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REVIEW ARTICLE

Moral Distress and Burnout among Critical Care Nurses in Low- and Middle-Income Countries: A Mini-Review

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ABSTRACT

Critical care nurses work in highly demanding environments characterized by severe patient illness, rapid clinical deterioration, complex treatment decisions, advanced technologies, and frequent exposure to death and suffering. These conditions may contribute to moral distress and occupational burnout. Moral distress occurs when nurses identify an ethically appropriate course of action but encounter constraints that prevent them from acting accordingly. Burnout is an occupational phenomenon associated with chronic workplace stress that has not been successfully managed and is characterised by exhaustion, increased mental distance from work or negativism, and reduced professional efficacy. Although distinct, these experiences may overlap when ethically challenging situations recur in demanding work environments. The issue is particularly relevant in low- and middle-income countries (LMICs), although these countries differ substantially in workforce availability, resources, professional autonomy, and healthcare structures. Recent international evidence indicates that moral distress remains an important concern among intensive care unit (ICU) nurses. The literature describes end-of-life decision-making, perceived non-beneficial treatment, inadequate resources, poor teamwork, hierarchical relationships, and limited professional autonomy as key factors. Burnout may be associated with overlapping organizational and occupational conditions. Addressing these challenges requires more than individual coping strategies. Supportive leadership, adequate staffing, effective interprofessional communication, ethical consultation, nurse participation in decision-making, psychological support, and appropriate end-of-life care processes may help strengthen professional well-being. An author-proposed "Empower–Engage–Enable" framework is presented as a practical, multilevel approach for consideration and future testing. Context-specific research is needed to establish its feasibility, acceptability, and effectiveness in LMIC settings.

Keywords: *Burnout, critical care nurses, intensive care, low- and middle-income countries, moral distress, nursing workforce.*

INTRODUCTION

Critical care nursing is one of the most complex areas of professional nursing practice. Patients admitted to intensive care units (ICUs) may require continuous monitoring, mechanical ventilation, vasoactive medications, invasive procedures, organ support, and rapid clinical interventions. Nurses provide continuous bedside care while communicating with patients and families and collaborating with multidisciplinary teams. The combination of high clinical acuity, technological complexity, emotional demands, and ethical uncertainty can place substantial pressure on critical care nurses.

In addition to managing physiological instability, critical care nurses frequently encounter ethically challenging situations. These may include decisions regarding resuscitation, continuation or withdrawal of life-sustaining treatment, treatment escalation, perceived non-beneficial interventions, patient autonomy, and family preferences. Because nurses remain closely involved in patient care, they may recognize suffering or treatment-related concerns but have limited authority to alter decisions. A perceived inability to act according to professional or moral judgement may contribute to moral distress.

Moral distress is conceptually different from general occupational stress. It involves an ethical conflict in which an individual identifies a morally appropriate action but encounters constraints that interfere with implementation. Repeated exposure to unresolved moral conflicts may contribute to frustration, powerlessness, emotional exhaustion, reduced job satisfaction, or withdrawal from ethically difficult situations. A 2026 systematic review and meta-analysis by Qu et al. included 34 studies involving 6,461 ICU nurses from 13 countries and reported overall moderate levels of moral distress. The review also found variation in reported severity across studies and instruments, highlighting the importance of measurement differences and context. These international findings should not be assumed to represent all LMICs equally.[1]

Burnout represents another important concern. The World Health Organization (WHO) defines burnout as an occupational phenomenon resulting from chronic workplace stress that has not been successfully managed. It is characterized by exhaustion, increased mental distance from work or feelings of negativism or cynicism, and reduced professional efficacy.[2] Critical care nurses may experience prolonged shifts, night duty, high patient acuity, emergencies, exposure to death, family distress, and sustained cognitive demands. An integrative review of ICU nursing literature identified personal, organisational, labour-relational, end-of-life, and COVID-19-related factors associated with burnout and moral distress.[3]

These issues may have particular relevance in LMICs. However, LMICs are heterogeneous, and healthcare systems differ substantially in workforce availability, infrastructure, professional autonomy, financing, and access to specialist services. Evidence from one country, hospital, or type of ICU should therefore not be generalized automatically to other LMIC settings. This mini-review discusses the clinical and organizational contexts associated with moral distress and burnout, considers implications for resource-constrained settings, and proposes a multilevel framework for future consideration.

REVIEW APPROACH

This article is a narrative mini-review informed by selected recent reviews and international guidance on moral distress, burnout, end-of-life care, and the nursing workforce. It is not a systematic review, and it makes no claim of exhaustive database searching or a formal risk-of-bias assessment. Findings are synthesised thematically to discuss overlapping and distinct contextual factors and to identify implications for LMIC critical care settings. Because the included literature uses different populations, designs, and measurement instruments, findings are interpreted cautiously and associations are not presented as proof of causation.

DISCUSSION

Moral distress in critical care is influenced by interacting patient, professional, organisational, and system-level factors. A scoping review identified powerlessness, end-of-life care, ineffective teamwork, and personal characteristics as major themes associated with moral distress among intensive care nurses.[4] These findings suggest that moral distress should not be considered solely an individual psychological response; the environment in which clinical decisions are made is also relevant.

End-of-life care is particularly important. Intensive care nurses may participate in decisions concerning cardiopulmonary resuscitation, treatment limitation, withdrawal of life-sustaining therapies, and transition toward comfort-focused care. Nurses may experience distress when they perceive ongoing treatment as non-beneficial or believe that patient preferences are not adequately incorporated into decision-making. Conversely, uncertainty about prognosis or disagreement regarding treatment limitation can also create ethical tension. A 2026 scoping review of end-of-life care in adult ICUs described structural, interpersonal, and organisational influences, including hierarchical power relationships, difficult interactions with families, systemic barriers, and inconsistent integration of palliative care.[5]

Interprofessional relationships are another important consideration. Critical care requires close collaboration between nurses, physicians, respiratory therapists, pharmacists, and other professionals. When treatment goals are unclear or professional opinions differ, nurses may

experience conflict between their observations and the final plan of care. Poor communication, inadequate teamwork, and limited opportunities for nurses to express concerns have been associated with moral distress.[3,4] Professional autonomy may modify these experiences: nurses who can communicate concerns, participate in treatment discussions, and advocate for patients may have greater opportunities to resolve ethical conflicts, whereas highly hierarchical environments may contribute to powerlessness.

Burnout develops within a broader occupational context shaped by interacting clinical, organisational, interpersonal, and individual factors.[3,4] The intensive care environment may involve sustained workload, insufficient recovery between shifts, emotional demands, repeated exposure to death and suffering, and frequent clinical emergencies. When these demands occur alongside inadequate staffing, limited resources, poor communication, or insufficient organizational support, nurses may experience increasing exhaustion and disengagement. Moral distress and burnout may share some contextual contributors, but they are conceptually distinct. Moral distress concerns ethical conflict and constraints on morally appropriate action, whereas burnout concerns chronic workplace stress. The relationship between them is likely to be multifactorial; moral distress should not automatically be interpreted as a direct cause of burnout because much of the available evidence is observational.

The LMIC context adds further complexity. WHO reporting emphasizes the importance of investment in nursing education, employment, leadership, workforce distribution, and service delivery.[6] In some LMIC settings, shortages of specialised critical care nurses may contribute to high workloads and increased responsibility for individual nurses. Limited availability of equipment, medications, diagnostic facilities, or specialist services may also create situations in which nurses recognize patient needs but are unable to provide the desired level of care. However, resource limitations alone do not explain moral distress. Organizational culture, leadership, teamwork, professional autonomy, communication, and access to ethical support are also relevant. A resource-constrained environment with strong teamwork and supportive leadership may be experienced differently from one in which nurses have limited participation in decisions and little access to support.

Moral distress and burnout can affect professional well-being and organizational stability. Persistent distress may be associated with reduced job satisfaction, disengagement, absenteeism, and intention to leave a clinical setting. Loss of experienced critical care nurses can further increase

Table 1. Contextual factors associated with moral distress and burnout among ICU nurses.

Contextual domain	Factors associated with moral distress	Factors associated with burnout
Clinical environment	Ethical conflicts involving perceived non-beneficial treatment, resuscitation, end-of-life decisions, and patient advocacy.	High-acuity care, frequent emergencies, heavy workload, and repeated exposure to death and suffering.
Staffing and resources	Inability to provide care considered ethically appropriate because of inadequate staffing, equipment, medications, or other resources.	Excessive workload, staff shortages, prolonged or rotating shifts, and insufficient recovery time.
Professional autonomy and leadership	Powerlessness, hierarchical decision-making, limited nurse participation, and restricted ability to advocate for patients.	Unsupportive leadership, low recognition, limited control over work, and inadequate organizational support.
Interprofessional relationships	Conflicts over treatment goals, ineffective communication, disagreements, and exclusion from clinical decisions.	Poor teamwork, interpersonal conflict, lack of respect, and insufficient support from colleagues or supervisors.
Emotional and ethical demands	Repeated unresolved ethical conflicts, guilt, frustration, and perceived inability to act according to professional values.	Emotional exhaustion, psychological distancing from work, and reduced professional efficacy associated with chronic workplace stress.
Personal and work–life context	Moral sensitivity, professional experience, and coping resources may influence how ethical conflicts are perceived.	Inadequate work–life balance, work-to-home spillover, and insufficient opportunities for psychological recovery.
Organizational culture	Negative ethical climate, lack of ethical consultation, and policies that constrain patient advocacy.	Persistent adverse working conditions, poor organizational support, and limited staff well-being resources.

Table 1 synthesizes contextual factors described in the cited reviews.[3-5] The factors are reported associations and potential contributors, not established causal pathways. The evidence base varies by country, ICU type, study design, and measurement instrument; it should not be interpreted as uniformly representative of all LMICs.

workload among remaining staff and create challenges for maintaining specialized services. These outcomes should be understood as possible consequences or correlates rather than inevitable effects in every setting.

Individual resilience strategies, including reflective practice, peer support, stress-management approaches, and professional development, may help nurses cope with difficult experiences. Nevertheless, interventions focused exclusively on individual resilience may be insufficient when sources of distress are organizational or structural. Healthcare institutions should combine individual support with system-level strategies. Structured ethical debriefing can provide nurses with opportunities to discuss ethically difficult cases and identify unresolved concerns. Multidisciplinary discussions may improve communication about goals of care and allow nurses to contribute bedside observations. In end-of-life situations, timely palliative-care involvement and clear communication among healthcare professionals and families may reduce uncertainty and conflict.

Nursing education also has a role. Undergraduate and postgraduate programs can prepare nurses to recognize moral distress, communicate ethical concerns, participate in shared decision-making, and seek appropriate support. Simulation-based education may allow nurses to practice communication and ethical decision-making before encountering complex situations in clinical practice. Implementation, however, should be adapted to local staffing, time, resources, cultural expectations, and institutional authority structures.

Proposed Empower–Engage–Enable framework

Based on the thematic synthesis in this mini-review, the author proposed an Empower–Engage–Enable framework to organize potential responses to moral distress and burnout at individual, team, and organizational levels (Figure 1). This is an author-proposed conceptual framework, not an established or validated model. Its rationale is that individual coping support is unlikely to be sufficient when distress is shaped by ethical conflicts, interprofessional relationships, leadership, staffing, and wider health-system constraints.

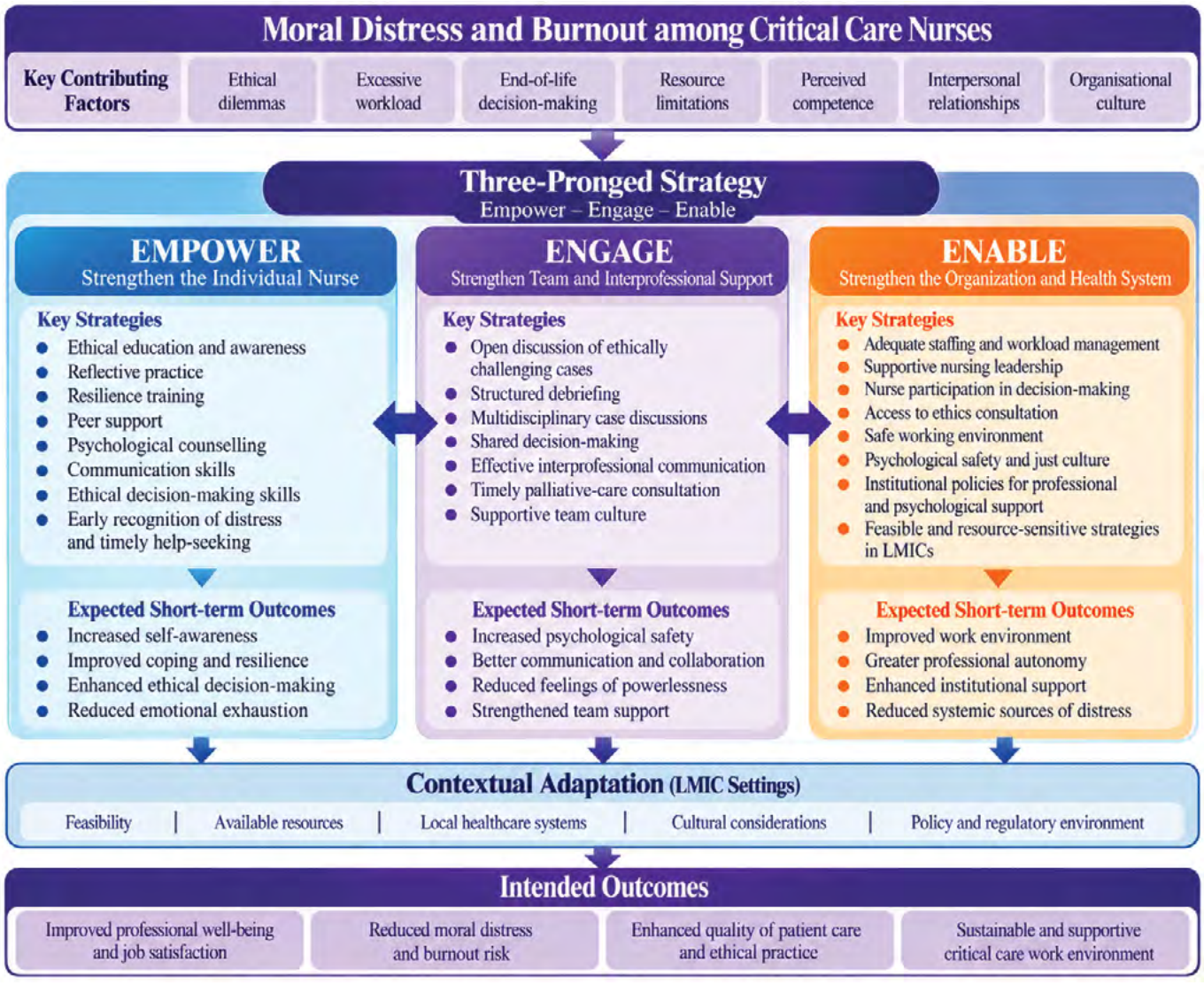


Figure 1. Nurse led innovation "Empower–Engage–Enable" framework for addressing moral distress and burnout among ICU nurses.

The three components are intended to be complementary and mutually reinforcing rather than a fixed sequence. In LMIC settings, strategies should be feasible, affordable, and adapted to local resources, culture, and healthcare structures.

1. Empower: strengthen the individual nurse

Build nurses' capacity to recognize and respond to moral distress through education, reflective practice, resilience and coping support, peer support, access to psychological counselling, and development of communication and ethical decision-making skills. Encourage nurses to recognize early signs of exhaustion and seek timely support without stigma. Individual strategies should not shift responsibility for systemic problems onto nurses.

2. Engage: strengthen team and interprofessional support

Create an environment where nurses can openly discuss ethically challenging cases with physicians and other healthcare professionals. Structured debriefing, multidisciplinary case discussions, shared decision-making, effective communication, and timely palliative-care or ethics consultation may help reduce feelings of powerlessness and support collaborative management of complex cases.

3. Enable: strengthen the organization and health system

Address structural contributors through adequate staffing, appropriate workload distribution, supportive nursing leadership, nurse participation in clinical decision-making, access to ethics consultation, safe working environments, and institutional policies for psychological and professional support.

Development, limitations, and future validation of the framework

The framework was developed by the authors as a pragmatic synthesis of the themes discussed in the selected literature: individual recognition and coping, interprofessional communication and ethical deliberation, and organizational or system-level conditions.[3-6] The literature supports considering these levels together, but it does not directly validate this specific three-pronged framework. The proposed components are therefore hypotheses for practice and research rather than evidence that the framework itself reduces moral distress or burnout.

This mini-review has limitations. It is not a systematic review; the literature selection was not exhaustive, formal quality appraisal was not undertaken, and evidence across LMICs is uneven. The framework has not yet undergone expert consensus, stakeholder consultation, or empirical testing. Its feasibility may vary with staffing, resources, professional hierarchies, cultural expectations, and access to psychological, palliative-care, and ethics services.

Future work should use a transparent review process and engage ICU nurses, nurse leaders, physicians, ethics professionals, administrators, and patients or family representatives where appropriate. Delphi consensus or other structured expert review could assess content validity and contextual relevance. Pilot implementation in diverse LMIC settings should examine acceptability, feasibility, resource requirements, and unintended effects. Subsequent controlled or longitudinal evaluations could assess changes in moral distress, burnout, ethical climate, staff retention, and patient- or family-relevant outcomes using validated instruments and prespecified methods. Adaptation should be locally led rather than assuming that one model fits all LMIC settings.

CONCLUSIONS

Moral distress and burnout are distinct yet potentially overlapping concerns among critical care nurses. They are associated with ethical dilemmas, end-of-life decisions, workload, interpersonal relationships, professional autonomy, and organizational culture. Although their direct causal relationship remains uncertain, supportive leadership, adequate staffing, teamwork, psychological safety, ethical consultation, and structured end-of-life processes may help address these concerns. The Empower–Engage–Enable framework is proposed as a literature-informed organizing model, not a validated intervention. Context-specific research is required to assess its relevance, feasibility, acceptability, and effectiveness in LMIC settings.

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DISCLOSURE

Generative AI was used to assist with language editing, organization, and refinement of the manuscript. The author reviewed and takes responsibility for the manuscript's final content, interpretation, and accuracy.

CONFLICT OF INTEREST

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