

Moral Distress, Work Engagement, and Meaningful Work in Healthcare: A Narrative Review

Sofrimento Moral, Empenho no Trabalho e Trabalho com Significado em Profissionais de Saúde: Uma Revisão Narrativa

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ABSTRACT

The psychological well-being of healthcare professionals is increasingly recognized as a critical determinant of patient safety, quality of care, and healthcare system sustainability. Among the constructs most relevant to this domain are moral distress, work engagement, and meaningful work. This narrative review aimed to synthesize conceptual and empirical evidence on these three constructs and to examine their interrelations and implications for healthcare practice. A selective narrative review of the literature was conducted, integrating theoretical frameworks, systematic and integrative reviews, and empirical studies, resulting in a final synthesis of 41 articles. Moral distress arises when clinicians are prevented from acting in accordance with their ethical convictions, often due to institutional or systemic constraints, and has been consistently associated with burnout, turnover, and compromised quality of care. In contrast, work engagement – characterized by vigor, dedication, and absorption – and meaningful work – reflecting the perception that professional activities have meaning and purpose – function as protective factors that enhance resilience and sustain intrinsic motivation. Evidence highlights the central role of organizational climate, leadership, resource availability, and ethical culture in shaping experiences of distress, engagement, and meaningfulness, a dynamic further intensified during the COVID-19 pandemic. The synthesis emphasizes that organizational and systemic interventions, including ethics consultation, supportive leadership, workflow redesign, and resilience-building programs, are essential to mitigate moral distress and promote engagement and meaningful work. The integration of these constructs aligns with the Quadruple Aim, reinforcing the premise that caring for healthcare professionals is indispensable to caring for patients.

Keywords: Attitude of Health Personnel; Burnout; Professional; Empathy; Ethical Dilemmas; Job Satisfaction; Occupational Health; Stress, Psychological; Work Engagement

RESUMO

O bem-estar psicológico dos profissionais de saúde é cada vez mais reconhecido como um determinante crítico da segurança do doente, da qualidade dos cuidados e da sustentabilidade dos sistemas de saúde. Entre os constructos mais relevantes neste domínio encontram-se o sofrimento moral, o envolvimento no trabalho e o significado do trabalho. Esta revisão narrativa teve como objetivo sintetizar a evidência conceptual e empírica sobre estes três constructos e analisar as suas inter-relações e implicações para a prática em saúde. Foi realizada uma revisão narrativa seletiva da literatura, integrando enquadramentos teóricos, revisões sistemáticas e integrativas e estudos empíricos, tendo sido incluídos 41 artigos na síntese final. O sofrimento moral surge quando os clínicos são impedidos de agir de acordo com as suas convicções éticas, frequentemente devido a constrangimentos institucionais ou sistémicos, estando consistentemente associado ao *burnout*, à rotatividade profissional e à diminuição da qualidade dos cuidados. Em contraste, o envolvimento no trabalho – caracterizado por vigor, dedicação e absorção e o significado do trabalho refletindo a perceção de que a atividade profissional tem significado e propósito – funcionam como fatores protetores, promovendo a resiliência e sustentando a motivação intrínseca. A evidência destaca o papel central do clima organizacional, da liderança, da disponibilidade de recursos e da cultura ética na modelação das experiências de sofrimento, envolvimento e sentido, uma dinâmica que foi ainda mais acentuada durante a pandemia de COVID-19. A síntese apresentada enfatiza que as intervenções organizacionais e sistémicas, incluindo a consulta ética, a liderança de suporte, a reorganização dos fluxos de trabalho e os programas de desenvolvimento da resiliência, são essenciais para mitigar o sofrimento moral e promover o envolvimento e o significado do trabalho. A integração destes constructos está alinhada com o *Quadruple Aim*, reforçando a premissa de que cuidar dos profissionais de saúde é indispensável para cuidar dos doentes.

Palavras-chave: Atitude do Pessoal de Saúde; Dilemas Éticos; Empatia; Envolvimento no Trabalho; Esgotamento Profissional; Satisfação no Trabalho; Saúde Ocupacional; Stress Psicológico

INTRODUCTION

Clinical efficiency is achieved when resources are used appropriately to foster an environment that supports teamwork and skill development while mitigating stress. This balance enables the delivery of high-quality care and a positive patient experience.¹ The evolution of modern healthcare and society marked by rising expectations and diminishing resources, continues to highlight the urgent need for innovative solutions that enhance care delivery, reduce provider stress, and improve the caregiving experience.^{2,3} Traditionally, interventions aimed at reducing poor well-being among healthcare professionals (HCPs) fall into two main categories: those targeting the healthcare system and those targeting the individual.⁴

The practice of healthcare is both technically demanding and ethically complex. Beyond clinical expertise, professionals must navigate conflicting responsibilities, limited resources, and systemic pressures that often compromise their ability

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to act in ways consistent with their values.⁵⁻⁷ These challenges have intensified in recent years, particularly during the COVID-19 pandemic, which exposed vulnerabilities in healthcare systems and magnified the psychosocial burdens borne by clinicians.⁸

High levels of moral distress have been associated with burnout, medical errors, impaired communication, and increased turnover among physicians and nurses.^{5-7,9} Conversely, work engagement has been shown to predict patient satisfaction, lower rates of adverse events, and higher organizational performance.¹⁰⁻¹³ Meaningful work contributes to professional retention and resilience, buffering against the psychological toll of high-stress environments.¹⁴⁻¹⁶

These issues have gained even greater urgency in the aftermath of the COVID-19 pandemic, which intensified moral conflicts, workload demands, and workforce shortages.^{8,9,17} International research priorities now emphasize the need to safeguard healthcare workers' mental health as a prerequisite for resilient and sustainable healthcare systems.^{18,19} Understanding how moral distress, work engagement, and meaningful work interact is therefore critical not only for protecting professionals but also for ensuring safe, effective, and sustainable patient care, particularly given the lack of studies integrating these three concepts. Although conceptually distinct, moral distress, work engagement and meaningful work intersect in ways that profoundly affect professional well-being and patient care. Moral distress, first introduced by Jameton in 1984,⁵ denotes the psychological suffering experienced when individuals know the ethically appropriate action but are unable to execute it. Work engagement, a concept developed by Schaufeli *et al* in 2002,¹⁰ represents a positive and persistent state of professional fulfillment. Meaningful work, which has roots in sociology and psychology, refers to the experience of work as being meaningful, valuable, and aligned with a broader purpose.¹⁴⁻¹⁶

The interconnections among these constructs are not merely theoretical. There is evidence that indicates that moral distress undermines engagement and erodes the sense of meaningful work, while engagement and meaningfulness buffer against distress by promoting resilience, purpose, and professional satisfaction.¹⁹⁻²¹ Exploring these relationships is therefore critical not only for the well-being of professionals but also for the sustainability of healthcare organizations and systems.

Despite growing attention to moral distress, work engagement, and meaningful work, important gaps remain in the literature. Most studies have examined these constructs in isolation, focusing predominantly on nurses and with limited integration of their interrelationships.⁵⁻⁷ Evidence on how meaningful work and engagement may buffer the effects of moral distress is scarce, with only a handful of empirical studies addressing this interaction.^{21,22} Moreover, most of the research derives from North American and Northern European contexts, leaving Portuguese-speaking countries and other healthcare systems underrepresented. Finally, while the COVID-19 pandemic exacerbated moral conflicts and intensified the search for purpose in healthcare, systematic examinations of how this crisis reshaped the three constructs remain limited.^{8,9,17}

Objectives

This review therefore aims to address these gaps by: (1) synthesizing evidence on the determinants, consequences, and potential overlap among moral distress, work engagement, and meaningful work in healthcare professionals; (2) examining whether engagement and meaningful work act as protective factors against moral distress; and (3) assessing the evidence on interventions targeting these constructs, with particular attention to their effectiveness and applicability in post-pandemic contexts.

This narrative review synthesizes current knowledge on moral distress, work engagement, and meaningful work, integrating conceptual frameworks, empirical studies, and practical interventions. It aims to provide a comprehensive understanding of how these constructs intersect, their consequences for healthcare delivery, and the strategies that may enhance both professional and patient outcomes.

Methodology for literature selection

This study is a narrative review aimed at synthesizing conceptual and empirical evidence on moral distress, work engagement, and meaningful work among healthcare professionals. A selective literature search was conducted in PubMed, Scopus, and Google Scholar using combinations of the terms "moral distress", "work engagement", "meaningful work", and "healthcare professionals". A total of 75 records were initially identified, of which 41 articles were included in the final narrative synthesis. Articles published primarily in English over the last 10 years were prioritized, alongside seminal theoretical papers and key consensus documents irrespective of publication date. Inclusion criteria comprised reviews, empirical studies, and conceptual papers addressing at least one of the three constructs within healthcare settings, while studies unrelated to healthcare professionals or lacking conceptual relevance were excluded. Data extraction focused on

definitions, determinants, consequences, and interventions related to the three constructs, and findings were narratively synthesized to identify convergent themes and knowledge gaps.

RESULTS

The results of this narrative review are presented thematically, according to the three core constructs analyzed.

Moral distress

Moral distress (MD) remains one of the most studied psychological phenomena in healthcare ethics, particularly within nursing, where it has been consistently documented as a pervasive experience.²³ Jameton⁵ first described MD as the distress that occurs when nurses recognize the ethically correct action but cannot carry it out due to institutional barriers. Subsequent scholarship expanded the concept, demonstrating that MD is not confined to nursing nor to individual-level barriers. Hamric and Epstein⁷ identified a broader spectrum of determinants, encompassing patient- and family-level dynamics (e.g., demands for futile therapies), team-level issues (e.g., communication breakdowns, hierarchical conflict), and systemic factors such as inadequate staffing, cost-containment policies, and bureaucratic pressures.

Distinguishing MD from related constructs is essential, particularly moral injury, a term originally used to describe psychological harm among military personnel. Moral injury refers to the enduring emotional and psychological trauma that can arise from repeated or unresolved experiences of MD. Whereas MD describes situational experiences, moral injury captures long-term psychological harm, often manifesting as guilt, shame, depression, or even suicidal ideation.²⁴

Determinants and consequences

Systematic and integrative reviews provide robust evidence of the triggers and consequences of MD. A systematic review by Lamiani *et al*²⁰ highlighted poor ethical climate, lack of collaboration, and instrumental leadership as major contributors. Integrative reviews in oncology, intensive care, and palliative care have consistently identified limited resources, poor communication, and end-of-life decision-making as recurrent triggers.²⁵⁻²⁷ Cross-sectional studies, such as Ramos *et al*,²⁸ confirmed that clinical conflicts and professional insecurity were strongly associated with moderate-to-high levels of distress. Validated tools such as the Moral Distress Scale – Revised (MDS – R) have been increasingly refined to improve cross-cultural measurement accuracy.²⁹ The more recent Measure of Moral Distress for Healthcare Professionals (MMD-HCP) is recommended as a replacement for the MDS-R, and it is validated for the Portuguese population.^{30,31}

The consequences of MD are profound and multifaceted. At the individual level, it is linked to burnout, emotional exhaustion, and decreased job satisfaction.^{9,32} At the organizational level, it contributes to turnover, absenteeism, and loss of morale, with substantial economic repercussions and has been shown to predict turnover intention across healthcare systems globally.^{33,34} At the clinical level, MD undermines the quality of care and compromises patient safety.^{5,6,19} A British Medical Association survey⁹ revealed that more than three-quarters of physicians reported significant repercussions of MD on their professional lives, with many intending to reduce hours or exit the profession.

Beyond its psychological toll on professionals, moral distress has direct repercussions on patient care and healthcare systems.^{5,9} Repeated exposure to unresolved ethical conflicts erodes empathy, fosters depersonalization, and compromises communication with patients and families,^{25,26} particularly in high-intensity settings such as intensive care and oncology. Empirical studies link moral distress to increased medical errors, delayed decision-making in end-of-life care, and reduced quality of interactions. At the organizational and systemic level, sustained moral distress contributes to workforce instability, increased institutional costs, and threatens the continuity and sustainability of care.³³

Strategies and interventions

Strategies to address MD must operate at both structural and individual levels. Structural approaches include ensuring adequate staffing and resources, developing ethical leadership, promoting a culture of openness, and reducing bureaucratic obstacles.^{7,35} Individual strategies encompass peer support, counseling, resilience-building, and participation in ethics consultation. Programs, such as the Moral Distress Consultation Model (MDCM)⁷ offer structured support for identifying ethical challenges, analyzing barriers, and co-developing actionable strategies, which has been associated with increased empowerment and reduced distress. Meaning-centered psychotherapy for healthcare professionals is another individual-level intervention, promising in reducing MD.³⁶

Work engagement

Work engagement has become one of the most studied indicators of positive occupational well-being. Defined by

Schaufeli *et al*¹⁰ as “a positive, fulfilling, work-related state of mind characterized by vigor, dedication, and absorption”, engagement reflects not a fleeting emotion but a sustained psychological connection to one’s work.

Theoretical foundations

The Job Demands–Resources (JD-R) model¹¹ provides the dominant theoretical framework. It posits that engagement arises when job resources – such as autonomy, feedback, and social support – buffer the effects of job demands, including workload, emotional strain, and organizational pressures. Resources not only mitigate stress but also stimulate personal growth, learning, and development. Job crafting¹² extends this framework by highlighting how workers actively shape their tasks and relationships to align with strengths and values, thereby increasing engagement.

Empirical evidence

Engagement has been positively associated with job satisfaction, perceived care quality, patient safety, and organizational commitment.^{10,13,37} These relationships complement broader models of occupational stress, in which well-being, burnout, and engagement are seen as interdependent constructs.³⁸ It is inversely correlated with burnout, turnover, and psychological distress.^{11,19} In nursing and medical contexts, higher engagement predicts better patient outcomes and lower incidence of adverse events.^{1,13} There are studies also suggesting that engagement fluctuates across tasks and contexts, influenced by team dynamics, leadership, and organizational culture.¹³

Promoting engagement

Promoting engagement requires multilevel strategies. Organizational interventions include redesigning jobs to enhance autonomy and feedback, fostering participatory decision-making, and cultivating a climate of psychological safety.^{11,34} Leadership plays a decisive role, with supportive and ethical leaders consistently associated with higher engagement.^{11,13} Individual interventions – such as resilience training, mindfulness-based practices, and coaching – support engagement.^{4,18,39}

Meaningful work

Meaningful work has emerged as a construct of increasing relevance in contemporary healthcare, where professionals often confront existential questions about the value and purpose of their work.

Conceptual foundations

Meaningful work refers to the subjective experience that one’s professional activities have meaning, are worthwhile, and aligned with broader values.¹⁴⁻¹⁶ It must be distinguished from the meaning of work, which refers to cultural and collective interpretations of work in society.¹⁴

Several theoretical frameworks provide insight: the Job Characteristics Model³⁷ identifies skill variety, task identity, task significance, autonomy, and feedback as determinants of meaningfulness; Rosso *et al*¹⁴ propose that meaning derives from the self, others, context, and spiritual life, mediated by mechanisms such as authenticity, self-efficacy, and belongingness; Steger *et al*¹⁶ emphasize positive meaning, meaning-making, and greater-good motivations.

Steger offers one of the most influential theoretical conceptualizations of meaningful work. However, it is important to note that the concept of meaning has existential origins and has, in recent years, been extensively developed in patient care, particularly through the work of Breitbart, which is grounded in Viktor Frankl’s work.^{15,16,40}

Dimensions and clinical significance

Authenticity, purpose, self-efficacy, belongingness, and transcendence are recurrently cited as central dimensions.^{14,15} Work as a calling – a notion deeply ingrained in the medical profession – represents one of the most powerful forms of meaningful work. Physicians who perceive their profession as a calling report greater satisfaction, resilience, and commitment to patient care.³⁹ Conversely, the erosion of calling through bureaucracy, commercialization, and technological pressures has been linked to disillusionment and burnout.^{19,41}

Models of prediction

The SPIRE model emphasizes personal-level predictors, such as values, strengths, and intrinsic motivations, while the CARMA model highlights organizational determinants, including leadership, resources, and culture.^{15,37} Together, these frameworks demonstrate that meaningful work is co-constructed by individuals and their environments, requiring alignment between personal values and organizational mission.

Integration of concepts

Although several studies examine moral distress in relation to work engagement or explore meaningful work as a protective factor for professional well-being, the literature integrating all three constructs simultaneously remains scarce or inexistent. None of the included studies explicitly conceptualized or empirically tested moral distress, work engagement, and meaningful work within a single integrative framework as defined in this review. The integration proposed herein therefore reflects a narrative and conceptual synthesis of existing evidence, aiming to bridge fragmented findings and to highlight a relevant gap in current research. This lack of integrated models underscores the need for future empirical studies examining the dynamic interplay among these constructs.

The interplay between MD, work engagement, and meaningful work reflects a complex dynamic with profound implications for healthcare delivery (Table 1).

Moral distress undermines engagement and erodes meaningfulness by obstructing ethical agency (which involves the ability of professionals to recognize ethical tensions, deliberate responsibly, and act in accordance with moral values despite institutional or systemic constraints) and reducing professional autonomy.⁵⁻⁷ Conversely, engagement and meaningful work act as protective factors, buffering against the negative effects of distress and sustaining motivation, resilience, and commitment.^{10,14,19} Empirical studies, although limited, support this interaction: Lamiani *et al*²⁰ found that higher levels of MD correlated with reduced engagement and satisfaction, and similar associations have been observed empirically among critical care nurses,²¹ while reviews of organizational factors repeatedly emphasize the role of the ethical climate (in healthcare organizations, an ethical climate reflects professionals' shared perceptions of how ethical concerns are addressed in clinical practice and organizational decision-making) and leadership in shaping all three constructs.^{2,3}

The organizational climate is particularly salient. A positive ethical climate reduces MD, fosters engagement, and reinforces meaningfulness.^{5,6,11,20} Conversely, instrumental leadership, poor communication, and resource scarcity exacerbate distress and reduce both engagement and meaning.^{6,7} The integration of these concepts aligns with the Quadruple Aim, a comprehensive framework for optimizing healthcare system performance. Originally derived from the Institute for Healthcare Improvement's Triple Aim – which sought to enhance the patient experience of care, improve population health outcomes, and reduce per capita healthcare costs – the Quadruple Aim introduces a fourth dimension: improving the work life and well-being of healthcare providers. This addition recognizes that the sustainability of high-quality, patient-centered care depends not only on system efficiency and patient outcomes but also on the moral, emotional, and professional well-being of clinicians. By addressing all four dimensions, the Quadruple Aim promotes a more holistic and resilient healthcare ecosystem that values both caregivers and recipients of care. Without attention to provider well-being, the sustainability of health systems is at risk.³⁵⁻³⁸

It is evident that these three concepts – moral distress, work engagement, and meaningful work – interact with one another. However, the exact mechanisms underlying these interactions remain unclear; therefore, understanding their synergistic influences may help inform the design of interventions aimed at promoting the wellbeing of HCPs'.

DISCUSSION

This narrative review integrates evidence on MD, work engagement, and meaningful work, highlighting their complex interrelations and implications for healthcare professionals and healthcare systems.

Contribution to current knowledge

This narrative review adds to current knowledge by integrating three constructs – MD, work engagement, and meaningful work – that have largely been examined in isolation within the existing literature. By synthesizing fragmented evidence, the review highlights how engagement and meaningful work may function as protective factors mitigating the negative impact of MD on HCPs. The review further identifies the absence of empirically integrated models as a critical gap in current research and clarifies the central role of organizational and systemic factors in shaping these constructs. In doing so, it provides a coherent conceptual framework to inform future research and the development of multilevel interventions aimed at promoting professional well-being and healthcare system sustainability.

It is hypothesized that, although operating through different psychological mechanisms, moral distress may negatively influence both work engagement and meaningful work (Fig. 1). Meaningful work is a broader concept, directly linked not only to the meaning, purpose and value of work, but also to meaning in life, according to Steger *et al* model,¹⁶ which comprises three dimensions: positive meaning, meaning-making, and greater good motivations.

Interventions and future directions

From an organizational perspective, the integrated analysis of MD, work engagement, and meaningful work allows the identification of concrete proposals to improve the professional quality of life of healthcare workers. The interventions outlined below should therefore be understood not only as isolated strategies reported in the literature, but as complementary organizational approaches addressing ethical, structural, and motivational dimensions of work.

Addressing moral distress and fostering work engagement and meaningful work require multilevel, integrated interventions that are directly linked to organizational commitment and support. At the systemic level, policies must address structural drivers of distress, including underfunding, staffing shortages, and excessive bureaucratic demands.^{1,9} Policymakers should prioritize investment in workforce sustainability, recognizing that professional well-being is inseparable from patient outcomes.

At the organizational level, interventions should target leadership development, open communication, interprofessional collaboration, and ethical consultation services.^{7,35} Creating environments that support autonomy, feedback, and alignment of values enhances both engagement and meaningfulness while reducing distress.^{11,37}

At the individual level, programs such as resilience training, mindfulness, and coaching provide tools for coping, but their effectiveness depends on organizational support.^{18,39} Evidence-based interventions such as the MDCM and MCP-HCP^{7,15} show promise. The MDCM facilitates ethical problem-solving through structured dialogue, while the MCP-HCP reconnects professionals with meaning and purpose, mitigating burnout and compassion fatigue.

The evidence base remains limited but informative. Pilot studies of the MDCM show improved empowerment and ethical clarity.⁷ The MCP-HCP has demonstrated reductions in burnout and distress in small randomized trials.¹⁵ Resilience and mindfulness interventions produce moderate benefits, especially when coupled with organizational support.^{18,39} Systematic reviews stress that multilevel approaches yield more sustainable results than isolated programs.^{19,20}

This narrative review is limited by its non-systematic literature selection, which may have excluded relevant studies and precludes quantitative synthesis, limiting generalizability. In addition, conceptual and methodological heterogeneity hampers direct comparison between MD, work engagement, and meaningful work. Future research should prioritize longitudinal designs to clarify causal relationships among these constructs and to assess their evolution over time. Interventional studies are needed to evaluate multilevel strategies across diverse clinical and organizational contexts, including underrepresented regions such as Portuguese-speaking countries. Further research should also explore the role of digital tools, including remote ethics consultation services delivered through telecommunication platforms to support healthcare professionals in complex ethical decision-making, as well as digital resilience programs, as scalable approaches to support healthcare professionals.

CONCLUSION

Moral distress, work engagement, and meaningful work are distinct but interrelated constructs that profoundly influence the experiences of healthcare professionals and the outcomes of healthcare organizations.^{5,10,14} Moral distress not only undermines clinician well-being but also jeopardizes patient safety and organizational sustainability.^{5,6,19} Engagement and meaningful work, by contrast, provide resilience, purpose, and motivation, supporting both professionals and the patients they serve.^{10,14,15,41}

The evidence reviewed here highlights the need for systemic, organizational, and individual-level interventions. Addressing MD while fostering engagement and meaning is not only an ethical imperative but also a strategic necessity for healthcare system sustainability. In line with the Quadruple Aim, the future of healthcare depends on the recognition that caring for patients requires caring for healthcare professionals.

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AUTHOR CONTRIBUTIONS

CS: Study design, literature search, data collection, writing of the manuscript.

GdP: Study design, literature search, data collection, writing and critical review of the manuscript.

All authors approved the final version to be published.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

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Table 1 – Comparison between moral distress, work engagement and meaningful work in health professionals

Dimension	Moral distress	Work engagement	Meaningful work
Definition	Psychological suffering when one knows the correct ethical action but cannot carry it out due to institutional barriers	Positive and persistent state of accomplishment at work, characterized by vigor, dedication, and absorption	Subjective experience that the work is valuable, meaningful, and contributes to a greater purpose
Origin / history	This concept was introduced by Jameton (1984), ⁵ initially in nursing	Defined by Schaufeli <i>et al</i> (2002), ¹⁰ based on positive organizational psychology	Developed from the Job Characteristics Model (Hackman <i>et al</i> , 1976) ³⁷ and Steger <i>et al</i> (2012) ¹⁶
Key determinants	Institutional barriers, lack of resources, ethical dilemmas, administrative pressures	Work resources (social support, feedback, autonomy), task design, organizational climate	Authenticity, purpose, self-efficacy, personal values, leadership, organizational framework
Consequences	Burnout, turnover, demotivation, lower quality of care, economic impact	Greater satisfaction, quality of care, lower burnout and turnover, greater organizational commitment	Retention of professionals, greater well-being, reduction of burnout, greater resilience
Relationship with clinical practice	It reduces the ability to provide ethical and quality care	Increases motivation, patient safety and organizational efficiency	It reinforces a sense of mission, commitment to patients and quality of care
Instrument	Measure of Moral Distress for Healthcare Professionals (MMD-HP) ³¹	Utrecht Work Engagement Scale (UWES) ¹⁰	Work and Meaning Inventory (WAMI) ¹⁶
Intervention strategies	Structural (resources, ethical leadership, bureaucratic simplification) and individual (resilience, support networks)	Organizational (task redesign, supportive leadership) and individual (mindfulness, coaching) interventions	Development of environments that promote purpose, alignment between personal values and institutional mission

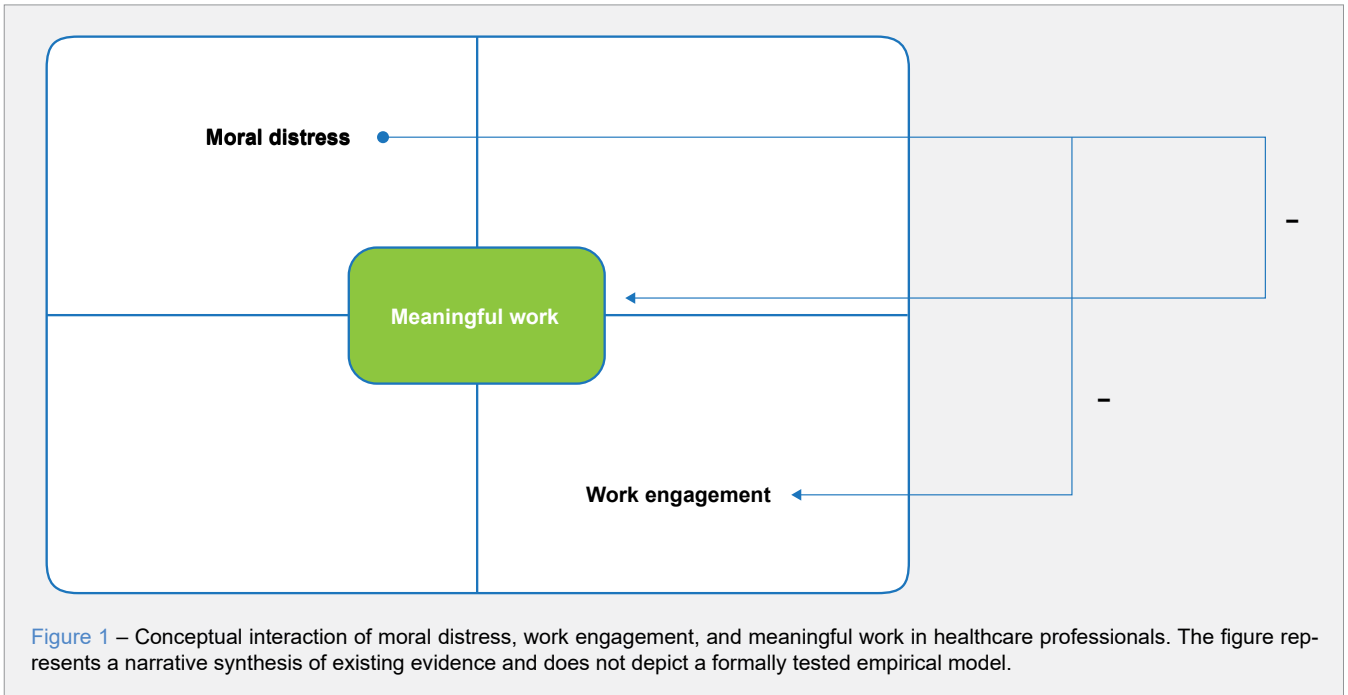


Figure 1 – Conceptual interaction of moral distress, work engagement, and meaningful work in healthcare professionals. The figure represents a narrative synthesis of existing evidence and does not depict a formally tested empirical model.