

Moral Distress and Ethical Decision-Making among Nurses Caring for Patients with Advanced Illness

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Abstract

Nurses caring for people with advanced illness face decisions in which patient preferences, expected benefit, treatment burden, family expectations, professional duties, and organizational realities may conflict. Ethical difficulty alone, however, does not establish moral distress. This article develops an ethical decision and moral-resilience account that separates the morally salient event, the nurse's appraisal, practical capacity to speak or act, criterion-based moral distress, persistence as moral residue, and conditions supporting recovery. Professional power and voice, ethical climate, resource constraints, recurrent exposure, reflective practice, and interprofessional ethics support are treated as interacting conditions rather than interchangeable causes. The central contribution is a conditional framework in which moral distress is most plausible when a morally consequential concern remains unresolved or cannot be ethically accommodated, while later outcomes depend on recurrence and multilevel support. Moral resilience is interpreted as professional ethical capacity, not a substitute for organizational responsibility.

Keywords: Moral distress, Ethical decision-making, Moral resilience, End-of-life care, Nursing ethics, Palliative care

Introduction

Advanced-illness nursing places professionals close to decisions about treatment escalation, limitation, comfort, surrogate involvement, and competing interpretations of benefit and burden. Moral distress is well documented across nursing, but reported causes and consequences vary across settings and methods [1]. In end-of-life care, nurses describe distress across intrapersonal, interpersonal, organizational, and structural domains [2], while systematic evidence identifies recurrent concerns involving autonomy, beneficence, communication, family-professional disagreement, and palliative practice [3]. These domains overlap with moral distress but are not synonymous with it.

Advanced illness reliably creates ethical complexity without necessarily creating moral distress. ICU end-of-life syntheses describe uncertainty, perceived disproportionate treatment, professional responsibility, and family expectations [4]. Some situations may culminate in moral distress; others remain difficult decisions among defensible options. This article therefore asks how ethically salient situations become distressing in a specifically moral sense, how professional voice affects that transition, and why similar clinical situations can produce different outcomes. The ethical decision and moral-resilience framework links ethical appraisal to practical actionability, recurrent exposure, reflective practice, ethics support, and organizational conditions without treating any one factor as sufficient.

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Conceptual foundations

Moral distress requires criteria that distinguish it from ethically difficult practice. Concept clarification shows that the term has been used for overlapping experiences including constraint, conflict, uncertainty, powerlessness, and psychological distress [5]. A narrative synthesis identified a morally salient event, psychological distress, and a defensible relation between the two as central features [6]. A difficult conversation, disagreement about goals, or prognostic uncertainty therefore cannot be classified as moral distress solely because it is emotionally taxing. Empirical bioethics further distinguishes moral tension, uncertainty, constraint, conflict, and dilemma, which differ in their relationships to action and what remains after an event [7]. Constraint is important but not exhaustive: distress may also arise when authority is contested or no ethically acceptable resolution can be reached. Moral resilience must likewise remain distinct from simple endurance. Concept analysis frames it as a capacity for preserving or restoring integrity in moral adversity [8], while newer synthesis emphasizes ethical appraisal, professional competence, and collaboration [9]. Here, resilience is a professional-ethical resource supporting agency; it neither validates the underlying situation nor replaces organizational responsibility [10].

Moral distress in advanced-illness nursing

Nurses caring for dying patients describe situations in which they perceive suffering, burdensome treatment, disagreement, or inadequate recognition of the patient's condition while remaining involved in care [11]. Pediatric intensive-care evidence similarly highlights dignity concerns, insider knowledge, and environmental constraints [12]. These findings place moral distress within relational and organizational contexts rather than solely within individual emotion.

Critical-care reviews identify perceived futile treatment, conflict, limited authority, teamwork problems, and resource constraints among recurrent sources [13]. Yet quantitative synthesis shows substantial heterogeneity in reported moral-distress levels across countries, clinical areas, and measurement approaches [14]. Comparable events can therefore be experienced differently according to role, setting, authority, relationships, and support.

A practical distinction is needed between the ethical event, appraisal, response constraints, and subsequent professional consequences. **Table 1** defines the article's working distinctions.

Table 1. Distinguishing ethical difficulty, moral distress, persistence, and adaptive ethical capacity in advanced-illness nursing

Analytical unit	Defining question	Core feature	What must not be assumed
Ethical tension or uncertainty	What is ethically at stake, and is the preferred course clear?	Competing considerations or incomplete information	That one uniquely correct action is already known
Ethical conflict or dilemma	Are values, duties, preferences, or stakeholder positions in conflict?	Competing morally relevant positions	That disagreement itself is moral distress
Constraint or limited actionability	Can the nurse influence, contest, escalate, or act?	Restricted authority, time, resources, communication, or influence	That all constraint is external or absolute
Moral distress	Is distress meaningfully related to a morally salient unresolved event?	Moral salience plus psychologically experienced distress	That sadness, workload stress, or disagreement alone is sufficient
Moral residue	Does moral impact persist beyond the episode?	Lingering unresolved moral effect	That every distressing event produces residue
Moral resilience	Can ethical agency be preserved or restored?	Reflective capacity, integrity, collaboration, adaptive engagement	That resilience removes the ethical problem

Note: Categories may coexist within one episode and are not a temporal staging model.

Ethical decision-making context

Ethical decisions in advanced illness occur within settings that distribute authority differently. Home hospice requires clinicians to negotiate responsibility within the patient's domestic space, where family practice and professional obligations intersect [15]. In intensive care, withdrawal-related decisions involve autonomy, uncertainty, emotional presence, and interprofessional responsibility within a more formal institutional structure [16]. The same ethical concern may therefore have different action possibilities across settings.

Constraint is not unique to end-of-life treatment decisions. ICU restraint decisions illustrate tension between safety, autonomy, dignity, and limited alternatives [17]. This evidence is not an end-of-life proxy; it clarifies a mechanism. Moral concern becomes professionally consequential when what a nurse judges ethically important diverges from what the nurse is authorized or practically able to influence. Ethical context thus supplies conditions in which moral distress may, but need not, develop.

Patient autonomy

Patient autonomy in advanced illness may be communicated directly, reconstructed through prior wishes, or interpreted through surrogates. Nurses often hold morally relevant knowledge because sustained bedside contact reveals changes in tolerance, preferences, and burden that may not automatically enter formal deliberation. In nursing-home end-of-life care, nurses described professional autonomy as shaping their ability to enact the moral dimension of care [18].

Autonomy is therefore partly an actionability problem. A nurse may recognize a preference yet lack authority to alter treatment or convene review; another may have meaningful access to deliberation and help translate values into decisions. Patient autonomy functions here both as an ethical principle and as a test of whether professional voice can carry relevant knowledge into care planning.

Beneficence and non-maleficence

Benefit and harm become difficult to judge when treatment offers uncertain physiological benefit while imposing burdens that may conflict with comfort, dignity, or goals. End-of-life literature repeatedly identifies beneficence and non-maleficence alongside autonomy [3], but these principles do not mechanically determine one course. Clinicians and families can legitimately weigh survival, reversibility, suffering, and uncertainty differently.

For nurses, the moral problem sharpens when observed burden is not reflected in the direction of care. Withdrawal-related critical-care evidence shows autonomy, uncertainty, and professional responsibility converging around benefit-burden judgments [16]. Nursing-home evidence likewise shows that professional autonomy affects the ability to act on one's moral understanding of end-of-life care [18]. These principles are therefore appraisal dimensions whose consequences depend partly on deliberation and actionability.

Family-professional value conflict

Family-professional disagreement may involve different interpretations of hope, duty, acceptable burden, prior wishes, or suffering. It can intensify ethical difficulty but does not establish that either party is unreasonable or that a nurse is experiencing moral distress. The relevant question is whether conflict remains unresolved in a way that links a morally salient concern to the nurse's distress.

Among ICU nurses caring for patients receiving comfort-measures-only care, preparedness for family questions and inclusion in relevant discussions were associated with moral-distress experiences [19]. This does not make families the cause of distress. It instead identifies a relational problem: bedside responsibility without adequate participation in deliberation can widen the gap between responsibility and influence.

Treatment limitation and perceived futility

Perceived disproportionate or futile treatment is a recurrent context for reported moral distress [13]. The ethical problem is rarely continuation alone. Prognostic uncertainty, different interpretations of benefit, family preferences, timing of goals-of-care discussions, and professional authority all shape whether treatment is viewed as proportionate or unacceptable. End-of-life qualitative evidence also locates the experience within relationships and care organization [11].

Perceived futility is therefore treated as a contested appraisal, not an objective trigger. Nurses may judge that treatment no longer serves the patient while physicians or families hold a different view under uncertainty. Moral distress depends not on disagreement alone but on a morally salient concern, distress related to that concern, and inadequate means of influencing or reconciling the situation. Nurse inclusion in comfort-focused discussions may narrow the gap between bedside responsibility and formal authority [19].

Resource and organizational constraints

Ethically responsive care requires time, staffing, information, coordination, and opportunity for deliberation. The "Slow Care" model argues that compressed time can erode relational nursing and the space required for attentive judgment [20]. Organizational evidence also links moral-distress experiences with leadership communication and resource conditions [21].

Canadian ICU nurses described responses including action, avoidance, and acquiescence, while recommending stronger institutional support and greater capacity to address distress-producing conditions [22]. These divergent responses resist a simple stimulus-response model. Limited resources may create workload stress, moral distress, both, or neither; classification depends on whether morally important care is obstructed and whether the conflict remains unresolved.

Ethical climate

Ethical climate concerns how organizational practices and relationships are experienced as supporting or constraining ethical care. It should not be treated as a deterministic cause. In one hospital study, ethical climate was related to job satisfaction whereas moral distress did not show the same relationship [23]. In pediatric intensive care, a more favorable ethical climate was associated with lower moral distress [24]. These findings require outcome- and setting-specific interpretation.

A recent meta-analysis nevertheless found an overall inverse association between ethical climate and nurses' moral distress, with variation across settings and methods [25]. Bibliometric mapping further shows multiple conceptual and measurement traditions within ethical-climate research [26]. The framework therefore treats climate as a contextual modifier that may shape voice, deliberation, and expectations of fair response, without eliminating ethically difficult events.

Professional power and voice

Professional voice includes access to decision processes, perceived legitimacy, practical influence, psychological safety, and an expectation that raising concern can prompt review. Nurse-leader moral distress has been conceptualized within a wider moral ecology in which organizational position shapes action and inaction [27]. A scoping review of care leaders likewise identifies both individual and structural pressures, showing that formal authority does not guarantee practical agency [28].

Leadership evidence identifies leadership qualities, workload and resource management, and organizational culture as recurring domains in moral-distress mitigation [29]. Moral injury must remain separate: palliative and oncology nurses can report both moral distress and moral injury, and the constructs may be strongly related without representing stages of one process [30]. Professional voice is therefore one condition affecting whether morally salient concerns can be translated into action, not a universal solution.

Table 2 summarizes the principal interaction domains while keeping clinical judgment, organizational conditions, authority, and responsibility distinct.

Table 2. Interaction domains shaping nurses' responses to treatment-limitation and perceived-futility decisions

Interaction domain	Central ethical question	Potential mismatch	Responsibility locus
Treatment benefit and burden	Does intervention remain proportionate to condition and goals?	Divergent clinical interpretations or prognostic uncertainty	Interprofessional team with patient/surrogate participation
Patient preference and authority	Are decisions aligned with expressed or reconstructable values?	Capacity limits, surrogate disagreement, incomplete preference information	Patient/surrogate and accountable clinicians
Family-professional relationship	Can disagreement be explored without adversarial escalation?	Communication breakdown or role ambiguity	Team and organization
Nursing professional voice	Can the nurse raise, document, escalate, and influence concern?	Hierarchy, exclusion, low psychological safety	Nursing/medical leadership and organizational governance
Resource and workflow capacity	Is there time and staffing for observation, communication, and reflection?	Time compression, workload, fragmented coordination	Organization and service leadership
Ethical climate and ethics infrastructure	Will concerns receive fair hearing and structured review?	Weak deliberative norms or inaccessible ethics support	Organization and interprofessional leadership
Recurrent exposure	Does the unresolved pattern recur?	Persistent systemic conditions	Structural causes remain organizational responsibilities

Note: The matrix identifies relationships and responsibility domains; it does not imply a deterministic sequence.

Development of moral distress

The framework's central transition begins with classification. An event must be morally salient to the nurse, and psychological distress must be meaningfully related to that moral significance [6]. Concept clarification likewise cautions against treating every ethically difficult or emotionally demanding event as moral distress [5]. Ethical uncertainty, conflict, or emotional difficulty can therefore be substantial without satisfying the criterion. Empirical bioethics supports preserving distinctions among tension, uncertainty, constraint, conflict, and dilemma because appraisal and capacity to respond differ across these experiences [7].

The second element is unresolved actionability. A nurse may know what seems ethically preferable, perceive several defensible options, or remain uncertain; in each case, professional voice and practical influence shape whether the concern can enter deliberation and whether an ethically acceptable accommodation is possible. Reported responses of action, avoidance, and acquiescence show that constrained situations do not produce one uniform outcome [22]. In the proposed synthesis, moral distress is most plausible when a morally salient concern is accompanied by distress and remains insufficiently resolvable through available professional action, communication, or deliberation. This is a conditional relationship, not a claim that every constraint causes distress or that constraint is the only route to moral distress.

Moral residue and recurrent exposure

Moral distress can resolve with the event, persist beyond it, or recur when similar circumstances return. A metaethnography of emergency and critical-care nurses describes continuing effects of morally distressing experiences, including emotional and professional consequences that may extend beyond an individual episode

[31]. Persistence is important because advanced-illness nurses may repeatedly encounter treatment conflict, perceived suffering, communication failures, or limited decision influence rather than one isolated ethical event. The term *moral residue* is used here for a lingering moral effect after the immediate event has passed. It should not be assumed whenever moral distress occurs, and recurrent exposure should not be treated as automatically cumulative. Some concerns are resolved; some are reinterpreted through team deliberation; others remain professionally significant. Moral injury must remain analytically separate from both distress and residue. Although distress and moral injury can coexist and are empirically related [30], the available evidence does not establish a universal sequence in which moral distress develops into moral injury. The framework therefore represents recurrence, persistence, and moral injury as distinguishable possible states rather than inevitable stages.

Moral resilience and reflective practice

Moral resilience offers one route through which nurses may preserve or restore ethical agency during moral adversity. Cross-sectional nursing research reports an inverse relationship between moral resilience and moral distress or moral injury [32]. This association is consistent with resilience as a potentially protective professional resource, but the study design does not establish that greater resilience causes lower distress. A systematic review and meta-analysis likewise identifies moral resilience as a meaningful nursing construct while documenting variation in its measurement and correlates [33].

Resilience is also relational. Among interdisciplinary healthcare professionals, moral resilience has been examined alongside burnout, emphasizing that adaptation occurs within professional environments rather than only within individual psychology [34]. Moral case deliberation provides a more explicitly ethical mechanism: structured reflection can help clinicians examine values, responsibilities, uncertainty, and possible actions while remaining attentive to the moral meaning of practice [35].

Reflective practice in the proposed framework therefore has two functions. First, it can improve ethical interpretation by separating disagreement, uncertainty, constraint, and moral distress. Second, it can help restore agency by identifying what can be raised, reconsidered, negotiated, or escalated. Reflection is not presented as a method for teaching nurses to tolerate unacceptable conditions. When recurrent distress reflects staffing, hierarchy, exclusion from decisions, or inaccessible ethics infrastructure, organizational correction remains necessary.

Interprofessional ethics support

Ethics support can create structured opportunities for concerns that ordinary workflow fails to resolve. Digital ethical reflection in home nursing has been experienced by nurses and leaders as a means of discussing ethically challenging situations across geographically dispersed practice [36]. Such approaches illustrate how reflection may be institutionalized rather than left to informal coping.

Evidence for intervention effectiveness remains limited. A systematic review of interventions intended to reduce moral distress among intensive-care clinicians found heterogeneous interventions and methodological limitations, preventing strong conclusions about what reliably reduces distress [37]. Action research involving targeted clinical ethics support has shown the feasibility of combining reflection with organizational engagement in morally demanding practice [38]. More recent intervention-development work likewise emphasizes that responses to moral distress should be informed jointly by empirical evidence and ethics rather than assuming that generic well-being interventions are sufficient [39].

Interprofessional ethics support is consequently treated as enabling infrastructure. Its functions may include clarifying the ethical problem, ensuring that relevant voices are heard, distinguishing disagreement from actionable constraint, creating escalation routes, documenting recurring organizational patterns, and facilitating follow-up. The evidence does not justify assuming that consultation, reflection, or debriefing alone will remove moral distress. Their value depends on accessibility, authority, timing, team participation, and whether recommendations can alter the conditions that generated the problem.

Proposed ethical decision–moral distress framework

The proposed framework integrates the preceding evidence without treating associations as established causal pathways. It begins with a morally salient advanced-illness decision or care situation. Examples include treatment limitation, perceived disproportionate intervention, competing interpretations of patient preferences, family-professional disagreement, or concern that organizational conditions prevent ethically appropriate care. The first analytical task is ethical appraisal: what values, duties, uncertainties, harms, benefits, preferences, and professional obligations are in tension?

The second task is assessment of actionability. Professional voice, formal authority, team relationships, available time, access to information, and ethics infrastructure influence whether a nurse can raise the concern and participate meaningfully in its resolution. Ethical difficulty can remain difficult without becoming moral distress when deliberation yields a defensible accommodation or when the nurse retains sufficient agency to act consistently with professional obligations. Conversely, unresolved moral concern accompanied by distress

becomes more plausibly classifiable as moral distress when relevant action is blocked, ineffective, excluded, or repeatedly unavailable [5-7].

The third task concerns what happens after the episode. Recurrent exposure may leave persistent moral effects [31], whereas reflection, moral resilience, meaningful professional voice, interprofessional ethics support, and organizational response may help preserve or restore ethical agency [32-39]. These are conditional resources rather than guaranteed remedies. Ethical climate and leadership operate across the framework because they influence whether concerns can be voiced, whether deliberation is taken seriously, and whether recurrent organizational causes are corrected [21, 25, 27-29].

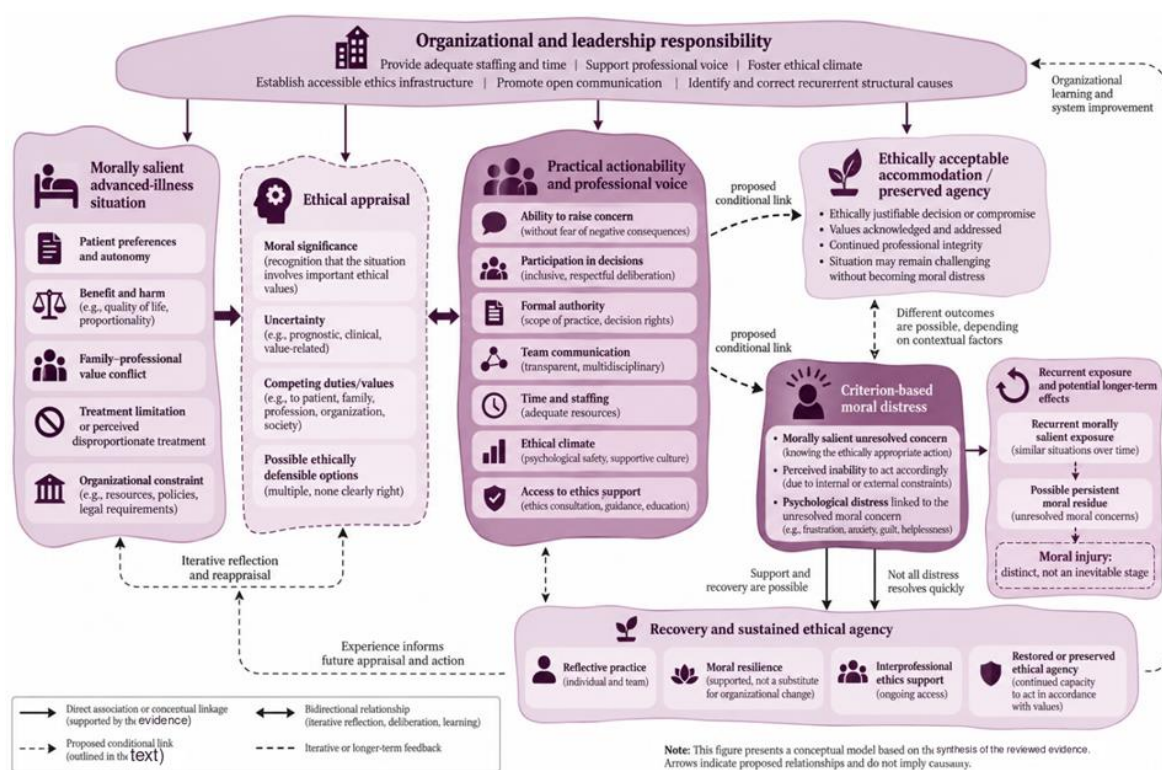


Figure 1. Conditional ethical-decision and moral-distress architecture in advanced-illness nursing

Failure and recovery pathways

The framework identifies failure when morally salient concerns remain unresolved while conditions that limit actionability persist. Failure can occur through exclusion from decision-making, repeated dismissal of bedside concerns, inadequate staffing or time for communication, inaccessible ethics resources, or an ethical climate in which speaking does not lead to meaningful review. These conditions can recur even when an individual nurse is reflective, experienced, and resilient [40-45].

Recovery is not simply the disappearance of distress. A morally difficult episode may remain painful while professional integrity and agency are preserved. Recovery may involve clarification of goals, better communication, meaningful participation in decisions, reassessment of treatment proportionality, formal ethics deliberation, peer reflection, leadership response, or correction of an organizational constraint. Evidence on moral resilience and ethics support makes these plausible resources [32-39], but their effectiveness is conditional and incompletely tested.

The framework therefore distinguishes *adaptation to moral adversity* from *resolution of the source of moral adversity*. The first may involve reflection and resilience; the second may require changes in authority, staffing, workflow, communication, ethics infrastructure, or policy. Conflating them risks transforming a structural ethical problem into an individual coping deficit [46-49].

Organizational responsibilities

Organizations influence whether ethically difficult care is discussable, reviewable, and correctable. Ethical climate is associated with moral-distress outcomes [24, 25, 50], and nurses identify communication, resources, and institutional support as relevant conditions [21, 22]. Organizational responsibility therefore extends beyond offering wellness resources after distress occurs.

A responsibility-preserving approach includes adequate staffing and time for communication; accessible escalation mechanisms; routine inclusion of nursing knowledge in goals-of-care deliberation; support for

interprofessional disagreement without retaliation; timely ethics consultation; and mechanisms for identifying recurrent patterns. If the same moral problem repeatedly emerges because a service lacks personnel, authority clarity, or functioning review pathways, repeated resilience training alone does not address the source. Organizations also require feedback. Ethics consultations, incident reviews, reflective forums, and leadership conversations should not function only as episodic support for individuals. Aggregated patterns can reveal recurring points where responsibility exceeds authority or where the same ethical conflict repeatedly becomes difficult to resolve. This learning function connects ethical support to governance.

Nursing leadership implications

Nursing leaders occupy an intermediate position between bedside experience and organizational authority. Their role includes creating routes through which concerns can be raised, ensuring that nurses participate in relevant decisions, protecting respectful disagreement, and translating recurrent bedside patterns into organizational action. Leadership reviews suggest that supportive leadership, workload management, resource allocation, and culture are important domains in moral-distress mitigation [29].

Leaders may also experience moral distress themselves when accountable for care quality but constrained by resources or higher-level decisions [27, 28]. Leadership should therefore not be conceptualized as a simple top-down remedy. Nurse managers require sufficient authority, information, resources, and executive responsiveness if they are expected to support frontline ethical agency.

Reflective practice and resilience initiatives are most defensible when paired with these structural responsibilities. Leaders can normalize ethical reflection without implying that distress signals personal weakness. They can also distinguish situations requiring emotional support from those requiring escalation, policy review, workload correction, or interprofessional decision reform.

Research agenda

Future research should first improve construct discrimination. Studies should distinguish moral distress from general occupational stress, burnout, grief, ethical uncertainty, role conflict, moral residue, and moral injury rather than treating correlated measures as interchangeable. Designs should specify the morally salient event and document how psychological distress is linked to it.

Second, longitudinal research is needed to test temporal propositions. Current evidence does not establish when distress resolves, when residue persists, or whether recurrent exposure produces cumulative effects. Repeated-measures studies could examine whether changes in voice, ethical climate, staffing, or ethics support precede changes in moral-distress trajectories.

Third, multilevel designs should test the proposed actionability mechanism. Measures of professional voice, decision inclusion, formal authority, team communication, staffing, leadership, and ethics infrastructure could be examined simultaneously rather than as isolated predictors. Such work should test alternative explanations including workload, burnout, traumatic exposure, and general organizational stress.

Fourth, intervention research should move beyond before-and-after satisfaction outcomes. Trials and robust quasi-experimental studies should distinguish interventions that strengthen individual reflective resources from those that change team deliberation or organizational structures. Outcomes should include ethical agency, recurrence of the precipitating problem, decision participation, moral-distress measures, implementation fidelity, and unintended effects.

Results and Discussion

This framework explains moral distress as a conditional relationship among morally salient events, ethical appraisal, practical actionability, and psychological distress rather than as a synonym for difficult care. That distinction matters in advanced illness because uncertainty, family disagreement, treatment limitation, and emotional burden are common even when clinicians retain meaningful agency and reach ethically defensible decisions.

Professional power and voice provide the framework's principal conditional link. Nurses may have extensive bedside knowledge and responsibility yet unequal access to formal decision-making. When concerns can be raised, discussed, and translated into action, ethical difficulty may remain without producing criterion-based moral distress. When concerns remain unresolved while meaningful action is repeatedly unavailable, moral distress becomes more plausible. This proposition integrates existing evidence but remains a synthesis requiring direct testing.

The framework also separates recovery from individual accommodation. Moral resilience and reflective practice may preserve ethical agency, while ethics support may improve deliberation and escalation. Yet recurrent organizational constraints require organizational responses. This distinction avoids interpreting resilience as a duty to withstand preventable ethical adversity.

Several rival explanations remain important. Workload, burnout, grief, exposure to death, poor communication, and generalized occupational stress can produce distress without a specifically moral mechanism. Future studies should therefore demonstrate moral salience rather than infer it from setting alone. Similarly, associations between ethical climate, resilience, and distress should not be read as proof of directionality.

Limitations

The framework draws on evidence from heterogeneous nursing settings, including intensive care, palliative care, nursing homes, home care, and broader hospital practice. Transfer across these contexts requires caution because authority structures, patient populations, resources, and decision processes differ.

Much of the empirical literature is cross-sectional or qualitative. Associations involving ethical climate, resilience, professional voice, and moral distress cannot establish causal direction. Measurement is another limitation: moral-distress instruments vary in definitions and may capture overlapping constructs. Evidence for interventions remains heterogeneous and insufficient for strong comparative conclusions [37].

The framework is conceptual rather than validated. Its proposed actionability and recovery pathways require prospective testing, and it should not be interpreted as a diagnostic algorithm. It also centers nursing while recognizing that advanced-illness decisions are interprofessional and relational. Perspectives of patients, families, physicians, other clinicians, and organizational decision-makers remain essential to testing the model [51-57].

Conclusion

Moral distress in advanced-illness nursing is best understood neither as every ethically difficult encounter nor as an exclusively individual response. It arises most plausibly when a morally significant concern is linked to psychological distress and remains inadequately resolvable within the nurse's available professional agency.

Ethical appraisal, professional power and voice, organizational conditions, recurrent exposure, resilience, reflective practice, and interprofessional ethics support should therefore be examined as distinct but interacting elements. Preserving these distinctions clarifies why similar clinical events can produce different professional experiences and why recovery cannot be assigned solely to individual resilience.

The proposed framework places responsibility at multiple levels. Nurses require capacities for ethical reflection and communication, but organizations and leaders remain responsible for the conditions under which concerns can be voiced, decisions reviewed, resources allocated, and recurrent ethical problems corrected. This combined focus offers a testable basis for studying moral distress while protecting both professional agency and organizational accountability.

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