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Occupational Burnout, Moral Distress, and Compassion Fatigue in Clinical Nurses: An Integrated Critical Narrative Review

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Abstract

Background and Objective: Clinical nurses work under sustained cognitive and physical demands and are repeatedly exposed to illness, suffering, ethical uncertainty, and organizational constraints. Occupational burnout, moral distress, and compassion fatigue are often discussed together, yet they arise from partly distinct processes and are measured with instruments that are not interchangeable. Conflating these constructs can obscure their determinants and lead to interventions that do not address the source of distress. To critically synthesize evidence on the conceptual definitions, measurement approaches, determinants, interrelationships, professional consequences, and responses associated with occupational burnout, moral distress, and compassion fatigue among clinical nurses.

Methods: A structured literature-search framework was developed around nursing personnel and the three focal constructs. Exploratory evidence identification used web-indexed PubMed records, PubMed Central full texts, publisher pages, targeted searches, and citation chaining. The source manuscript records 12 November 2026 as the evidence-update date; this is not supported by a complete platform-specific search log. Full searches in CINAHL, Embase, Scopus, Web of Science, and PsycINFO, comprehensive record exports and deduplication, independent dual-reviewer screening, and formal study-level risk-of-bias appraisal were not completed. The evidence was therefore synthesized narratively, without a systematic study count or PRISMA flow diagram.

Results: The evidence supports treating the three constructs as related but non-equivalent. Burnout is an occupational phenomenon associated with chronic unmanaged workplace stress and is commonly described in terms of exhaustion, cynicism or depersonalization, and reduced professional efficacy. Moral distress arises in morally salient situations and is associated with constraints or conflicts affecting ethically appropriate action. Compassion fatigue remains inconsistently defined and is linked in different literatures to secondary traumatic stress, cumulative exhaustion, or both. ProQOL assesses compassion satisfaction, burnout, and secondary traumatic stress as separate subscales; it does not provide a single validated total score for compassion fatigue. One included study used a study-specific composite derived from all three ProQOL subscales, whereas another study reported discrepancies between its stated sample and mediation-table sample and between corresponding P values. Primary nursing studies report associations between moral distress and compassion fatigue among emergency nurses, associations between moral distress and ProQOL dimensions among critical-care nurses, and associations linking work environment, missed care, moral distress, and burnout. Most studies examining relationships between constructs are cross-sectional and cannot establish temporal or causal pathways.

Conclusions: Research and clinical management should distinguish the sources and defining features of each construct rather than treating them as interchangeable expressions of stress. Responses should be matched to the dominant exposure and should address workload, staffing, autonomy, ethical climate, access to moral deliberation, trauma-informed supervision, and opportunities for recovery. Longitudinal studies using construct-specific measures are needed to clarify temporal relationships and evaluate interventions.

Keywords: Nurses; Burnout, Professional; Moral Distress; Compassion Fatigue; Secondary Traumatic Stress; Professional Quality of Life; Occupational Stress; Nursing Practice.

1. Introduction

Nursing involves sustained cognitive and physical work alongside repeated exposure to illness, uncertainty, suffering, death, and family distress. Nurses must also make decisions in which clinical priorities, patient preferences, professional obligations, and institutional constraints may not align. These demands are not inherently pathological; close patient relationships can provide professional meaning and compassion satisfaction. Distress may arise, however, when demands persist and the resources needed to manage them are inadequate, with potential consequences for nurses' health, work participation, therapeutic relationships, and continuity or quality of care [1-4]. Three constructs recur in accounts of nursing-related occupational distress: burnout, moral distress, and compassion fatigue. They may share manifestations such as exhaustion, frustration, withdrawal, or reduced capacity to sustain caring work, but their defining antecedents differ. Burnout is primarily associated with chronic workplace stress and an imbalance between job demands and available resources. Moral distress is rooted in moral experience: a nurse identifies an ethically appropriate action or obligation but encounters constraints, conflict, or circumstances that make it difficult or impossible to act. Compassion fatigue is associated with sustained empathic engagement with people who are suffering or traumatized and is frequently discussed alongside secondary traumatic stress [5-11].These distinctions matter when selecting responses. Changes to staffing or workload may reduce exhaustion related to excessive job demands, but they will not necessarily resolve recurring situations in which nurses perceive that care is inconsistent with patients' interests or their own professional obligations. Ethics consultation may help teams deliberate about morally difficult care, but it cannot by itself address the effects of repeated exposure to traumatic narratives or patient deaths. Individual resilience training is likewise insufficient when unsafe staffing, inadequate resources, limited professional autonomy, or a culture that discourages staff from raising concerns remain unchanged [4,12].

Measurement further complicates comparisons. Burnout is commonly assessed using the Maslach Burnout Inventory (MBI), Copenhagen Burnout Inventory (CBI), or Oldenburg Burnout Inventory (OLBI). Moral distress has been measured with several versions of the Moral Distress Scale, the Moral Distress Scale-Revised (MDS-R), and the Measure of Moral Distress for Healthcare Professionals (MMD-HP). Compassion fatigue has been assessed using Figley-derived measures, Professional Quality of Life (ProQOL) instruments, and secondary traumatic stress scales. These instruments differ in construct content, reference periods, response formats, and scoring; consequently, studies using the same label may not be measuring the same operational construct [2,3,5-9,11,13-27]. The issue is particularly evident in ProQOL-based research. ProQOL assesses compassion satisfaction, burnout, and secondary traumatic stress as separate dimensions. Some publications use compassion fatigue as an umbrella term for the negative dimensions, whereas others use it to refer primarily to secondary traumatic stress or to a broader combination of trauma-related symptoms and cumulative occupational exhaustion. The ProQOL burnout subscale should not be treated as equivalent to a multidimensional occupational burnout measure, and its secondary traumatic stress subscale should not be assumed to capture every definition of compassion fatigue [7-11,13,24].

Recent reviews have expanded the evidence base but have generally focused on a single construct, a restricted set of outcomes, or a specific nursing population. These include a 2025 umbrella review of burnout prevalence and contributing factors among nurses, a 2025 systematic review and meta-analysis of the relationship between moral distress and ethical climate, a 2024 meta-analysis of professional quality of life among mental-health nurses, and a 2026 umbrella review of the prevalence, severity, determinants, and consequences of moral distress [23,28-30]. A 2025 umbrella review of psychiatric mental-health nurses also mapped overlapping forms of work-related distress, although its population and conceptual scope differ from the broader clinical nursing workforce considered here [31]. Primary studies published in 2026 have begun to examine moral distress alongside compassion fatigue, resilience, missed nursing care, and burnout in larger or more diverse nursing samples [49,50].

This review does not claim that the three constructs have not previously been examined together. Its purpose is to clarify their conceptual boundaries, show how measurement choices shape apparent overlap, identify shared and construct-specific determinants, and interpret reported associations without implying causation. The review also considers the implications of these distinctions for professional support, nursing management, and future research.

2. Review Methods

2.1. Review design and reporting approach

A critical narrative review with a structured literature-search framework was selected to integrate conceptual analyses, psychometric studies, cross-sectional and longitudinal research, qualitative inquiry, intervention studies, and existing evidence syntheses. The review was not designed to estimate a single pooled effect or prevalence. Narrative synthesis allows comparison of constructs with different theoretical foundations and measurement approaches while permitting examination of terminology and context. SANRA was used as a quality-oriented guide for the rationale, aims, search description, referencing, scientific reasoning, and presentation of evidence [32]. PRISMA-S principles informed the planned reporting of searches; PRISMA 2020 is not claimed as the reporting standard for this narrative review [33].

2.2. Review question and scope

The guiding question was: How are occupational burnout, moral distress, and compassion fatigue conceptualized and measured among clinical nurses; how do they overlap and differ; and which individual-, interpersonal-, organizational-, and system-level factors and professional outcomes are associated with them? The population comprised qualified nurses providing direct or indirect clinical care in hospitals and other healthcare settings. The concepts of interest were the three focal constructs and closely related terms relevant to their measurement. Settings included intensive care, emergency care, oncology, mental health, palliative care, general acute care, and community-based services.

2.3. Eligibility principles

Empirical studies were considered relevant when they used cross-sectional, cohort, longitudinal, qualitative, mixed-methods, or interventional designs involving practicing nurses and explicitly measured or analyzed at least one focal construct. Studies assessing two or three constructs were particularly informative for the analysis of interrelationships. Instrument-development and validation studies were eligible for the measurement section. Systematic reviews, meta-analyses, umbrella reviews, and concept analyses were treated as secondary evidence and were not counted as independent primary studies. Studies limited to nursing students were not treated as evidence about practicing nurses unless nurse-specific results could be separated. Studies involving other healthcare professionals were used only when nurse-specific findings were available or when a review-level estimate was explicitly identified as representing a mixed-profession sample.

Studies of generic stress, anxiety, depression, fatigue, or job dissatisfaction were not treated as direct evidence unless at least one focal construct was defined or measured. Moral injury, moral residue, secondary traumatic stress, vicarious trauma, and compassion satisfaction were considered related but distinct concepts and were not automatically merged with the three focal constructs.

2.4. Information sources, search strategy, and search status

A search framework was drafted for PubMed/MEDLINE, CINAHL, Embase, Scopus, Web of Science, PsycINFO, and the Cochrane Library. ScienceDirect and Google Scholar were identified as supplementary

discovery sources, together with reference-list checking and citation tracking. The planned search combined controlled vocabulary, where available, with free-text terms for nurses, burnout, moral distress, and compassion fatigue or secondary traumatic stress. Separate construct-specific searches and pairwise and three-way combinations were specified to reduce the risk of missing studies that assessed only one or two constructs.

2.4.1. Search date and completion status

The source manuscript records 12 November 2026 as the evidence-update date. This date is retained as the last update date reported by the authors; however, the supplied material does not include dated, platform-specific search histories or retrieval logs, so it cannot be verified as the date of a fully executed final database search. Exploratory identification for this draft drew on web-indexed PubMed records, PubMed Central full texts, publisher pages, targeted searches for primary studies and reviews, and citation chaining.

The planned searches were not completed in the native interfaces of CINAHL, Embase, Scopus, Web of Science, or PsycINFO, and complete exports from these databases were unavailable. Although the Cochrane Library was included in the search framework, the supplied record does not document a complete, dated search and export for that source. The file also does not provide database-specific retrieval totals or a consolidated search log. Accordingly, the date above should be interpreted as a reported evidence-update date, not as evidence that all planned databases were searched on that date.

2.5. Search concepts and draft PubMed strategy

The following PubMed strategy is provided as a reproducible starting point, not as a record of a completed search. The three construct sets should be run separately and in pairwise and combined forms. MeSH mapping and Search Details should be checked at the time of execution because indexing terms may change.

Nursing population set: ("Nurses"[Mesh] OR "Nursing Staff"[Mesh] OR nurs*[tiab] OR "registered nurse*"[tiab] OR "clinical nurse*"[tiab] OR "staff nurse*"[tiab] OR "nursing personnel"[tiab]).

Burnout set: ("Burnout, Professional"[Mesh] OR burnout[tiab] OR "occupational burnout"[tiab] OR "job burnout"[tiab] OR "emotional exhaustion"[tiab] OR depersonalization[tiab] OR depersonalisation[tiab] OR "reduced personal accomplishment"[tiab]).

Moral distress set: ("Moral Distress"[Mesh] OR "moral distress"[tiab] OR "ethical distress"[tiab] OR "moral residue"[tiab] OR "moral constraint*"[tiab] OR "moral conflict*"[tiab] OR "ethical conflict*"[tiab]).

Compassion fatigue set: ("Compassion Fatigue"[Mesh] OR "compassion fatigue"[tiab] OR "secondary traumatic stress"[tiab] OR "secondary trauma*"[tiab] OR "vicarious trauma"[tiab] OR "professional quality of life"[tiab] OR ProQOL[tiab]).

The core combinations are nursing AND burnout; nursing AND moral distress; nursing AND compassion fatigue/secondary traumatic stress/ProQOL; and each pairwise combination plus the three-way combination. Moral injury should be searched separately as a related concept and should not be treated as synonymous with moral distress. Date and language restrictions should not be imposed at the initial search stage unless feasibility requires them and the decision is reported.

2.6. Study selection and extraction

For a reproducible selection process, all retrieved records should be exported to EndNote, Zotero, or equivalent software, with database, search date, and retrieval count retained for each source. Duplicates should then be identified using DOI, PMID, title, author, and year, and title/abstract and full-text screening should be documented separately. These steps were not completed for the present draft: comprehensive

exports and deduplication were unavailable, and independent dual-reviewer screening and extraction were not performed. They are therefore described as outstanding procedures rather than completed methods.

The extraction framework included authorship, year, country, setting, design, sample size, nurse characteristics, construct definition, measurement instrument, scoring approach, relevant covariates, effect estimates, outcomes, limitations, and funding or conflicts of interest where reported. Multiple publications arising from the same underlying sample should be linked to avoid counting one cohort more than once. Values not reported by the source should remain coded as not reported rather than being inferred.

2.7. Quality appraisal and synthesis

Methodological appraisal should be matched to study design: RoB 2 for randomized trials; ROBINS-I for non-randomized intervention studies where appropriate; JBI analytical cross-sectional and cohort checklists for observational studies; JBI or CASP tools for qualitative studies; and MMAT for mixed-methods studies. SANRA assesses the quality of the narrative review itself, not the risk of bias in primary studies. A formal study-by-study appraisal was not completed for this draft. Findings were synthesized narratively, with attention to construct definitions, measurement, population, setting, temporal design, and whether reported associations were adjusted or unadjusted. No new pooled estimates, P values, heterogeneity statistics, or forest plots were calculated.

3. Results: Critical Narrative Synthesis of the Available Evidence

3.1. Occupational burnout: definition and characteristic pattern

The World Health Organization classifies burnout in ICD-11 as an occupational phenomenon rather than a medical condition. It is described as resulting from chronic workplace stress that has not been successfully managed and is characterized by energy depletion or exhaustion, increased mental distance from work or job-related negativism or cynicism, and reduced professional efficacy [1]. This occupational framing distinguishes burnout from psychological distress arising from non-work-related events.

The Maslach framework has strongly influenced empirical research. Its three dimensions are emotional exhaustion, depersonalization or cynicism, and reduced personal accomplishment or professional efficacy [2,3,52]. Emotional exhaustion reflects depletion of emotional and physical resources; depersonalization captures distancing or impersonal responses toward care recipients; and reduced accomplishment concerns diminished perceived effectiveness. These dimensions are related but not interchangeable. The CBI distinguishes personal, work-related, and client-related burnout, whereas the OLBI generally assesses exhaustion and disengagement. Scores from these instruments cannot be assumed to be equivalent to MBI subscales [25-27,34]. A nurse may experience marked exhaustion while retaining a strong sense of professional efficacy, or may report cynical detachment without scoring similarly across all burnout dimensions.

Burnout should not be framed solely as an individual failure to cope. The Job Demands–Resources model offers an organizational explanation: sustained demands, including workload, time pressure, emotional labor, role conflict, and administrative burden, consume energy; resources such as adequate staffing, autonomy, supportive leadership, effective teamwork, feedback, and opportunities for professional development may sustain motivation and buffer strain [4,12,34]. An integrative review of reviews in nursing identified work overload, lack of formal rewards, and work–life interference as prominent demands. Supervisor support, fair

management, leadership, interpersonal relationships, autonomy, and professional resources were identified as relevant resources [12].

A 2025 umbrella review reported substantial variation in global estimates of nurse burnout. It estimated pooled proportions of 33.45% for high emotional exhaustion (95% CI 27.31–39.59), 25.00% for depersonalization (95% CI 17.17–33.00), and 33.49% for low personal accomplishment (95% CI 28.43–38.55). Between-review heterogeneity was extremely high for all three dimensions (I^2 approximately 99.6% or greater), precluding interpretation of these figures as universal prevalence estimates [29]. The same review identified work-related and individual correlates, including role conflict, negative emotions, stress, family problems, moral distress, commuting distance, task predictability, and opportunities for advancement. Because umbrella reviews inherit limitations from the reviews they include, these estimates should be interpreted in light of heterogeneity and potential overlap among primary studies.

Earlier syntheses also illustrate the difficulty of deriving a single prevalence figure. A global meta-analysis reported substantial variation in nurse burnout symptoms across definitions and settings [53]. During the COVID-19 period, a meta-analysis of 16 studies involving 18,935 nurses estimated pooled prevalence of 34.1% for emotional exhaustion, 12.6% for depersonalization, and 15.2% for low personal accomplishment [54]. These pandemic-period estimates are not directly comparable with the 2025 umbrella-review estimates because the study periods, instruments, thresholds, and included studies differ.

The relationship between nurse burnout and care quality has been examined in a large body of quantitative research. A 2024 systematic review and meta-analysis included 85 studies and 288,581 nurses from 32 countries; 81 studies were cross-sectional and four were longitudinal. Burnout was associated with poorer patient-safety climate and safety grades, more reported nosocomial infections, falls, medication errors, adverse events, and missed care, as well as lower patient satisfaction and lower nurse-assessed quality of care. Because most included studies were cross-sectional, these findings support associations but do not establish that burnout directly causes each adverse outcome [35].

3.2. Moral distress: ethical constraint, moral events, and institutional context

Jameton introduced moral distress into nursing discourse to describe situations in which a professional identifies the ethically appropriate action but is constrained from carrying it out [14]. Corley subsequently proposed a nursing-specific theory linking moral sensitivity, ethical constraints, and psychological responses [83]. Wilkinson's early account emphasized the psychological disequilibrium and negative emotions associated with being unable to act on an ethical decision [15]. Later scholarship broadened the concept and questioned whether institutional constraint must be present in every instance. Morley and colleagues proposed that moral distress involves a morally significant event, psychological distress, and a direct causal relationship between the event and the distress [16-19]. This formulation helps distinguish moral distress from general work stress, moral disagreement unaccompanied by distress, and distress unrelated to a moral event.

Potential triggers include perceived futile or non-beneficial treatment, inadequate staffing or resources, barriers to patient advocacy, conflict with colleagues or senior clinicians, poor communication, decisions inconsistent with patient preferences, and institutional policies that restrict ethically preferred care. The effect of a trigger depends on the nurse's moral appraisal, professional responsibilities, available options, and organizational context. A single event may cause acute distress; unresolved or repeated episodes may leave moral residue and contribute to a crescendo effect, in which accumulated experiences intensify responses to subsequent events [18].

Moral distress has an important organizational dimension and should not be reduced to an individual nurse's difficulty coping with ethical complexity. Hierarchical relationships, staffing, resource allocation, unit

culture, access to ethics consultation, leadership responsiveness, and the perceived safety of speaking up can influence whether an ethically troubling situation is acknowledged and addressed. Austerity and resource scarcity may make the same moral conflict recurrent rather than exceptional [19].

Measurement has developed from the Moral Distress Scale and MDS-R toward instruments intended to cover a wider range of healthcare professionals and clinical contexts. Hamric, Borchers, and Epstein described the development and testing of an instrument for healthcare professionals [21]. Epstein and colleagues subsequently developed the 27-item MMD-HP, drawing on prior MDS-R datasets, causes identified through consultation, and literature spanning several healthcare professions [22]. These instruments assess the frequency, intensity, or both dimensions of morally distressing situations. Their scores should not be compared without examining the version, item content, response scale, scoring method, and validation population.

A 2025 systematic review and meta-analysis of 31 studies involving 7,635 nurses found a moderate inverse association between moral distress and ethical climate ($r = -0.49$, 95% CI −0.59 to −0.38). The association between moral-distress frequency and ethical climate was also negative ($r = -0.37$, 95% CI −0.45 to −0.28) [23]. These findings support the relevance of organizational ethical climate, although heterogeneity suggests that participant characteristics, clinical settings, sampling, and measurement instruments may affect the magnitude of the associations.

Nurse-focused integrative work has described moral distress as a multidimensional experience involving morally conflicted situations, moral judgment, constraints at individual or system levels, perceived wrongdoing, and moral suffering. Unresolved episodes may accumulate as moral residue [61]. Reviews of non-Western nursing literature have also emphasized that the expression and sources of moral distress are shaped by cultural, professional, and organizational contexts, which may limit transferability across health systems [62].

A 2026 umbrella review included 19 systematic reviews published between 2009 and 2025 and found considerable variation in moral-distress scores by setting and instrument. Higher levels were reported in intensive care, coronary care, and oncology settings. Recurrent contributors included poor teamwork, inadequate resources, perceived futile care, and demographic or work-related factors. Reported consequences included burnout, depression, reduced care quality, medication errors, and intention to leave [30]. The umbrella review highlighted substantial heterogeneity and used narrative synthesis rather than producing a new pooled estimate across the included reviews.

Earlier systematic reviews and meta-analyses also estimated moral-distress levels among nurses, but their findings varied by instrument, clinical specialty, and threshold [55,56]. The oncology-specific synthesis further illustrates the influence of specialty and exposure context [60]. These sources support the conclusion that moral distress is a recurring nursing experience, but they do not justify a single prevalence estimate for all clinical settings.

3.3. Compassion fatigue: exposure to suffering and secondary traumatic stress

The term compassion fatigue entered nursing discourse in the early 1990s and was subsequently developed in trauma literature to describe the costs of caring for people affected by trauma [5,6]. In nursing, it is commonly used for emotional, physical, and psychological strain associated with repeated exposure to suffering, distress, or traumatic experiences, particularly when empathic engagement is sustained and opportunities for recovery are limited [7-9]. Conceptual analyses have documented inconsistent usage, including overlap with burnout, secondary traumatic stress, and vicarious trauma [7,8].

Secondary traumatic stress refers more specifically to trauma-related symptoms that may follow indirect exposure to another person's traumatic experience, including intrusive recollections, avoidance, and heightened arousal. Vicarious trauma is often used to describe changes in a helper's cognitive schemas or worldview after sustained empathic engagement with trauma narratives. Compassion fatigue is broader and less consistently defined. Some authors describe it as a combination of secondary traumatic stress and cumulative burnout, whereas nursing concept analyses emphasize diminished empathic capacity and the effects of repeated exposure to patient suffering [7-10]. These concepts are related, but they should not be used interchangeably.

Reviews across nursing, trauma, and broader healthcare literature have repeatedly documented inconsistent definitions of compassion fatigue. Some accounts emphasize depleted empathic capacity; others use the term as an umbrella for secondary traumatic stress and burnout-related exhaustion. Meta-narrative and systematic reviews identify this definitional variation as a barrier to comparing prevalence estimates and intervention outcomes [63,84]. The operational definition used by each primary study should therefore be retained rather than replaced retrospectively with a single standardized meaning.

The ProQOL framework is influential because it assesses both positive and negative aspects of professional caregiving. ProQOL-5 includes separate subscales for compassion satisfaction, burnout, and secondary traumatic stress [11]. Compassion satisfaction reflects the meaning and gratification derived from helping; it is not simply the absence of fatigue. Although some researchers combine the two negative dimensions when discussing compassion fatigue, ProQOL measures them separately. Reports should specify the instrument version, subscale, scoring procedure, and underlying definition instead of using compassion fatigue as a substitute for all negative ProQOL scores.

Compassion fatigue is also context-sensitive. Nurses in emergency, intensive care, oncology, mental-health, and palliative-care settings may encounter death, severe illness, trauma, pain, family distress, and moral uncertainty repeatedly. Specialty alone, however, does not determine risk. Exposure intensity, case mix, workload, continuity of contact, team support, organizational resources, personal trauma history, and access to supervision may all influence the impact of clinical work [9,13,36].

A 2024 systematic review and meta-analysis of professional quality of life among mental-health nurses included 24 studies with 4,274 participants; 18 studies involving 3,163 participants contributed to the quantitative synthesis. Pooled mean scores were 32.79 for compassion satisfaction, 24.99 for burnout, and 21.99 for secondary traumatic stress. These estimates apply to mental-health nursing and the ProQOL measurement framework; they are not prevalence estimates for all nurses or universal thresholds for compassion fatigue [28].

Yi and colleagues' 2024 systematic review included 196 studies involving 73,034 registered nurses and 4,551 nursing students. Among practicing nurses, pooled ProQOL mean scores were 26.81 for burnout (95% CI 26.28–27.35) and 25.88 for secondary traumatic stress (95% CI 25.39–26.37). The review also identified work environment, social support, job satisfaction, workload, and psychological capital as factors associated with these dimensions. Because the review included students as well as registered nurses and analyzed burnout and secondary traumatic stress as separate dimensions, its estimates should not be interpreted as a single pooled prevalence of compassion fatigue among clinical nurses [37]. A 2016 systematic review of interventions for compassion fatigue among healthcare, emergency, and community-service workers identified 13 studies, 10 of which focused on nurses; the authors described the intervention evidence as relatively recent and limited [36]. A 2025 review of controlled studies included 11 studies and 763 participants and reported post-intervention increases in compassion satisfaction and reductions in fatigue and burnout, while calling for higher-quality prospective follow-up [38].

A separate meta-analysis of 79 studies involving 28,509 nurses from 11 countries described compassion fatigue and compassion satisfaction as generally moderate, with variation by specialty and region and higher reported levels in intensive-care settings and Asian samples [57]. An earlier nursing meta-analysis reported pooled proportions of 47.55% for compassion satisfaction, 52.55% for compassion fatigue, and 51.98% for burnout [58]. These figures require cautious interpretation because operational definitions and thresholds differed; they do not show that compassion fatigue and occupational burnout are the same construct. A broader systematic review of healthcare providers also found substantial variation in how compassion fatigue was defined and measured [63].

3.4. Conceptual boundaries and measurement overlap

The three constructs share some manifestations but differ in their defining triggers and explanatory frameworks. Burnout is anchored in chronic occupational stress and conditions in the work environment. Moral distress is linked to morally salient events and the distress associated with constraint, conflict, or inability to act in accordance with ethical judgment. Compassion fatigue is associated with empathic exposure to suffering or trauma and may involve diminished compassionate capacity or trauma-related symptoms. Nurses may experience more than one construct at the same time, but co-occurrence does not establish conceptual equivalence.

Table 1. Conceptual comparison of occupational burnout, moral distress, and compassion fatigue.

Construct	Defining reference point	Typical antecedents	Core dimensions or manifestations	Common instruments
Occupational burnout	Chronic unmanaged workplace stress	Workload, low control, inadequate resources, role conflict, work–life interference	Exhaustion; cynicism; diminished professional efficacy	MBI; Copenhagen Burnout Inventory; Oldenburg Burnout Inventory; ProQOL burnout subscale
Moral distress	Moral event and distress linked to constraint, conflict, or inability to act according to moral judgment	Perceived futile care, advocacy barriers, hierarchy, resource limits, ethically troubling policies	Moral conflict, guilt, frustration, anger, powerlessness, moral residue	MDS; MDS-R; MMD-HP; context-specific moral distress questionnaires
Compassion fatigue / STS	Repeated empathic exposure to suffering or trauma	Patient trauma, death, severe illness, sustained empathic engagement, insufficient recovery/support	Compassionate depletion or withdrawal; secondary trauma symptoms; emotional and physical strain	ProQOL STS and burnout subscales; Figley-derived scales; STS-specific measures

An instrument's label does not, by itself, determine the construct being measured. A study using the ProQOL burnout subscale assesses one dimension within a professional quality-of-life framework; it should not be assumed to measure the same construct as a study using all MBI dimensions. Similarly, moral-distress questionnaires capture morally salient experiences as defined by their items and response structure. Scores may depend on how frequently an event occurs, how distressing it is, and whether the instrument assesses frequency, intensity, or both.

Psychometric findings also require contextual interpretation. A Singapore study of 1,338 nurses reported acceptable internal consistency and discriminant validity for ProQOL subscales, alongside correlations among compassion satisfaction, burnout, and secondary traumatic stress [24]. Such correlations are compatible with related but distinct constructs. They do not establish that the underlying dimensions are identical or justify replacing subscale-level reporting with a single total score. The ProQOL manual likewise directs users to calculate and interpret its three subscales separately [11].

3.5. Interrelationships between moral distress, burnout, and compassion fatigue

Evidence of interrelationships comes from studies with different populations, measures, and designs. The findings should therefore be interpreted according to the construct actually assessed in each study, rather than treated as estimates of a single underlying relationship.

Moral distress has been associated with emotional exhaustion, a central dimension of burnout. A broader meta-analysis of workers indirectly exposed to trauma also reported an association between job burnout and secondary traumatic stress, although its mixed occupational sample does not provide a nurse-specific estimate [39]. A 2025 systematic review and meta-analysis of 14 studies involving 2,425 healthcare professionals reported a pooled correlation of 0.33 (95% CI 0.27–0.39) between moral distress and emotional exhaustion [40]. Most included studies were cross-sectional, and the samples were not limited to nurses. The estimate therefore supports an association in healthcare professionals but should not be presented as a nurse-only result or as evidence of causation.

A cross-sectional study of 262 emergency nurses in Ardabil, Iran, reported a positive correlation between moral distress and compassion fatigue ($r = 0.29$, $P < 0.01$) [41]. This provides direct evidence of co-occurrence in a nursing sample. Its single-region setting, cross-sectional design, and use of specific questionnaires limit generalizability. The result cannot establish whether moral distress precedes compassion fatigue, whether repeated exposure to patient suffering increases sensitivity to ethically troubling care, or whether both are partly associated with workload and resource constraints.

Studies combining ProQOL and moral-distress measures provide further evidence of associations between moral experience and dimensions of professional quality of life. In a cross-sectional study of 130 female nurses in Ukraine who had direct or indirect exposure to military trauma, Zasiekina and Martyniuk examined moral distress, continuous traumatic stress, compassion satisfaction, burnout, and secondary traumatic stress [42]. War-related continuous traumatic stress statistically mediated associations between moral distress and ProQOL dimensions. Because all variables were assessed cross-sectionally in a highly specific crisis setting, the mediation model does not establish temporal mediation and should not be assumed to represent routine hospital conditions.

A 2026 cross-sectional study of 200 nurses in four teaching hospitals in northern Iran included participants from ICU, coronary care, and dialysis settings and assessed moral distress, self-compassion, and professional quality of life [43]. Moral distress correlated with the ProQOL burnout and secondary traumatic stress subscales ($r = 0.38$ and $r = 0.29$, respectively) and inversely with compassion satisfaction ($r = −0.32$); all reported correlations were statistically significant at $P < 0.01$. Self-compassion was also associated with more favorable ProQOL dimensions. The cross-sectional, self-report design does not establish causal direction, and the three ProQOL dimensions should remain analytically distinct.

A nationwide cross-sectional online survey recruited 645 ICU nurses in China between July and December 2023 and was published online on 4 December 2025 before assignment to the 2026 volume [44]. The investigators assessed compassion fatigue using the 30-item ProQOL and moral distress using the MDS-R. They operationalized compassion fatigue as a study-specific composite: the burnout and secondary traumatic stress subscale scores were scored in the usual direction, the compassion-satisfaction items were reverse-scored, and the three subscale scores were summed (possible range, 30–150; higher scores indicated greater compassion fatigue). This composite is distinct from the usual ProQOL reporting convention, which interprets compassion satisfaction, burnout, and secondary traumatic stress as separate dimensions. The study reported a nonlinear association between the composite and moral distress (adjusted model $R^2 = 0.161$). Restricted cubic spline analysis indicated a steeper increase in moral distress at moderate composite scores, followed by a plateau. Network analysis and in-silico simulations identified candidate symptom-level targets; these model-based findings do not demonstrate that the proposed targets improve outcomes when used in an intervention.

A multicenter cross-sectional structural equation modeling study of ICU nurses from five hospitals in Saudi Arabia assessed compassion fatigue, burnout, moral distress, moral courage, and moral resilience [45]. The article reports that 250 nurses were included in the final analytic sample; it states that 272 of 400 invited

nurses responded and that 22 were excluded. The model-fit table also reports n = 250. In the re-specified model, compassion fatigue was inversely associated with moral courage (β = −0.51, P = 0.001); moral courage was inversely associated with moral distress (β = −0.29, P = 0.001) and burnout (β = −0.33, P = 0.001); and moral distress was positively associated with burnout (β = 0.16, P = 0.021). The mediation table, however, is captioned n = 207 and reports P = 0.028 for the same moral-distress-to-burnout path. It also reports P = 0.034 for the direct moral-resilience-to-burnout path, whereas the narrative results report P = 0.030. The article does not explain the smaller mediation-table sample or reconcile these P-value differences. The sample size and estimates are therefore reported according to their respective locations in the original article rather than resolved by assumption. The sample was predominantly male (92.4%). Given the cross-sectional design and sex imbalance, the structural paths should be interpreted as model-consistent associations, not causal mediation.

A 2026 descriptive correlational study of 289 clinical nurses in South Korea, each with at least three years of experience, examined moral distress, compassion fatigue, resilience, and quality of nursing work life [49]. Moral distress was positively correlated with compassion fatigue and negatively correlated with resilience and work-life quality. The authors reported a serial indirect association from moral distress through compassion fatigue and resilience to quality of nursing work life (indirect effect = −0.051, 95% CI −0.081 to −0.032). Because the data were cross-sectional, the serial mediation model is statistical rather than temporal evidence and does not establish a causal sequence.

A large US study using data from 4,258 direct-care adult ICU nurses in the 2024 Penn Nurses4All Study examined work environment, missed nursing care, moral distress, and burnout [50]. A more favorable work environment was associated with lower burnout (total effect B = −0.67, P < 0.001). Significant indirect pathways were reported through missed care (B = −0.11), moral distress (B = −0.05), and sequentially through both (B = −0.03), all P < 0.001. The direct association remained significant (B = −0.48, P < 0.001). This study adds large-sample evidence linking work conditions, missed care, moral distress, and burnout, but it did not measure compassion fatigue. Its cross-sectional design does not verify the temporal sequence proposed by the mediation model.

An earlier survey of 205 certified critical-care nurses assessed moral distress, compassion fatigue, and perceptions of medication errors in the same sample and reported statistically significant associations among these domains [59]. Although it predates the recent multi-construct studies and used setting-specific measures, it provides an early example of simultaneous assessment. In oncology nursing, a systematic review and meta-analysis of eight cross-sectional studies examined moral distress and work-related outcomes, including burnout [60]. These specialty-specific findings should not be generalized to all nurses without considering differences in patient trajectories, treatment burden, and ethical decision-making.

Moral injury is related to moral distress and compassion fatigue but should not be treated as synonymous with either. Originating in military and trauma research, moral injury refers to potentially enduring psychological, social, or spiritual consequences of perpetrating, failing to prevent, witnessing, or being exposed to events that violate deeply held moral beliefs [74,75]. Scoping reviews in healthcare have documented terminological overlap while emphasizing the different conceptual traditions from which moral distress and moral injury emerged [76]. The COVID-19 pandemic increased attention to potentially morally injurious experiences among frontline workers [77]. A 2025 nursing study examined compassion fatigue and moral injury in hospital nurses [46]. A 2026 cross-sectional study of 1,323 nurses in German acute inpatient care measured moral distress and moral injury as distinct constructs and found positive associations between moral-distress scores and several moral-injury symptom domains [51]. These studies support examining related concepts together while retaining separate definitions and measures. They do not show that moral

distress inevitably progresses to moral injury, nor do they directly establish the three-way relationship among burnout, moral distress, and compassion fatigue.

The findings are compatible with an integrative model in which the three constructs share some upstream organizational exposures but retain distinct proximal pathways. High workload and inadequate staffing may contribute to exhaustion and may also make ethically preferred care difficult to provide, creating conditions for moral distress. Repeated exposure to suffering and trauma may contribute to secondary traumatic stress or compassion-related depletion. These exposures can coexist, but the proposed pathways remain hypotheses; longitudinal and multilevel research is required to test their temporal order and reciprocal effects.

Table 2. Selected empirical studies informing the analysis of interrelationships among the focal constructs and organizational pathways. This purposive table is not a complete inventory of eligible studies.

Study and setting	Design, sample, and measures	Main findings relevant to the review	Interpretive limitations
Karimollahi et al. (2024), emergency departments in Ardabil, Iran [41]	Cross-sectional, consensus sample; 262 emergency nurses. Figley compassion-fatigue questionnaire and 21-item Hamric moral-distress instrument.	Moral distress and compassion fatigue were positively correlated ($r = 0.29$, $P < 0.01$). Mean compassion-fatigue score was below the study-defined midpoint; moral distress varied by hospital type.	Single province and emergency setting; cross-sectional self-report; study-specific tools and cut points limit comparison with other instruments.
Zasiekina and Martyniuk (2025), Ukraine [42]	Cross-sectional; 130 female nurses, all exposed directly or indirectly to military trauma. ProQOL, Moral Distress Questionnaire for Nurses, and Continuous Traumatic Stress Response Scale.	War-related continuous traumatic stress statistically mediated the associations between moral distress and ProQOL dimensions, including burnout, secondary traumatic stress, and compassion satisfaction.	All-female, highly specific war-exposed sample; cross-sectional mediation cannot establish temporal mediation or causal direction.
Deylampasha et al. (2026), northern Iran [43]	Cross-sectional; 200 critical-care nurses from ICU, CCU, and dialysis units in four teaching hospitals. Hamric Moral Distress Scale, ProQOL, and Self-Compassion Scale.	Moral distress correlated with ProQOL burnout ($r = 0.38$), secondary traumatic stress ($r = 0.29$), and compassion satisfaction ($r = −0.32$); all $P < 0.01$.	Self-report and cross-sectional design; single regional health system; ProQOL subscales are separate outcomes, not a single compassion-fatigue total.
Zheng et al. (2026), ICU nurses in China [44]	Nationwide cross-sectional online survey; 645 ICU nurses in China. 30-item ProQOL and 22-item MDS-R; restricted cubic splines and symptom-network analysis.	The authors calculated a study-specific compassion-fatigue composite by summing the ProQOL burnout and secondary traumatic stress subscales with the reverse-scored compassion-satisfaction subscale (range 30–150; higher scores indicate greater compassion fatigue). A nonlinear association with moral distress was reported.	The composite combines all three ProQOL subscales and is not equivalent to the usual separate-subscale interpretation. Network and in-silico simulation findings are exploratory and do not establish intervention effects.
Villagracia et al. (2026), five hospitals in Saudi Arabia [45]	Multicenter cross-sectional SEM study; 250 ICU nurses from five hospitals in Saudi Arabia; five self-report scales. The model-fit table reports n = 250, whereas the mediation table is captioned n = 207.	The narrative results report compassion fatigue → moral courage ($\beta = −0.51$, $P = 0.001$), moral courage → moral distress ($\beta = −0.29$, $P = 0.001$) and burnout ($\beta = −0.33$, $P = 0.001$), and moral distress → burnout ($\beta = 0.16$, $P = 0.021$).	The mediation table reports n = 207 and $P = 0.028$ for the moral-distress-to-burnout path (vs $P = 0.021$ in the narrative); for moral resilience → burnout it reports $P = 0.034$ (vs $P = 0.030$ in the narrative). The article does not explain these discrepancies. Cross-sectional SEM and a predominantly male sample (92.4%) limit causal and generalizability claims.
Lee et al. (2026), South Korea [49]	Descriptive correlational study; 289 clinical nurses with ≥3 years' experience. KMDS-R, ProQOL, CD-RISC-10, and Korean QNWL.	Moral distress was positively associated with compassion fatigue and negatively associated with resilience and quality of nursing work life. Serial indirect effect through compassion fatigue and resilience: −0.051 (95% CI −0.081 to −0.032).	Cross-sectional survey; mediation is statistical and does not establish a temporal or causal sequence.
Connell et al. (2026), United States [50]	Cross-sectional analysis; 4,258 direct-care adult ICU nurses from the 2024 Penn Nurses4All Study. Work environment, missed nursing care, moral distress, and burnout were modeled using serial mediation.	A more favorable work environment was associated with lower burnout (total $B = −0.67$); indirect pathways through missed care (−0.11), moral distress (−0.05), and sequentially through both (−0.03) were significant (all $P < 0.001$). The direct association remained ($B = −0.48$, $P < 0.001$).	Large sample, but cross-sectional associations cannot establish the proposed temporal cascade. Compassion fatigue was not measured.
Maiden et al. (2011), critical-care nurses [59]	Survey of 205 certified critical-care nurses; measures of moral distress, compassion fatigue, and perceptions of medication errors.	The study reported statistically significant associations among moral distress, compassion fatigue, and perceptions about medication errors.	Earlier cross-sectional evidence; setting-specific sample and instruments limit comparison with newer ProQOL- and MDS-R-based studies. Associations do not establish direction or causality.

3.6. Shared and construct-specific determinants

Individual-level correlates include professional experience, coping style, self-compassion, sleep and recovery, personal trauma exposure, emotion-regulation capacity, and expectations about professional responsibility. These factors may influence appraisal, vulnerability, or recovery, but they should not be taken to mean that distress originates primarily within the individual. Individual-level support is most defensible when it accompanies changes to the conditions that generate or sustain distress.

Interpersonal determinants include team communication, collegial support, psychological safety, supervisor availability, interprofessional respect, and relationships with patients and families. Poor teamwork and conflict may intensify moral distress by limiting the options nurses perceive as available. Supportive supervision and reflective discussion may help staff process difficult encounters and identify possible responses. In trauma-exposed specialties, peer support and clinical supervision may also facilitate recognition of secondary traumatic stress and earlier access to assistance [10,30,36].

Organizational determinants include staffing adequacy, workload, shift patterns, control over work, documentation burden, role clarity, leadership behavior, fairness, access to continuing education, and the availability of equipment and treatment resources. The 2020 integrative review of nursing job demands and resources identified work overload, lack of formal rewards, and work–life interference as demands. Supervisor support, authentic management, interpersonal relationships, autonomy, and professional resources were described as relevant resources [12]. These domains are consistent with the Job Demands–Resources model and its application to burnout prevention [4].

Ethical climate is particularly relevant to moral distress. When staff can raise concerns, discuss uncertainty, and participate in ethically complex decisions, unresolved moral conflict may be easier to identify and address. Xue and colleagues' 2025 meta-analysis found a moderate inverse association between ethical climate and moral distress among nurses [23]. A positive ethical climate cannot eliminate all distress, because morally difficult decisions are intrinsic to some clinical situations. Organizational processes may nevertheless influence whether ethically troubling experiences are acknowledged, discussed, and acted upon.

Clinical exposure is more directly relevant to compassion fatigue and secondary traumatic stress. Nurses in emergency, intensive care, oncology, mental-health, and palliative-care settings may encounter trauma, death, pain, and family suffering repeatedly. The effect depends on the nature and intensity of exposure and the context in which care is delivered. Repeated exposure without adequate recovery, supervision, or team support may increase risk; meaningful patient relationships, compassion satisfaction, and organizational support may also coexist with demanding clinical work [9,13,28,36,37,47].

Studies of home-care nurses and broader nursing reviews identify organizational resources, constraints, and relational conditions as relevant to moral distress, including support, communication, and the ability to respond to ethically troubling care [78,79]. Research on psychological capital, moral resilience, and job embeddedness suggests that individual and professional resources may be associated with more favorable occupational outcomes. These resources should be viewed as potential buffers, not substitutes for safe staffing, effective leadership, or removal of recurrent ethical constraints [80-82].

Table 3. Multilevel determinants and possible organizational responses. These domains represent a conceptual synthesis, not a validated causal model.

Level	Examples of determinants	Most directly implicated constructs	Potential organizational response
Individual	Coping, self-compassion, sleep, prior trauma, professional experience	All three, through context-specific pathways	Confidential support, recovery opportunities, skills training, access to occupational health
Interpersonal	Teamwork, communication, supervision, respect, psychological safety	Moral distress and compassion fatigue; also burnout	Structured debriefing, reflective supervision, team communication, speaking-up pathways

Level	Examples of determinants	Most directly implicated constructs	Potential organizational response
Unit/organizational	Staffing, workload, autonomy, leadership, ethical climate, resource availability	Burnout and moral distress; compassion fatigue when exposure is sustained	Staffing and workload redesign, ethics support, participatory governance, manager training
System	Funding, workforce shortages, regulation, care models, access to services	All three through distinct mechanisms	Workforce planning, safe staffing policy, service redesign, trauma-informed systems

3.7. Professional and patient-care consequences

Potential consequences for nurses include emotional exhaustion, sleep disturbance, irritability, anxiety or depressive symptoms, reduced professional satisfaction, withdrawal from emotionally demanding situations, sickness absence, intention to leave, and actual workforce attrition. The pattern varies by construct and by the severity, duration, and context of exposure. Moral distress may involve guilt, anger, powerlessness, and moral residue; secondary traumatic stress may include intrusion, avoidance, and hyperarousal; burnout is characterized more directly by work-related exhaustion, distancing, and reduced professional efficacy [2,15-18].

The strongest quantitative evidence linking these forms of distress to patient and organizational outcomes concerns burnout. The meta-analysis of 85 studies found associations with patient-safety climate, medication errors, falls, infections, missed care, patient satisfaction, and nurse-assessed quality of care [35]. Earlier systematic reviews also linked healthcare-worker well-being and burnout with patient-safety outcomes and synthesized nurse-specific associations with patient and organizational outcomes [64,65]. Evidence relating moral distress to patient outcomes is more heterogeneous and often indirect, with reported associations involving care quality, medication errors, and intention to leave [30,59,60]. Compassion fatigue may affect empathic engagement and therapeutic relationships, but the available evidence does not establish that every elevated ProQOL secondary-traumatic-stress score corresponds to objectively poorer care. Staffing, patient acuity, leadership, safety culture, and reporting practices may confound observed associations.

It is useful to distinguish proximal nurse outcomes from downstream organizational and clinical outcomes. Emotional exhaustion, moral distress, and trauma-related symptoms are proximal experiences. Missed care, turnover, team instability, and patient-safety outcomes occur further downstream and may be influenced by multiple factors. Observational findings can inform risk recognition and organizational improvement, but they should not be interpreted as evidence of a single causal mechanism.

3.8. Prevention and management: matching interventions to mechanisms

Interventions should target the source of distress. For burnout, the first priority is to address excessive or poorly organized job demands, including unsafe staffing, unpredictable schedules, excessive overtime, low autonomy, administrative burden, and inadequate resources. Mindfulness, exercise, sleep support, cognitive-behavioral approaches, and resilience training may benefit some nurses, but these strategies should not replace work redesign. Changes to staffing, leadership, role clarity, participation, and team functioning are more closely aligned with the organizational antecedents of burnout [4,12].

Intervention syntheses suggest that person-directed programs, particularly mindfulness-based approaches, may provide short-term benefits for some burnout dimensions. The magnitude and pattern of effects differ across reviews and outcomes. A systematic review and meta-analysis of 30 studies, 24 of which contributed to quantitative synthesis, reported reductions in emotional exhaustion (SMD = −0.752) and depersonalization (SMD = −0.822), but no clear improvement in reduced personal accomplishment [66]. A separate meta-analysis of mindfulness training also reported reductions in nurse burnout [67]. Other reviews reported effects across additional burnout dimensions, although differences in eligibility criteria, interventions, instruments, and follow-up periods limit direct comparison [68,69]. These findings support considering evidence-informed

individual programs, but not using them as substitutes for structural changes to workload, staffing, or control over work.

For moral distress, interventions should help nurses recognize, discuss, and respond to morally significant events. Options include ethics consultation, structured moral case deliberation, interprofessional rounds, facilitated reflection, ethics education, communication training, and transparent escalation processes. A systematic review of interventions for critical-care nurses included eight studies (three randomized and five quasi-experimental) and identified promising findings for educational workshops, moral-empowerment programs, ethics huddles, social-work interventions, and multicomponent approaches. The authors emphasized, however, that the evidence was limited and heterogeneous, with restricted generalizability across settings [48]. These approaches are more likely to help when leaders can act on the organizational constraints identified by nurses. Discussion forums may make distress visible without reducing it if staffing, resources, or care processes cannot be changed [16–19,23,30,48].

A broader systematic review of moral-distress interventions also identified educational and facilitated approaches as promising, while emphasizing methodological limitations and uncertainty about which strategies work consistently across settings [71]. A scoping review of recommendations highlighted reflective discussion, peer support, ethics resources, and organizational responsiveness, but found the evidence base uneven [72]. These reviews complement the critical-care intervention synthesis [48] and suggest that education and deliberation alone are unlikely to reduce distress when nurses lack the authority or organizational support to address underlying constraints.

For compassion fatigue and secondary traumatic stress, relevant approaches include trauma-informed supervision, peer support, reflective practice, confidential mental-health care, adequate recovery time, workload management, and training to recognize trauma-related symptoms. Compassion satisfaction may be supported through meaningful participation in care, appropriate recognition, and continuity of relationships. A systematic review restricted to randomized trials in healthcare providers included 15 trials (1,740 participants), but 13 were judged to have a high overall risk of bias, and heterogeneity prevented a reliable pooled estimate [73]. By contrast, a 2025 review of controlled nursing studies included 11 studies and 763 participants and reported post-intervention improvements in compassion satisfaction and reductions in compassion fatigue and burnout [38]. These findings are not necessarily contradictory because the reviews applied different eligibility criteria and populations. Together, they suggest possible benefit while leaving uncertainty about durability, optimal components, and transferability.

A multicomponent approach is more defensible than reliance on a generic resilience program. Organizations should first determine whether the predominant problem is workload-related exhaustion, recurring morally constrained care, repeated trauma exposure, or a combination. Interventions should then address both the individual experience and the operational conditions that sustain it. Evaluation should include validated construct-specific measures, workforce outcomes, and patient-care indicators rather than relying only on staff satisfaction or attendance at training.

Evidence from controlled organizational interventions in healthcare workers supports changes to job and task design, with more moderate evidence for flexible scheduling and improvements to the physical work environment [70]. This evidence is not limited to nursing, but it is consistent with the work-related antecedents identified in nursing studies. In nursing services, organizational changes should also be evaluated against ethical-climate and morally distressing-care outcomes rather than judged solely by changes in burnout scores.

Table 4. Mechanism-matched prevention and evaluation options.

Dominant problem	Examples of matched response	Evaluation indicators
Burnout	Staffing review; workload and workflow redesign; schedule predictability; greater control and participation; supportive management	MBI/CBI/OLBI dimensions; overtime; sickness absence; turnover; missed care
Moral distress	Ethics consultation; moral case deliberation; escalation routes; shared decision-making; review of recurrent non-beneficial care and resource constraints	MDS-R or MMD-HP; ethical climate; unresolved cases; speaking-up safety; intention to leave
Compassion fatigue / STS	Trauma-informed supervision; peer support; protected recovery; confidential psychological support; case-mix and exposure review	ProQOL subscales; STS-specific symptoms; compassion satisfaction; retention and well-being
Co-occurring distress	Integrated unit-level assessment; multidisciplinary improvement plan; leadership accountability; follow-up at repeated intervals	Separate construct scores plus organizational and patient-safety measures

Table 5. Selected evidence syntheses informing the integrated narrative review.

Source	Design and scope	Principal findings reported	Interpretive limitations
Getie et al. (2025) [29]	Umbrella review of reviews on nurse burnout	Pooled proportions for high emotional exhaustion, depersonalization, and low personal accomplishment were 33.45%, 25.00%, and 33.49%, respectively; between-review heterogeneity was extremely high.	Review-level estimates vary by definition, instruments, and included reviews.
Woo et al. (2020) [53]	Global systematic review and meta-analysis of nurse burnout	Reported substantial global prevalence of burnout symptoms, with estimates varying across dimensions and settings.	Definitions and cut-offs differ across primary studies.
Galanis et al. (2021) [54]	Meta-analysis of 16 studies and 18,935 nurses during COVID-19	Pooled prevalence: emotional exhaustion 34.1%, depersonalization 12.6%, and low personal accomplishment 15.2%.	Pandemic-period estimates should not be generalized to all periods.
Mansour Arad et al. (2026) [30]	Umbrella review of 19 systematic reviews of nurse moral distress	Reported setting- and instrument-related variation in severity, determinants, and consequences; no new pooled estimate across reviews.	Substantial heterogeneity across reviews and clinical settings.
Alimoradi et al. (2023) [55]	Systematic review and meta-analysis of moral distress in nurses	Synthesized estimates of moral distress across nursing populations.	Pooled scores depend on instrument, setting, and thresholds.
Xue et al. (2025) [23]	Systematic review and meta-analysis; 31 studies, 7,635 nurses	Moral distress was inversely associated with ethical climate ($r = -0.49$, 95% CI −0.59 to −0.38).	Observational associations do not show that climate changes alone cause reduced distress.
Lobo et al. (2024) [28]	Systematic review and meta-analysis of mental-health nurses	Pooled ProQOL means: compassion satisfaction 32.79, burnout 24.99, and secondary traumatic stress 21.99.	Mental-health nursing and ProQOL-specific results; not population-wide prevalence.
Yi et al. (2024) [37]	Systematic review and meta-analysis of registered nurses and nursing students	For practicing nurses, pooled ProQOL means were 26.81 for burnout and 25.88 for secondary traumatic stress.	The review included students; the reported subscales are not a single compassion-fatigue prevalence.
Xie et al. (2021) [57]	Meta-analysis; 79 studies, 28,509 nurses in 11 countries	Reported moderate overall compassion-fatigue and compassion-satisfaction levels, with variation by specialty and region.	Definitions and measurement thresholds varied.
Zhang et al. (2018) [58]	Meta-analysis of compassion satisfaction, compassion fatigue, and burnout in nursing	Pooled proportions were 47.55% for compassion satisfaction, 52.55% for compassion fatigue, and 51.98% for burnout.	These figures are sensitive to operational definitions and cut-offs.
Orgambídez et al. (2025) [40]	Systematic review and meta-analysis; 14 studies, 2,425 healthcare professionals	Moral distress was correlated with emotional exhaustion ($r = 0.33$, 95% CI 0.27–0.39).	Mixed healthcare-professional sample; not a nurse-only estimate.
Li et al. (2024) [35]	Systematic review and meta-analysis; 85 studies, 288,581 nurses	Burnout was associated with poorer patient-safety and care-quality indicators and lower patient satisfaction.	Most included studies were cross-sectional; causal effects cannot be inferred.
Lee and Cha (2023) [66]	Systematic review and meta-analysis of burnout interventions in clinical nurses	Interventions reduced emotional exhaustion and depersonalization; effects on reduced personal accomplishment were not clear.	Intervention and outcome heterogeneity across studies.
Aust et al. (2024) [70]	Systematic review of controlled organizational mental-health interventions in healthcare workers	Job and task modifications had the strongest evidence; flexible scheduling and physical work-environment changes had moderate evidence.	Evidence included healthcare workers beyond nursing.
Morley et al. (2021) [71]	Systematic review of interventions to mitigate moral distress	Educational and facilitated approaches were promising, but methodological limitations constrained conclusions.	Small and heterogeneous intervention evidence base.
Patole et al. (2024) [73]	Systematic review of 15 randomized trials in healthcare providers (n = 1,740)	Thirteen trials were judged at high overall risk of bias; heterogeneity limited synthesis.	Mixed-provider population and high risk of bias.

Source	Design and scope	Principal findings reported	Interpretive limitations
Manzanedo-Moreno et al. (2025) [38]	Systematic review and meta-analysis of 11 controlled nursing studies (n = 763)	Reported post-intervention improvements in compassion satisfaction and reductions in compassion fatigue and burnout.	Small evidence base; prospective follow-up and intervention fidelity require further study.

4. Discussion

This review indicates that occupational burnout, moral distress, and compassion fatigue overlap in some manifestations but remain conceptually distinct. Their co-occurrence in nursing is consistent with shared exposures and interdependent work processes; it does not establish that they represent a single underlying condition. Each construct points to a different source of strain and, consequently, to different intervention targets.

The association between moral distress and emotional exhaustion is consistent with the possibility that unresolved ethical conflict contributes to sustained emotional strain. Orgambídez and colleagues reported a moderate pooled correlation (r = 0.33, 95% CI 0.27–0.39), but their 2,425 participants were healthcare professionals from mixed disciplines, not nurses alone, and the underlying evidence was observational [40]. The association between moral distress and compassion fatigue among emergency nurses in Ardabil provides a direct nursing example, although its modest correlation and cross-sectional design do not establish temporal direction [41]. The Ukrainian study and recent ICU studies extend the evidence by examining ProQOL dimensions alongside moral distress or by modeling several of the focal constructs in the same sample [42–45]. The 2026 Korean study adds evidence of a positive association between moral distress and compassion fatigue in clinical nurses, while the large US ICU study links work environment with burnout through pathways involving missed care and moral distress [49,50]. The German study informs the distinction between moral distress and moral injury rather than the three-way relationship among burnout, moral distress, and compassion fatigue [51]. Differences in setting, measurement, sample composition, and study design limit direct comparison across these findings.

The strongest quantitative evidence concerning patient-care outcomes relates to burnout. Li and colleagues' meta-analysis supports associations between nurse burnout and several indicators of safety and care quality [35]. These findings should not be extended automatically to moral distress or compassion fatigue. A nurse may experience substantial moral distress while remaining committed to patient advocacy; another may report secondary traumatic stress without reduced professional efficacy. Burnout may also occur in settings without repeated trauma exposure or a clearly identifiable moral event. Studies should therefore measure each construct separately and examine its relationship with specific outcomes.

This interpretation is consistent with earlier reviews of nurse burnout and patient or organizational outcomes [64,65], while the more recent large-scale meta-analysis provides a broader quantitative synthesis [35]. The evidence remains predominantly observational. Associations between burnout and safety or quality outcomes should not be interpreted as proof that burnout alone caused each outcome.

The organizational implications differ by construct. Burnout prevention requires attention to workload, staffing, autonomy, and management. Moral distress mitigation requires ethically responsive decision-making and the capacity to address recurring constraints. Responses to compassion fatigue require recognition of trauma exposure, support for empathic work, and adequate opportunities for recovery. Poor teamwork, inadequate resources, and unsupportive leadership may contribute to more than one construct, but an intervention should not be assumed to have the same effect across all three. The inverse association between ethical climate and moral distress reported by Xue and colleagues supports attention to organizational ethical climate; the Job Demands–Resources literature provides a broader account of demand-

resource imbalance in nursing work [4,12,23]. The large ICU analysis by Connell and colleagues is consistent with a pathway linking work environment, missed care, moral distress, and burnout, although its cross-sectional data cannot establish the proposed temporal sequence [50].

Intervention evidence requires the same caution. Individual programs, including mindfulness and related stress-management approaches, have shown benefits for some burnout dimensions, but effects on professional efficacy are less consistent across meta-analyses [66-69]. Organizational reviews identify job and task modification as promising, although controlled evidence specific to nursing remains limited [70]. Moral-distress interventions may be useful when education and facilitated deliberation are accompanied by an organizational response, but rigorous evaluations remain scarce [48,71,72]. For compassion fatigue, high risk of bias in many randomized trials contrasts with more favorable findings from controlled-study reviews. Taken together, these reviews suggest possible benefit but do not establish the effectiveness or durability of specific approaches [38,73].

The proposed multilevel framework (Figure 1) is heuristic and has not been validated as a causal model. Individual and interpersonal factors operate within unit-level and system-level conditions. These conditions may be associated with different patterns of burnout, moral distress, and compassion fatigue, which may in turn relate to nurse well-being, workforce retention, therapeutic relationships, and care outcomes. Feedback loops are plausible; for example, staff turnover may increase workload among those who remain. However, the cross-sectional evidence summarized here does not establish such loops. Longitudinal and multilevel studies are needed to test temporal ordering and reciprocal effects.

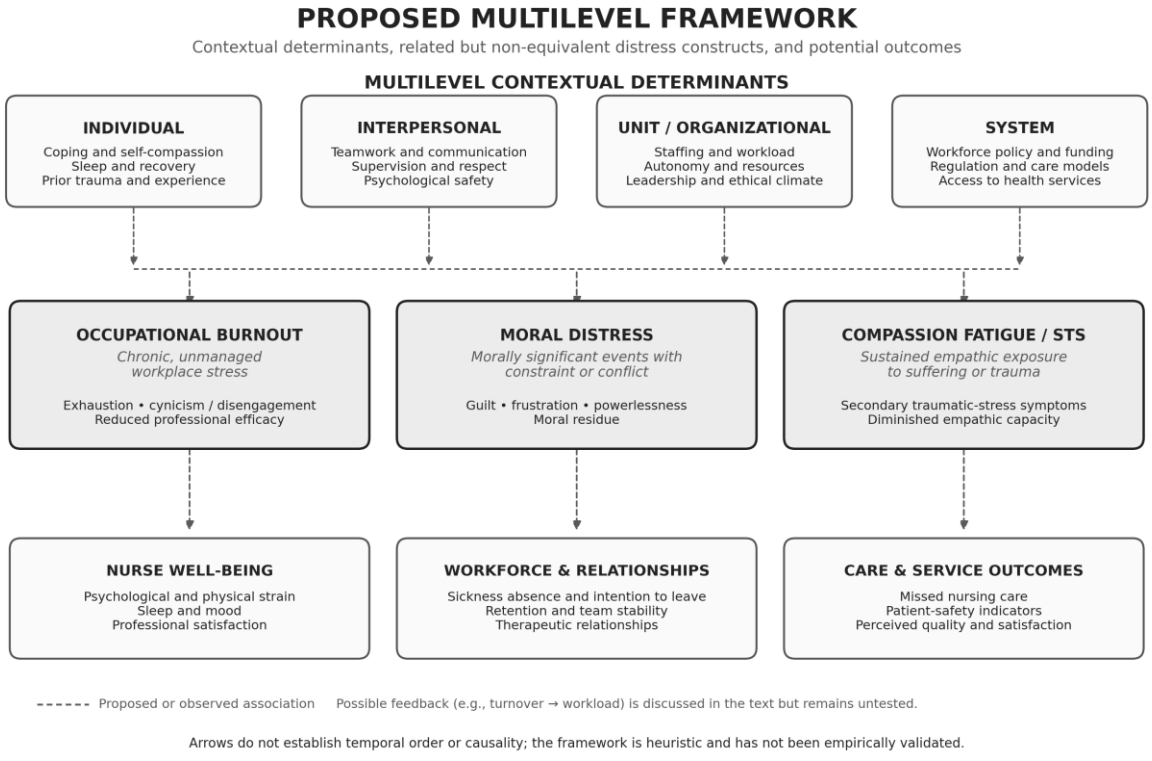

Figure 1. *Proposed multilevel framework linking contextual determinants with occupational burnout, moral distress, compassion fatigue, and potential professional and care outcomes. The constructs are related but*

non-equivalent. Arrows indicate proposed or observed associations; the potential feedback from turnover to workload is discussed in the text but has not been empirically tested.

4.1. Implications for nursing practice and management

Clinical leaders should avoid relying on a single aggregate "staff distress" score when selecting interventions. Assessment should distinguish work-related exhaustion and cynicism from morally distressing events and trauma-related symptoms. When burnout is prominent, staffing and workload require review. When moral distress recurs, leaders should identify the ethical event, the perceived constraint, the decision-making process, and whether the constraint can be changed. When compassion fatigue or secondary traumatic stress is suspected, nurses should have access to confidential assessment and trauma-informed support without stigma or implications of professional weakness.

Ethics support should be part of routine clinical governance rather than reserved for exceptional disputes. Unit-based moral case deliberation, accessible ethics consultation, and reliable escalation mechanisms may help teams identify recurring concerns. In trauma-exposed services, reflective supervision and peer support require protected time and referral pathways. Neither ethics support nor psychological support should substitute for safe staffing and adequate material resources.

4.2. Implications for research

Future studies should define each construct explicitly and report the instrument version, subscales, reliability, and validity evidence. ProQOL subscales should not be used as interchangeable proxies for independent constructs without a clear rationale. Longitudinal designs are needed to test whether moral distress precedes exhaustion, whether secondary traumatic stress predicts later burnout, and whether changes in ethical climate or staffing alter these trajectories. Multilevel models should account for nurse-, unit-, and hospital-level characteristics. Qualitative studies could examine how nurses distinguish moral suffering from trauma-related and workload-related distress across clinical contexts.

Intervention trials should specify their proposed mechanisms and select outcomes accordingly. A compassion-fatigue intervention should not be evaluated solely with a general burnout score; an ethics intervention should include moral-distress and ethical-climate outcomes; and an organizational intervention targeting burnout should assess job demands, resources, and workforce indicators. Follow-up beyond the immediate post-intervention period is needed to determine whether changes persist. Patient-care outcomes should be defined prospectively and analyzed with adjustment for acuity, staffing, and institutional context.

5. Strengths and Limitations

This review integrates conceptual, measurement, observational, and intervention literature on three constructs that are often examined separately. It also distinguishes primary studies from secondary evidence and considers whether reported relationships are direct, indirect, or based on model-derived pathways. Several limitations nevertheless affect the completeness and strength of the synthesis.

First, this is a structured critical narrative review, not a completed systematic review. The source manuscript records 12 November 2026 as the evidence-update date, but the supplied material does not include dated, platform-specific search histories or retrieval logs. Exploratory evidence identification drew on web-indexed PubMed records, PubMed Central full texts, publisher pages, targeted searches, and citation chaining. Searches were not completed in the native interfaces of CINAHL, Embase, Scopus, Web of Science, or PsycINFO, and a complete Cochrane Library search record was not available. Second, comprehensive record exports and deduplication across sources were not completed, and independent dual-reviewer screening and

extraction were not performed. Third, a formal risk-of-bias assessment of all included primary studies was not completed. Fourth, full-text access was unavailable for every potentially relevant article, so the literature base may be incomplete. Fifth, the supplied file did not include the reference list corresponding to its in-text citations; comprehensive citation-to-reference verification therefore remains outstanding. Sixth, construct definitions, measures, scoring approaches, and thresholds vary substantially; prevalence estimates and ProQOL subscale scores are not directly comparable across studies. Seventh, evidence from crisis settings, single regions, and highly specialized units may not generalize to the wider nursing workforce. Finally, evidence for causal relationships and long-term intervention effects remains limited. Cross-sectional model-based indirect pathways should not be interpreted as evidence of temporal mediation.

The article should therefore be regarded as an integrated critical narrative review draft rather than as evidence of comprehensive literature coverage or a submission-ready systematic review. Before submission, the authors should complete and document the planned database searches through institutional access; record the exact date, platform, strategy, and retrieval total for each source; export and deduplicate all records; screen titles, abstracts, and full texts using independent reviewers; verify bibliographic details and study-level numerical results; complete design-appropriate appraisal where feasible; and update the synthesis against the final screening and extraction record. The full reference list must also be restored and checked against all in-text citation numbers.

6. Conclusion

Occupational burnout, moral distress, and compassion fatigue are related forms of distress in nursing, but they should not be used as synonyms. Burnout is primarily associated with chronic workplace stress and the balance between job demands and resources. Moral distress is rooted in morally significant events and the distress associated with constraints or conflicts affecting ethically appropriate action. Compassion fatigue is associated with sustained empathic exposure to suffering and may involve secondary traumatic stress or diminished compassionate capacity. Observational evidence supports the co-occurrence of these experiences, but their temporal and causal relationships remain uncertain. A defensible response requires construct-specific assessment and interventions matched to the source of distress. Healthcare organizations should address staffing, workload, autonomy, leadership, and ethical climate while providing accessible ethics support, trauma-informed supervision, and confidential psychological care. Future research should use explicit definitions, validated measures, longitudinal designs, and intervention outcomes aligned with the proposed mechanisms. Distinguishing the three constructs is necessary for valid measurement and for selecting responses that address the conditions associated with each form of distress.

7. Declarations

Authors' Contributions

All authors contributed to the preparation of this manuscript.

Conflict of Interest

The authors declare that there is no conflict of interest regarding the publication of this article.

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