Nurses’ Moral Distress, Burnout, and Intentions to Leave: An Integrative Review

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ABSTRACT
Moral distress has been widely addressed across the nursing profession and within other disciplines. Forensic nurses are a vital part of the nursing profession as they care for complex patients who may suffer physically and psychologically. However, forensic nurses’ moral distress in the context of caring for victims of violence has not been addressed. This integrative review of the literature reveals the consequences of moral distress on the nursing workforce particularly regarding nurses’ burnout and intentions to leave their jobs. Turnover contributes to the country’s critical shortage of nurses, which affects the quality of care patients receive and increases the costs for healthcare institutions.

KEY WORDS:
Burnout; forensic nurses; intention to leave; moral distress; nurses

Background
Forensic nurses are an integral part of the nursing profession as they address the needs of patients who are affected by different types of violence such as sexual assaults or abuse. In addition to caring for victims of trauma, forensic nurses collaborate with healthcare providers and social and legal personnel to investigate and interpret clinical signs to determine the reasons for intentional and unintentional injuries, describe the relationships between injury and evidence, and interpret the association of influencing factors (International Association of Forensic Nurses & American Nurses Association, 2015). Because forensic nurses care for patients with complex healthcare needs, these nurses encounter situations in which they face many ethical challenges—such as reporting the abuse of patients who wish to remain anonymous. This may be challenging to forensic nurses, as they are committed to protecting patients' confidentiality and respecting their wishes (Walker, 2017). These situations, among others, may lead forensic nurses to experience moral distress.

Defined by Jameton (1984) as the phenomenon in which a person knows the right action to take but is constrained from taking it, moral distress depends on the individual’s obligations and values and is separate and distinct from emotional distress. Moral distress relates to the professional integrity of persons that constrains them from taking the ethically correct action (Epstein & Hamric, 2009). Emotional distress, on the other hand, occurs when a person encounters distressing situations without the ethical component (McCarthy & Deady, 2008). Although all healthcare providers may experience moral distress, nurses are at a higher risk (Allen et al., 2013; Whitehead, Herbertson, Hamric, Epstein, & Fisher, 2015).

Implementing treatments that will not benefit patients’ outcomes is believed to cause the highest level of moral distress in nurses (Cavaliere, Daly, Dowling, & Montgomery, 2010; Piers et al., 2012; Rice, Rady, Hamrick, Verheijde, & Pendergast, 2008). In addition, nurses’ work environments have been shown to affect nurses’ moral distress; when nurses’ work environments deteriorate, the level of nurses’ moral distress increases (Hiler, Hickman, Reimer, & Wilson, 2018). Lack of communication, providing care to terminally ill patients, and working with incompetent...
coworkers have also been linked to moral distress in nurses (de Veer, Francke, Struijs, & Willems, 2013; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012; Woods, Rodgers, Towers, & La Grow, 2015).

Studies related to the work experience of forensic nurses highlight significant concerns that may be connected to moral distress. For example, forensic nurses have higher levels of burnout—a syndrome characterized by depersonalization, emotional exhaustion, and decreased personal accomplishment (Maslach & Jackson, 1986)—during their careers because they are exposed to obligations and stresses that are unusual for the general nursing population (Ewers, Bradshaw, McGovern, & Ewers, 2002; Townsend & Campbell, 2009). In one study, 73% of forensic nurses had moderate to high levels of burnout and moderate to high levels of secondary traumatic stress (Flarity, Nash, Jones, & Steinbruner, 2016). In a different study, 46% of sexual assault nurse examiners across four states experienced vicarious trauma and burnout (Maier, 2011). Burnout has been found to be a reason that nurses leave their jobs and even the nursing profession (Moloney, Boxall, Parsons, & Cheung, 2017; Rudman, Gustavsson, & Hultell, 2014).

Nurses leaving the profession contributes to the critical shortage the United States is currently experiencing. It is predicted that, by 2022, 500,000 experienced nurses will retire, and there will be a need for 1.1 million new nurses in the United States alone (American Nurses Association, 2018). Nurse turnover affects quality of care and leads to adverse patient outcomes (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; O’Brien-Pallas et al., 2006), decreases nurses’ job satisfaction (Aiken et al., 2002), and increases the cost for healthcare institutions. The cost of replacing one nurse is between $12,000 and $67,000 (Purcell, Kutash, & Cobb, 2011).

Optimal healthcare, specifically in forensic nursing, requires an adequate number of trained professionals, yet the number of forensic nurses who are in practice is much lower than the demand (U.S. Government Accountability Office, 2016). Therefore, understanding whether moral distress results in the loss of experienced and trained forensic nurses is of paramount importance. Although there are no studies specific to moral distress in forensic nurses, the literature on nurses in general will help to illuminate this topic’s significance.

### Problem Identification and Specific Aims

Violence of all types is a social phenomenon that necessitates specialized and skilled forensic nurses who are prepared to provide the necessary treatment and support to meet the needs of victims, suspects, and perpetrators. However, evidence suggests that sexual assault nurse examiner retention is challenging (Logan, Cole, & Capillo, 2007).

The purpose of this integrative review is to describe the relationship between nurses’ moral distress and burnout, and intentions to leave their nursing position. Understanding the moral distress experienced by nurses is the first step in determining interventions to potentially provide support and retention. A broad exploration of nurses and nursing will inform thinking and future research about forensic nurses.

### Review Method

This study is an integrative review using the method of Whittemore and Knafl (2005), which allows researchers to include experimental and nonexperimental studies in the review to help readers to fully understand a phenomenon of concern (Whittemore & Knafl, 2005).

### Literature Review

CINAHL, PubMed, and Scopus were searched to identify primary research studies that investigated the effects of moral distress on practicing nurses. The time frame of the research results was restricted to the period from January 2000 to June 2018. In addition, the Nursing Ethics journal was manually scanned from 2000 to 2017 to find relevant articles. The original search of the literature included quantitative, qualitative, and mixed-methods studies that reported nurses’ subjective experiences along with more objective measures of the consequences of moral distress on nurses. The literature review was conducted by electronic searching of databases using the keywords “moral distress,” “burnout,” “intention to leave,” and other synonyms and search terms (see Table 1, List of Search Terms, Supplemental Digital Content 1, http://links.lww.com/JFN/A30, for a detailed list of all search terms).

The primary investigator screened titles and abstracts and included studies if they met the following criteria: (a) empirical quantitative, qualitative, or mixed-methods research; (b) addressed the relationship between nurses’ moral distress and burnout or nurses’ moral distress and their intentions to leave their positions; and (c) published in English from 2000 to 2018. Articles in foreign languages; articles that were not primary research; articles not discussing the relationship between moral distress, burnout, and/or intentions to leave; and articles not involving nurses were excluded from this review.

All relevant articles were exported to Endnote7 where the duplicates were removed. The investigator screened the titles and abstracts of the remaining articles for relevance based on the inclusion and exclusion criteria. The initial search revealed 602 articles. Five hundred fifty-eight articles were excluded because they discussed sources, intensity, and frequency of moral distress. The remaining 44 articles were screened, and only the articles meeting the inclusion criteria were included in this review. Seventeen articles matched the inclusion criteria. Figure 1 shows the details of the data collection process.

### Data Evaluation

Each study was critically appraised using an assessment sheet prepared and tested by Hawker, Payne, Kerr, Hardey, and
Powell (2002). The quality appraisal sheet includes nine components: (a) title and abstract, (b) introduction and aims, (c) method and data, (d) sampling, (e) data analysis, (f) ethics and bias, (g) results, (h) transferability, and (i) implications for practice. The primary author assessed each area of the articles using the standard scale of 1 = very poor to 4 = very good. The scores were calculated and tallied; a score of 9 indicated a very poor study, and a score of 36 indicated a very good study. Methodological quality appraisal for most of the studies was generally good, and the scores ranged from 21 to 33. None of the articles was excluded on the basis of inadequate rigor. All of the articles had an abstract, included a research question and/or an objective, described the design, identified the tools used, and explained and justified the sample size. Some studies determined the sample size by using power analysis, and most of the articles explained the process of ethical consideration. The most common weaknesses in the studies resulted from the researchers’ failures to adequately explain the implications and usefulness of their research and their failure to propose ideas for further research.

### Data Analysis

In this review, data abstraction, organization, and synthesis were accomplished by reading and rereading the articles, comparing them, and categorizing the relevant themes and information. Results were classified and then summarized into two categories: nurses’ moral distress and its relation to their burnout, and nurses’ moral distress and its relation with their intentions to leave their positions. A matrix table was developed that outlined the aims, population, sample size, key outcomes from each study, and tools researchers used to measure nurses’ burnout and their intentions to leave their positions. A matrix table was developed that outlined the aims, population, sample size, key outcomes from each study, and tools researchers used to measure nurses’ burnout and their intentions to leave their positions. A matrix table was developed that outlined the aims, population, sample size, key outcomes from each study, and tools researchers used to measure nurses’ burnout and their intentions to leave their positions.

![Data Collection Process Diagram](image-url)
and patterns, the primary investigator analyzed and organized the results using a constant comparative method (Whittemore & Knafl, 2003).

**Review Results**

**Description of Sample Studies**

Demographic characteristics, including participants’ gender, age, educational level, and years of experience, varied among the studies. Most of the participants in these studies were female, and the percentage of female participants varied from 56.9% (Hamaideh, 2014) to 100% (Gutierrez, 2005; Harrowing & Mill, 2010). The ages of the participants in this review ranged from 19 to 64 years (See Table 2, Supplemental Digital Content 2, http://links.lww.com/JFN/A31). One study did not report participants’ ages (Harrowing & Mill, 2010).

Five of the 17 studies recruited healthcare professionals in addition to nurses. However, in each of those five studies, nurses comprised the largest proportion of the total sample of participants. The percentage of nurses among these studies ranged from 48% (Fumis, Junqueira Amarante, de Fátima Nascimento, & Vieira Junior, 2017) to 77.1% (Larson, Dryden-Palmer, Gibbons, & Parshuram, 2017). The overall nurses’ educational level in the studies varied from associate degree to PhD, and most of the nurses either had a diploma or an associate’s degree in nursing. Table 2 (Supplemental Digital Content 2, http://links.lww.com/JFN/A31) provides the details of participants’ demographic characteristics.

Among the 13 quantitative studies, sample sizes ranged from 100 to 1,541 participants, and the nurses who participated were employed in intensive care departments, cardiovascular surgical intensive care, mental health, pediatric intensive care, geriatrics, all units in a Veterans Health Administration, neonatology, and hematopoietic cell transplantation settings. Study locations included the United States, Iran, Southern Rio Grande do Sul, Japan, Italy, Jordan, Canada, and Brazil.

In the three qualitative studies, sample sizes ranged from 12 to 49 participants. Two of three qualitative studies were conducted in critical care units in the United States, and one was conducted with nurses providing care to HIV patients in Africa. One mixed-methods study that included nine nurses working in critical care units in the United States is included in this review. (see Table 2, Supplemental Digital Content 2, http://links.lww.com/JFN/A31).

**Measures**

**Measures for Moral Distress**

Three different versions of the Moral Distress Scale—the Moral Distress Scale (MDS), the Moral Distress Scale-Revised (MDS-R), and the Moral Distress Scale for Psychiatric Nurses (MDS-P)—were used to determine participants’ perceptions of moral distress. The MDS (Corley, Elswick, Gorman, & Clor, 2001) was used in seven studies. The reliability of the MDS in these studies varied between Cronbach’s $\alpha \geq 0.70$ (Kelly, 2012) and Cronbach’s $\alpha \geq 0.97$ (McClendon & Buckner, 2007). The MDS-R (Hamric, Borchers, & Epstein, 2012) was used in five studies, and the reliability of the MDS-R in these studies varied between Cronbach’s $\alpha = 0.88$ (Austin, Saylor, & Finley, 2017) and Cronbach’s $\alpha = 0.89$ (Larson et al., 2017). The MDS-P (Ohnishi et al., 2010) was used in two research articles, and the reliability of the MDS-P was measured by Cronbach’s $\alpha$, which was 0.89 and 0.90. In the qualitative studies, researchers asked open-ended questions to determine participants’ perceptions of moral distress (see Table 2, Supplemental Digital Content 2, http://links.lww.com/JFN/A31, for further details).

The results of this review reveal that all healthcare providers experience moderate to high levels of moral distress. Scores of moral distress range from 0 to 336; higher scores on the MDS indicate higher levels of moral distress (Hamric et al., 2012).

**Measures for Burnout**

To measure burnout, six studies used the Maslach Burnout Inventory (MBI; Maslach, Jackson, Leiter, Schaufeli, & Schwab, 1996). The MBI has 22 items divided in three subscales: emotional exhaustion, depersonalization, and personal accomplishment. Higher scores for both emotional exhaustion and depersonalization indicate higher levels of burnout. In contrast, lower levels on personal accomplishment indicate higher burnout levels. The reliability of the MBI varied from Cronbach’s $\alpha = 0.61$ (Dalmolin, Lunardi, Lunardi, Barlem, & Silveira, 2014) to Cronbach’s $\alpha = 0.87$ (Fumis et al., 2017). Although most of the quantitative studies employed the MBI, Austin, Lemermeyer, Goldberg, Bergum, and Johnson (2005) used the Professional Quality of Life Scale, and the Cronbach’s $\alpha$ for the three subscales of the Professional Quality of Life Scale was measured to show the reliability of the instrument: (a) For compassion satisfaction, Cronbach’s $\alpha$ was 0.89; (b) for burnout, Cronbach’s $\alpha$ was 0.80; and (c) for secondary traumatic stress, Cronbach’s $\alpha$ was 0.81. Shoorideh, Ashktorab, Yaghmaei, and Alavi Majid (2015) used the Copenhagen Burnout Inventory, which showed with high reliability that Cronbach’s $\alpha$ was 0.82.

In the qualitative studies, participants were asked open-ended questions to determine if they were experiencing burnout. Despite the studies’ use of different methods to explore participants’ burnout, the results reveal that all healthcare providers experience moderate to high levels of burnout. Higher scores on the two subscales from the MBI, emotional exhaustion and depersonalization, signal a high level of burnout, whereas lower scores on personal accomplishment from the MBI signal a high level of burnout (Maslach et al., 1996; see Table 2, Supplemental Digital Content 2, http://links.lww.com/JFN/A31, for further details).
Measures for Intentions to Leave Positions

Participants’ intentions to leave were determined by using the last two items from the MDS, the MDS-R, or the MDS-P. Some researchers used other tools: Maningo-Salinas (2010) and Shoorideh et al. (2015) used the Anticipated Turnover Scale; Fogel (2007) used the Intent to Turnover of the Quality of Work Life Measurement tool; Hamaideh (2014) used the Job Satisfaction Scale; Karanikola et al. (2014) used Varju et al.’s Autonomy Scale; Kelly (2012) used the Practice Environment Scale of Nursing Work Index; and Neumann et al. (2017) asked participants to either strongly agree, agree, strongly disagree, or disagree with the statement “I am satisfied with my career” to show their level of career satisfaction (see Table 2, Supplemental Digital Content 2, http://links.lww.com/JFN/A31, for further information).

Although intention to leave was assessed with many different tools, it is clear that healthcare providers experiencing high levels of moral distress had high intentions to leave their positions. Evidence shows that 10%–38% of nurses leave their jobs because of moral distress (Fogel, 2007; Wiegand & Funk, 2012).

Difference in Moral Distress Among Healthcare Professionals

In three of the five studies that recruited healthcare professionals in addition to nurses, nurses had higher mean scores of moral distress than other healthcare professionals (scores ranging between 62.3 and 107.7; Fumis et al., 2017; Larson et al., 2017; Neumann et al., 2017). In two of the five studies, nurses had lower mean scores of moral distress than physicians; nurses’ mean score of moral distress ranged from 92.9 to 47.3 compared with physicians’ mean score of moral distress ranging from 106.1 to 62.8 (Austin et al., 2017; Trotochaud, Coleman, Krawiecki, & McCracken, 2015; see Table 2, Supplemental Digital Content 2, http://links.lww.com/JFN/A31).

Difference in Burnout Among Healthcare Professionals

Four of the five studies that recruited healthcare professionals in addition to nurses measured burnout (Austin et al., 2017; Fumis et al., 2017; Larson et al., 2017; Neumann et al., 2017). Two of these four studies determined that nurses had higher levels of burnout compared with other healthcare professionals (Austin et al., 2017; Fumis et al., 2017). Neumann et al. (2017) found that pharmacists had a higher prevalence of burnout compared with other healthcare providers. Larson et al. (2017) did not specify the prevalence of burnout for each of the groups; the authors provided the median level of burnout (6) and explained that 39% of all participants had high levels of depersonalization (see Table 2, Supplemental Digital Content 2, http://links.lww.com/JFN/A31).

Difference in Intentions to Leave Among Healthcare Professionals

Two of the five articles that recruited healthcare professionals in addition to nurses explored caregivers’ intentions to leave in relation to moral distress (Austin et al., 2017; Trotochaud et al., 2015). In both studies, nurses had higher intentions to leave compared with other healthcare professionals (see Table 2, Supplemental Digital Content 2, http://links.lww.com/JFN/A31).

Nurses’ Moral Distress and Its Relation With Burnout

Seven quantitative articles in this review reported a positive correlation between moral distress and burnout. Neumann et al. (2017) had the largest sample, with 1,541 participants, and found that moral distress was the only variable correlated with healthcare providers’ burnout. Neumann et al. also found that each additional point of moral distress increased the risk of healthcare providers’ burnout by 2% and participants who had burnout had lower levels of career satisfaction (see Table 2, Supplemental Digital Content 2, http://links.lww.com/JFN/A31).

In qualitative studies, moral distress and burnout were reported differently. As a result of moral distress, nurses expressed experiencing emotional issues such as sadness, anger, and frustration (Gutierrez, 2005; Wiegand & Funk, 2012). Some nurses experienced professional effects such as withdrawing from patients and their families (Gutierrez, 2005). Furthermore, nurses felt that moral distress led to a lower standard of care (Harrowing & Mill, 2010; Wiegand & Funk, 2012) and prohibited them from completing their tasks (McClenndon & Buckner, 2007).

Nurses’ Moral Distress and Their Intentions to Leave Their Positions

Ten studies explored the relation between nurses’ moral distress and their intentions to leave their jobs/profession (see Table 2, Supplemental Digital Content 2, http://links.lww.com/JFN/A31). Six of these studies found that high levels of moral distress increased nurses’ intentions to leave their jobs. Three studies did not find any correlation between moral distress and intentions to leave jobs (Harrowing & Mill, 2010; Kelly, 2012; Shoorideh et al., 2015). One qualitative study found that, although 38% of the participants will change their jobs if they face similar situations in the future, 62% of the participants will not (Wiegand & Funk, 2012). The overall percentage of participants who were thinking of leaving their jobs as a result of moral distress ranged from 10% (Fogel, 2007) to 49% (Austin et al., 2017). Trotochaud et al. (2015) had the largest sample size with 1,113 participants and found that 35.7% of respondents reported having left their position or were thinking about leaving their positions because of moral distress.
Two of these studies explored the relationship between nurses' moral distress with burnout and their intentions to leave (Hamaideh, 2014; Shoorideh et al., 2015). Whereas Hamaideh (2014) found that moral distress is strongly positively related to both nurses' burnout and their intentions to leave ($r^2 = 0.193$ for burnout and 0.202 for intentions to leave), Shoorideh et al. (2015) did not find a significant relation between moral distress and anticipated nurse turnover. Specific statistics were not provided; results were presented as $p > 0.05$. However, Shoorideh et al. found that there was a positive correlation between age and years of nurses' experience with burnout ($p < 0.01$) and moral distress ($p < 0.05$) and a positive correlation between nurse-to-patient ratio, and burnout and moral distress ($p < 0.001$).

**Strengths and Limitations of the Studies**

Research designs in these studies were qualitative open-ended interviews or quantitative surveys in which strong reliability and validity of each of the instruments were reported. However, most of the participants in the studies were female, and male participants constituted a small percentage of the total number of participants, a fact that may have affected the results. Some studies did not provide detailed information about the characteristics of the sample such as nurses' years of experience or nurses' ethnicity, which limits the amount of information regarding the samples. Nurses' years of experience may influence the way they handle conflicting situations, and therefore, they may not experience moral distress or have intentions to leave their jobs. Previous research has shown that experienced nurses are more comfortable with patients and physicians and therefore do not experience the negative consequences of moral distress (Traudt, Liaschenko, & Peden-McAlpine, 2016). Research findings also showed that experienced nurses are more satisfied with their jobs and have fewer intentions to leave than nurses who have less experience (Delobelle et al., 2011; Masum et al., 2016).

Most studies did not take into consideration nurses' work environments or the perceived organizational support that may also lead to nurses' moral distress, burnout, and intentions to leave their jobs. Previous studies have shown that, when the work environment is favorable, nurses have low levels of job dissatisfaction (Unruh & Zhang, 2013), low levels of burnout (Li et al., 2013), and fewer intentions to leave positions (Van den Heede et al., 2013); on the other hand, a poor work environment is related to high levels of nurses' moral distress (Hiler et al., 2018), high levels of burnout (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Maslach, Schaufeli, & Leiter, 2001), and high turnover rates (Aiken et al., 2012; Van Bogaert, Clarke, Willems, & Mondelaers, 2013). Therefore, because the information on nurses' years of experience and their work environment is missing, the ability to infer specific reasons for nurses' moral distress, burnout, and intentions to leave their jobs is limited. In addition, the relationship of type of nursing (e.g., bedside nurse, nurse manager, unit director) and moral distress was not specified in most of the studies. Although the meaning of the nursing profession is universal, nurses' moral distress may be different depending on the role of the nurse within the workplace environment. In future studies, it would be beneficial to determine the different levels of moral distress in relation to the nurse's role and context of nursing care.

Furthermore, lack of longitudinal work across the studies made causal statements impossible. Researchers conducted their research in different settings, each of which brought unique challenges to participants; these differences resulted in different dimensions for nurses' moral distress, burnout, and intentions to leave and affected the generalizability of the findings.

### Discussion

This review examined the relation between nurses' moral distress and burnout, and nurses' moral distress and intentions to leave their position. The evidence clearly shows that moral distress is positively correlated with burnout. All nurses included in this review experienced burnout because of moral distress. Although not all of the studies determined the level of nurses' burnout, all of the studies showed a positive correlation between moral distress and burnout.

However, studies examining nurses' intentions to leave their jobs in relation to their moral distress had mixed results. Whereas most studies found that moral distress increased nurses' intentions to leave their jobs, three studies did not find any correlation between moral distress and nurses' intentions to leave their jobs (Harrowing & Mill, 2010; Kelly, 2012; Shoorideh et al., 2015). This can be explained by the fact that these three studies were conducted with specific groups of participants who worked under unique conditions and circumstances that may have affected participants' decisions to stay in their jobs. Harrowing and Mill (2010) conducted their study in Africa where nurses had financial needs and their chances of finding another job were minimal, leading them to maintain their positions regardless of their moral distress. Kelly's (2012) study was conducted with experienced nurses; 61% of them had over 11 years of experience in the Veterans Health Administration system. When nurses work in one place for a long period, they develop a sense of security and comfort that may prevent them from leaving their positions (Nathaniel, 2006). Shoorideh et al. (2015) conducted their study in Iran where 72.3% of the participants were female. Women in Iran were expected to be more submissive and introverted, and obtaining employment was difficult for everyone, which may have affected participants' decisions to stay in their jobs (Shoorideh et al., 2015).

People with different cultural backgrounds have different perceptions of nursing, which may affect nurses' decisions...
to stay in their jobs. For example, the restriction of Iranian women’s rights in 2015 may have affected Iranian nurses’ decision to stay in their jobs. A recent study explained that they tolerated poor working conditions because they valued having a role in and being useful for society and the family (Alilu, Zamanzadeh, Valizadeh, Habibzadeh, & Gillespie, 2017). On the other hand, nurses working in Africa had no intention to leave their jobs despite experiencing moral distress as they needed the financial income to support their families (Harrowing & Mill, 2010).

Although most studies showed that moral distress leads to negative consequences, some studies reported positive effects. Some nurses expressed a desire to advocate for their patients (Gutierrez, 2005), and other nurses maintained their moral integrity and showed resilience and perseverance to alleviate the suffering of their patients (Harrowing & Mill, 2010). These studies also showed that nurses experienced high levels of moral distress, which illustrates the importance of addressing this issue in the nursing profession and more specifically in forensic nursing.

It is evident that the literature on moral distress and its relation with nurses’ burnout and intentions to leave their jobs is a universal topic; however, the lack of research on forensic nurses’ moral distress is a concern. Although forensic nurses in different countries may have different practice parameters, it is important to explore if these nurses experience moral distress as they care for victims of violence, suspects, or perpetrators.

Implications for Forensic Nursing

Studies have shown that, when forensic nurses care for victims of violence, the number of hours victims wait in the emergency room decreases and the quality of care improves (Campbell, Bybee, Kelley, Dworkin, & Patterson, 2012; Campbell, Patterson, & Lichty, 2005). However, the number of forensic nurses is less than the demand, and retaining forensic nurses in practice is challenging (Iritani, 2016). This may be related to the fact that forensic nurses work in high-stress work environments where they face frustrations, challenges, and ethical issues as they care for vulnerable patients who are suffering not only physically but also psychologically. In addition to the stressful work environments, forensic nurses are at a high risk of being subjected to verbal and physical aggression, which increases their risk of experiencing burnout (Mason, 2002). Defined as the psychological syndrome involving depersonalization, emotional exhaustion, and a reduced sense of personal accomplishment that happens to professionals who work with other people during challenging situations (Maslach, 1982), burnout has been found to be a reason that nurses leave their jobs and even the nursing profession (Moloney et al., 2017; Rudman et al., 2014).

Studies in this review revealed that moral distress was positively correlated with burnout (Austin et al., 2017; Dalmolin et al., 2014; Fumis et al., 2017; Larson et al., 2017). Evidence also shows that moral distress increases nurses’ intentions to leave their jobs and nursing overall (Fogel, 2007; Hamaideh, 2014; Karanikola et al., 2014; Trotochaud et al., 2015; Wiegand & Funk, 2012). Considering the shortage of forensic nurses, the profession cannot afford to lose experienced nurses because of moral distress, a potentially preventable condition. It is therefore important to determine if forensic nurses experience moral distress while caring for patients in their professional roles; the information in the literature is missing. Helping forensic nurses recognize the situations that lead to moral distress is the first step in helping them to relieve their distress, reduce their burnout, and continue longer in practice.

Implications for Practice, Policy, and Research

This integrative review provides important information for hospital administrators, unit directors, and unit managers about nurses’ burnout and their intentions to leave their positions as potentially serious consequences of moral distress. Nurse turnover affects the quality of care, leading to adverse patient outcomes (Aiken et al., 2002; O’Brien-Pallas et al., 2006), and decreases job satisfaction (Aiken et al., 2002). Therefore, understanding the potential causes of moral distress and developing effective interventions to combat it, is of paramount importance. This is an important step in helping administrators find ways to relieve nurses’ moral distress to retain them longer in practice, and ultimately, improve the quality of care patients receive.

Several gaps in the literature are identified. None of the studies included in this review evaluated nurses’ physical and emotional well-being before or during the study. Hanna (2005) questions the consequences of moral distress on nurses who have underlying conditions or chronic illnesses. Therefore, conducting a study that takes into consideration nurses’ health conditions will be beneficial for understanding if nurses who have predisposing conditions react differently to morally distressing situations than nurses who have no underlying health issues. In addition, there is a lack of longitudinal studies related to the effects of moral distress. Longitudinal studies that look at phenomena over time may show the pattern of moral distress, its causes, and its effects, helping researchers understand the cause-and-effect relationships between moral distress, burnout, and intentions to leave. This is important for the nursing profession because it will help directors and administrators understand the long-term effects of moral distress on nurses.

Furthermore, to date, forensic nurses’ moral distress in the context of caring for victims of violence and their families has not been addressed in the literature. Forensic nurses are at the front line of contact with the most vulnerable populations, both deceased and living. From victims to abusers and perpetrators, forensic nurses treat intentional/unintentional physical and psychological injuries, and therefore, they may experience moral distress. However, what is missing in the
literature is information on forensic nurses’ moral distress. Therefore, it is worthwhile to conduct studies that focus on forensic nurses’ moral distress, as a way of determining reasons for their burnout, and to keep them in practice longer.

It is important to note that this body of literature covers a wide span of years and, during this time, the nursing profession and the characteristics of patients have changed, which may have affected the results of this research. For example, with an aging and more diverse population, nurses need to have the necessary training and education to care for patients with complex health conditions. Without the necessary training and education, nurses may not be confident in caring for these patients, leading nurses to experience burnout and leave their jobs. Therefore, it is important to explore nurses’ education and determine if their education/training affects their moral distress, burnout, and intentions to leave their jobs.

Limitations
This integrative review provides information on the effects of moral distress on nurses’ burnout and their intentions to leave their jobs. Despite the rigor of the methodology and the analysis of this review, several limitations are identified. In this review, the authors tried to capture all of the articles that discussed nurses’ moral distress and its relation with burnout and their intentions to leave their positions. However, the concept of moral distress is used broadly in the literature, and it is therefore possible that some studies were unintentionally excluded. Furthermore, the scoring of the articles included in this review was done by one author, and therefore, it is possible that some articles were excluded because of the investigator’s bias.

On the basis of this review, burnout and increased intentions to leave positions are the major effects of nurses’ moral distress. However, burnout and intentions to leave are not the only side effects of moral distress. This review does not encompass all of the physiological and psychological consequences of moral distress on nurses and their patients. Therefore, a more in-depth approach to the literature review should be attempted in the future.

Finally, because of the relatively small amount of empirical work in this specific area, this review covers a relatively broad period (2000–2018), and thus there have likely been significant changes in healthcare delivery, financing, and the nursing profession that may also contribute to the key outcomes. This review is fairly comprehensive of work to date, but given the increasing attention to the topic, the authors anticipate a significant increase in the body of literature moving forward.

Conclusion
Despite the diversity of the instruments, the different sample sizes, and the different countries and work environments in which these studies were conducted, this set of studies shows that moral distress is related to negative consequences on nurses’ professional and personal lives, potentially contributing to burnout and leading to an increase in intentions to leave. Nurses leaving their positions lead to poor quality of care (Aiken et al., 2002; O’Brien-Pallas et al., 2006), jeopardizing the safety of patients and threatening the reputation of institutions. Therefore, moral distress needs to be addressed with diligence to achieve nurses’ moral comfort and help them continue longer in practice.

In a world where violence is prevalent and highly visible, forensic nurses are needed more than ever. Forensic nurses experience a variety of events and situations that may be associated with moral distress. It is therefore important to find the sources of moral distress and develop strategies to assess, prevent, and decrease forensic nurses’ moral distress. Findings from this review reveal an important gap in the literature: forensic nurses’ moral distress in the context of providing care to victims of violence is not addressed. Evidence shows that providing care to victims of violence and their families is stressful and traumatizing to forensic nurses (Zimmer & Cabelus, 2003). Therefore, future research should be conducted to investigate nurses’ moral distress as they provide care to victims, suspects, or perpetrators of violence.

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