscience driven by ethical dilemmas [17, 23]. Other data show that nurses experience severe stress of conscience when

institutional barriers prevent them from delivering the standard of care they consider a professional obligation [8, 23, 29], aligning with the trends observed here.

In the current sample, female nurses in intensive care units with a departmental tenure of two years or more recorded significantly higher PCDS scores, consistent with previous findings among palliative care clinicians [30]. Conversely, one study noted that palliative care practices and difficulties had no meaningful relationship with sex, clinical placement, or professional experience [31]. The discrepancy observed in this study may reflect regional variations or localized cultural expectations regarding female gender roles.

Finally, only participants with postgraduate education showed significantly elevated SCQ scores. Prior Turkish data contrast with this finding, showing that age, professional tenure, voluntary career choice, and ward understaffing significantly impacted nurses' SCQ scores [29]. Another study reported a significant correlation between conscientious intelligence and educational background, with bachelor's degree holders achieving higher mean scores [31]. Based on our results, the increased stress of conscience observed among postgraduates may indicate that greater academic training augments a clinician's ethical awareness and moral sensitivity.

No statistically significant differences were observed between participants' scores on the SCQ and the PCDS for variables such as receipt of palliative care training, clinical caregiving approach, weekly working hours, or intentions to resign. In an investigation by Van Diepen *et al*. [32], a decrease in the volume of patients managed corresponded to a reduction in the level of stress of conscience. Similarly, Özden & Parlar Kılıç demonstrated that total professional experience and departmental tenure exerted a significant positive influence on palliative care practices [31]. Within the current inquiry, nursing staff who had not undergone palliative care training recorded significantly higher scores on the Palliative Care Difficulties Scale; conversely, attributes such as educational status, institutional tenure, overall professional experience, and the completion of palliative care training showed no meaningful correlation with conscientious intelligence [31]. These conflicting outcomes across studies are likely attributable to discrepancies in participant workloads.

Because the primary objective of healthcare operations is to secure optimal and correct outcomes for individuals requiring medical interventions and nursing care, clinical practice inherently constitutes a moral endeavor. In this study, the cohort's mean SCQ score was moderate (86.8 ± 48.7), whereas the mean PCDS score exceeded the midpoint (42.6 ± 8.3). No statistically significant correlation was identified between the mean scores of these two metrics. In comparison, a prior study using a version of the PCDS with a maximum possible score of 160 reported a participant mean score of 56.51 ± 7.81 [31]. In another evaluation, the mean SCQ score reported by participants closely matched those obtained in the present investigation [29]. It is well documented that palliative care nurses routinely encounter ethical dilemmas while attempting to make optimal decisions for patient welfare, which can induce emotional distress. Research indicates that clinicians who view conscience as an internal alarm preventing harm to others endure more severe stress of conscience [3]; furthermore, critical care nurses have reported that heavy workloads, time constraints, institutional regulations, and administrative demands for rigorous documentation precipitate conscience-based conflicts [33]. Consequently, palliative care obstacles and moral distress are major factors shaping care delivery.

To mitigate conscience-related issues among nursing professionals, it is vital to foster ethical reasoning, critical self-awareness, and efficient interpersonal communication competencies through integrated theoretical and clinical education [1]. Additionally, ensuring that staff feel supported and understood by leadership—effectively establishing a professional culture where clinicians can openly communicate their perspectives and emotions—remains highly critical [22]. Jodaki *et al*. [33] highlighted the need to draft clinical guidelines to minimize the factors driving conscience conflicts among intensive care nurses. They also recommended tracking stressors of conscience and occupational burnout, providing psychological counseling support, implementing internal institutional rotations, and conducting stress management workshops. Guided by the findings of this study and the existing literature, it is evident that nurses experience stress of conscience throughout the palliative care continuum, underscoring the need to heighten professional awareness further.

Limitation

The generalizability of these findings may be limited because this inquiry used a cross-sectional, single-center design that included only nurses delivering palliative care in intensive care and oncology wards. Furthermore, relying on self-reported instruments introduces the potential for response and recall biases. Finally, the descriptive framework of this investigation precludes the determination of definitive causal relationships.

Implications and recommendations for practice

This research demonstrated that nursing staff assigned to intensive care and oncology departments where palliative care is administered endure prominent levels of stress of conscience. Although a direct correlation between stress of conscience and global perceptions of palliative care was not established, stress intensity fluctuated in accordance with specific sociodemographic and professional parameters, including gender, academic background, and years of clinical experience. Similarly, nurses' views on palliative care varied by assigned department and length of employment.

The participating nurses predominantly linked the concept of conscience with compassion and empathy, while equating palliative care with holistic and effective interventions, thereby underscoring the moral framework of palliative operations. These insights point to a clear necessity for targeted institutional and policy-driven interventions to alleviate stress of conscience among nurses, particularly within supportive care environments. Furthermore, expanding ethics coursework concerning conscience and palliative care within both undergraduate and graduate nursing curricula may better prepare clinicians to navigate ethical dilemmas, ultimately raising the standard of patient care.

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Participants/nurses gave written consent for the publication of personal information contained in this study.

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