Review Article

Consequences of Moral Outrage among Nurses: A Scoping Review

Sima Pourteimour[1], Abbasali Ebrahimian[2], Hesamedin Askari-Majdabadi[3], Naser Parizad[4], Ali Fakhr-Movahedi[3,5]

[1]Student Research Committee, Semnan University of Medical Sciences, Semnan, Iran, [2]Health in Emergencies and Disasters Group, Faculty of Paramedical Sciences, Qom University of Medical Sciences, Qom, Iran, [3]Nursing Care Research Center, Semnan University of Medical Sciences, Semnan, Iran, [4]Patient Safety Research Center, Clinical Research Institute, Urmia University of Medical Sciences, Urmia, Iran, [5]Department of Pediatric and Neonatal Nursing, Nursing School, Semnan University of Medical Sciences, Semnan, Iran

Abstract

Background: Clinical nurses often encounter situations that challenge their professional integrity and values. In the face of these issues, many nurses have been subjected to moral outrage (MO) in response to moral violations by others, which can have different outcomes. This scoping review aimed to synthesize and summarize findings from existing articles regarding the consequences of moral outrage among nurses. **Materials and Methods:** This paper presents a scoping review based on the Joanna Briggs Institute (JBI) methodology. PubMed, Springer, Scopus, and ScienceDirect databases were systematically searched using the keywords "moral outrage", "nurses or nursing" and "consequences or outcomes or impacts or effects or influences of moral outrage" (viz., moral OR ethical AND outrage AND nurse*). The PRISMA checklist was used for the scoping review to evaluate articles thoroughly. The results were summarized using the inductive content analysis suggested by Elo and Kyngäs. **Results:** In total, 1014 articles were identified as potentially relevant to this study with 34 articles synthesized, including 24 qualitative studies, 5 quantitative studies, and 5 reviews focused on the consequences of moral offenses in nursing. Negative consequences such as mental exhaustion, job burnout, and interpersonal failures were observed, alongside positive consequences like nurses' altruism, callousness, and professional solidarity. **Conclusions:** These findings underscore the importance of addressing MO among nurses to prevent negative consequences such as burnout and moral degradation. Moreover, recognizing and fostering the altruistic and resilient aspects of nurses in response to moral outrage can lead to a more positive work environment and improved patient care.

Keywords: *Anger, clinical ethics, morals, nurses, review*

Introduction

The tensions and emotions in clinical settings can provoke unusual behaviors in nurses, such as anger.[1] Sometimes, this feeling of anger can be equated with Moral Outrage (MO). From a psychological perspective, MO is experienced as a feeling of anger with a motive to uphold violated ethics and principles of justice.[2] Nursing professionals may also experience MO when they witness neglect or mistreatment of patients, unethical behavior by colleagues or superiors, or systemic injustices, and violations or breaches of professional standards in the healthcare system.[3] This feeling can also stem from an altruistic concern for the wellbeing of others and the desire to address injustice.[4]

The consequences of MO can be complex and multifaceted.[5] While it can serve as a motivator for positive change and action, it can also negatively affect the nurses' wellbeing and professional practice. This includes feelings of helplessness and indifference to extreme stress[6] and frustration and burnout.[7] As MO harms nurses' self, behavior, and professional performance, it should not be allowed to persist.[8] To provide high-value health care, some conditions must be met to ensure that Health Care Providers (HCPs) find joy and meaning in their professional work.[9]

Reviewing studies conducted in various countries on MO has revealed different aspects of this concept. To better understand the impact of MO on nurses, a scoping review was conducted to explore existing literature on this topic. This article aims to summarize the findings of this review, focusing on the consequences of MO among nurses. By shedding light on this important issue, we hope to raise awareness and initiate discussions on how healthcare organizations can better support nurses in dealing with MO and promoting ethical practice. This review aimed to synthesize

How to cite this article: Pourteimour S, Ebrahimian A, Askari-Majdabadi H, Parizad N, Fakhr-Movahedi A. Consequences of moral outrage among nurses: A scoping review. Iran J Nurs Midwifery Res 2025;30:150-63.

Submitted: 24-Oct-2023. **Revised:** 16-Nov-2024. **Accepted:** 17-Nov-2024. **Published:** 10-Mar-2025.

Address for correspondence:
Dr. Ali Fakhr-Movahedi, Department of Pediatric and Neonatal Nursing, Nursing School, Semnan University of Medical Sciences, Semnan, Iran. E-mail: Alimovi49@semums.ac.ir

Access this article online

Website: https://journals.lww.com/jnmr

DOI: 10.4103/ijnmr.ijnmr_330_23

Quick Response Code:

and summarize findings from existing articles regarding the consequences of MO among nurses.

Materials and Methods

The present study is part of a larger ongoing project that employed a mixed-methods approach to develop a scale related to this concept. This study was conducted using available databases from 1990 to 2023. A scoping review was designed to synthesize, explain, and interpret the strong evidence on MO in nurses using the Joanna Briggs Institute (JBI) methodology.[10] This review method can potentially permit different essential research strategies to become a more significant part of evidence-based practice holistically. The research question was formulated by choosing the Population, Concept, and Context (PCC) mnemonic.[11]

The literature was searched and collected across PubMed, Springer, Scopus, and ScienceDirect databases. The following combinations of relevant terms, formed using the Boolean search phrases AND and OR, were applied in searches of all the databases: "moral outrage", "nurses or nursing", and "consequences or outcomes of moral or ethical outrage" (viz., moral OR ethical AND outrage AND nurse*), which led to the retrieval of 400 results [Figure 1].

The main inclusion criteria were aligned with the PCC mnemonic. For the first mnemonic term (Population), studies were included if nurses were the target study population. Concerning the second term (Concept), studies were eligible for inclusion if reporting on any description of the effects, impacts, influences, consequences, or outcomes of MO. Regarding the third term (Context), the included studies in context were set in the clinical settings, publication date: primary and secondary studies, included all types of research methodology with quantitative or qualitative designs, were in English, and were published in peer-reviewed journals with an available abstract (January 1979 to March 2023). In 1979, the article by Mahon and Everson introduced the concept of MO. Therefore, searches were limited to studies published in English from 1979 to March 2023. The relevant articles regarding MO outcomes among nurses were thus searched; studies were selected for inclusion in the scoping review based on the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) statement[12] to ensure the transparency of the study selection process. Studies focused on related concepts, such as moral empathy, personal anger, and vicarious anger, studies reporting on guidelines, single interventions, management protocols, conference abstracts, editorials, reviews, research protocols, opinion articles, or publications where the full-text could not be accessed were excluded from the review.

In the first phase of the review, searches of the four databases identified 1014 potentially relevant studies. For the retrieved documents, the primary screening to satisfy the eligibility criteria was independently reviewed based on the article title and abstract. All identified citations were reviewed, and the research team held a meeting to resolve any disagreements in including or excluding any articles. The researchers documented all these processes. In the secondary screening, a careful review of the content of the articles was conducted, presented in Table 1 with the categorization of the most important content for the review. After excluding duplicates, screening, and excluding irrelevant studies, the full texts of 55 studies were analyzed;

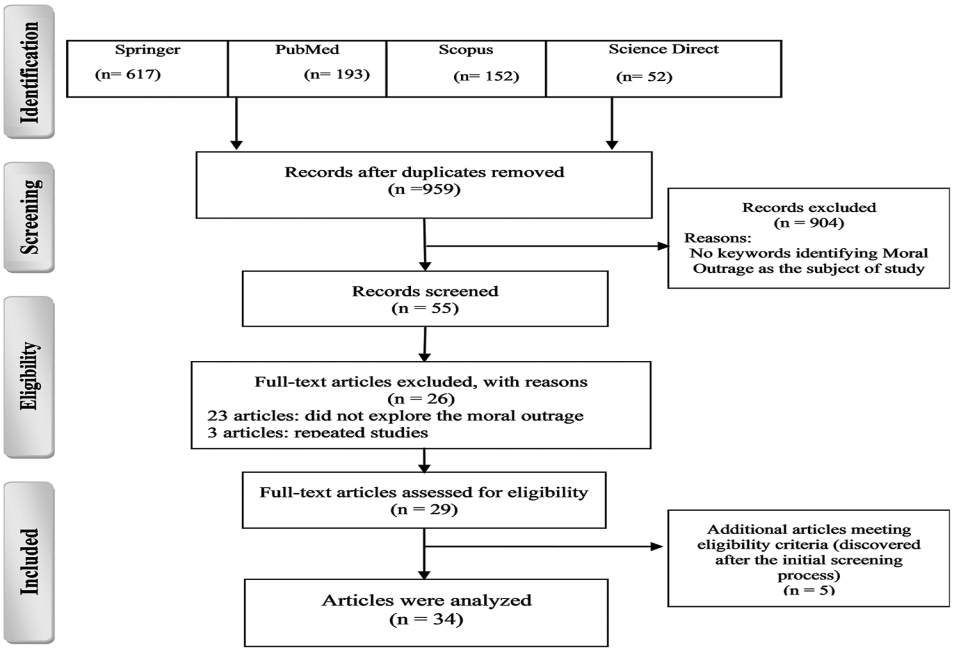

Figure 1: The PRISMA flow diagram of the study (adapted from PRISMA 2020 guidelines for systematic reviews)"

26 studies were excluded, and 5 were included as the final sample. This process culminated in 34 relevant studies included in this review, providing a critical analysis of the consequences of MO in clinical nurses. Figure 1 shows the search process in this scoping review study.

Narrative synthesis was used to summarize and explain the results of the included studies using words and text. Inductive content analysis was conducted on selected studies based on the research question. The data organization process included open coding and theme generation. In the open coding phase, we wrote headings to describe the findings of the articles and then created lists of categories. Subsequently, the extracted units of analysis were identified by similarities and differences and categorized into subthemes and finally into main themes.[45] These articles were then imported into the MAXQDA software program (version 10; VERBI GmbH, Berlin, Germany) to generate codes and themes.[46] The results were subsequently scanned for the keyword references to MO, consequences, outcomes, nurses, and clinical HCPs (n = 30). The reference lists from the articles included here were also checked for additional studies. Next, the research team vetted the articles, and four articles that met all the criteria were added following the reference list review and article screening.

A structured approach has been applied to ensure rigor and trustworthiness in this scoping review.[47,48] The studies were appraised by three reviewers (SP, AM, and NP) for descriptions of the quality of the selected studies. In the first stage, a single reviewer screened all studies based on their titles and abstracts. Two more reviewers, who were unaware of the screening results of the initial reviewer, examined a random selection of 20 of these studies and reached 100% agreement with the first reviewer. During the second stage, all reviewers independently evaluated all full-text articles for eligibility, with a 90% agreement on which articles should be included. The research group discussed any conflicting views on the critical evaluation and reached an agreement. Thus, detailed explanations of methods and procedures were provided to ensure that the sequence of steps could be easily understood, replicated, and validated. The approach involved adhering to established protocols for conducting a scoping review, documenting the search and selection process using the PRISMA flowchart, utilizing technology to minimize search and data management errors, and conducting multiple rounds of coding in MAXQDA to improve accuracy and gain a comprehensive grasp of the data to identify prominent themes. Throughout the research project, a detailed journal was kept to document all procedures, activities, and thoughts as an audit trail. Thirty-four entries were made over 6 months, starting from data collection and ending after the literature sample analysis was finished.

Ethical considerations

This study was derived from a Ph.D. thesis in nursing sponsored by REDACTED (with the approved ethical code: IR.SEMUMS.REC.1400.178). In addition, this research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Results

The articles were conducted in various countries, including the United States (n = 20), Canada (n = 3), China (n = 1), Australia (n = 2), United Kingdom (n = 2), South Africa (n = 1), Turkey (n = 1), Italy (n = 1), South Korea (n = 1), New Zealand (n = 1), and Sweden (n = 1). The studies comprised 24 qualitative research articles, 5 quantitative studies, and 5 review articles, as summarized in Table 1.

After the review, relevant data were extracted as codes concerning the research question. Subsequently, the research team members qualitatively categorized the data into main themes. As outlined in Table 2, the consequences of MO were delineated as follows: mental exhaustion, nurses' callousness, job burnout, failure in interpersonal relationships, risk-aversive management, moral degradation, altruistic approach, and professional solidarity [Table 2].

Mental exhaustion

One of the consequences of MO among clinical nurses was a disturbed emotional state, manifested primarily as mental exhaustion. This encompassed feelings of anxiety,[16,20] post-traumatic stress disorder (PTSD),[6,18,32-34] depression, and suicidal ideation.[18] Some nurses also experienced lingering distressing feelings from morally challenging situations,[6,8,21] including feelings of inadequacy,[25] frustration,[17,20,23,33,41,43] worthlessness,[44] being overwhelmed,[6] distressed,[27] emotional exhaustion,[16] isolation,[34] and disillusionment with the reality of health care services.[19]

Nurses' callousness

Nurses' callousness emerged as another consequence of MO, involving changes in their professional roles. This manifested as role conflict,[16] diffusion of responsibility.[24] low professional respect,[41] loss of integrity in pursuing moral actions,[8,40] emotional hardening, reduced empathy,[15] and even compassion fatigue.[29] Sometimes, nurses might think they cannot respond thoughtfully and consider countervailing values.[6]

Job burnout

In terms of job burnout,[29,38] nurses experienced chronic boredom at work,[29-31,38] reduced job satisfaction,[16] poor job performance,[16] low quality of care,[23,31] desire to leave the job,[17,26,41] absenteeism in the workplace,[26] limited organizational commitment,[23] and financial constraints and insufficient time to address ethical violations.[26]

Failure in interpersonal relationships

Regarding failure in interpersonal relationships, nurses faced challenges in cooperation[6,15,34] and empathy for ethical solutions.[34] They exhibited a lack of capacity for

Table 1: Summary of articles included in the scoping review listed in alphabetical order

Code	Author (Year)	Research Design	Sample (Country)	Research design	Research results
R1	Andersen[13] (1990)	Patient Advocacy and Whistle-Blowing in Nursing: Help for the Helpers	(Canada)	Case report	- Moral outrage arises from unresolved moral distress when nurses subvert patient support measures. - It involves emotional turmoil, pain, disbelief, anger, and rage. - Solutions include whistle-blowing, confirming the nurse's supporting role, and addressing the moral problem.
R2	Batson *et al*.[14] (2007)	Anger at unfairness: Is it moral outrage?	48 female undergraduate psychology students (The United States)	A randomized clinical trial (RCT) with randomized block sampling	- The individual's moral outrage is channeled toward reinstating and reaffirming violated moral standards. - This redirection creates motivation towards the goal of supporting moral standards and principles.
R3	Dudzinski[15] (2022)	Moral outrage toward willfully unvaccinated COVID-19 Patients	(The United States)	Case story	- Escalating the burden of pain and fostering resentment and humiliation in the nurse-patient relationship due to yielding to uncontrolled moral outrage - Resisting succumbing to moral outrage preserves core values during a crisis, requiring thoughtful considerations - Expressing vocal anger while maintaining reason, cooperation, and readiness for sacrifices for public health - Gradually losing clinical compassion, leading to emotional hardening and reduced empathy for unvaccinated patients
R4	Fry *et al*.[16] (2002)	Development of a model of moral distress in military nursing	13 Nurses (The United States)	Contractual qualitative content analysis	- Experiencing role conflict, low job satisfaction, subpar job performance, damaged work relationships, emotional exhaustion, and depersonalization as outcomes of experiencing moral outrage or burnout differently
R5	Georges and Grypdonck[17] (2002)	Moral problems experienced by nurses when caring for the terminally ill: a literature review	Nurses (The United States)	A literature review	- Nurses resigning due to moral outrage, publicizing their resignation letters online while asserting their voice. - Coping within a community of colleagues all striving to adapt and persevere - Experiencing a profound loss of integrity and passion for their profession, accompanied by rising anger - Feeling compelled to seek survival elsewhere, leaving behind the beloved community they once cherished
R6	Godshall[18] (2021)	Coping with moral distress during COVID-19	(*United Kingdom)*	Review article	- Nurses encountering elevated levels of depression and thoughts of suicide, indicative of symptoms associated with post-traumatic stress disorder (PTSD) following experiences of moral outrage - Initially not being concerned about developing PTSD, but eventually being impacted, particularly during the COVID-19 pandemic
R7	Hallaran[19] (2023)	New nurses' perceptions on transition to practice: a thematic analysis	217 nurses (Canada)	qualitative content analysis	- In the process of graduate nurse socialization, new nurses experience disillusionment and distress when they realize that the ideals taught in school are not realistic.

Contd...

Table 1: Contd...

Code	Author (Year)	Research Design	Sample (Country)	Research design	Research results
					- This stage of moral outrage emerges as they come to terms with the disparity between the healthcare reality and the sanctuary-like environment of nursing school. - The concerns about this disillusionment persist over time.
R8	Hamric[20] (2000)	Moral distress in everyday ethics	(The United States)	Case report	- Moral outrage leads to feelings of frustration, depression, anxiety, and anguish. - Nurses experience this distress when confronted with institutional barriers and value conflicts. - Reactive distress arises without any action taken based on the initial distress. - Reactive distress can manifest as poor ethical practice, an inability to recognize ethical issues, or a lack of awareness of alternatives at the bedside.
R9	Johnstone[21] (2002)	Poor working conditions and the capacity of nurses to provide moral care	(Australia)	Case report	- Uncontrolled stress and moral distress can escalate to become moral outrage. - This moral outrage, in turn, can worsen the initial distress. - When moral stress, moral distress, and moral outrage remain unresolved, they can lead to the development of "moral dissociation." - Moral dissociation is characterized by moral indifference, reduced moral conscience, and a decline in one's overall moral sense.
R10	Koçak[22] (2021)	Moral outrage, intolerance of uncertainty and relational interdependence during the COVID-19 pandemic: A social psychology research	821 adults (Turkey)	Descriptive correlational study	- Altruism is experienced as a source of inspiration and insight that drives compassionate actions. - Nurses try to understand the principles of safety, integrity, or wellbeing at risk, particularly in challenging situations like the COVID-19 pandemic. - Altruism serves as a motivation in significant social events. - It provides an avenue to explore the moral boundaries of courage, patience, and responsibility. - Sensitivity to moral outrage might be present, but its constructive application in nurses' interactions may be limited. - Undefined moral outrage can lead to increased differences, exacerbated discrimination, and undermined social behavior.
R11	Kim *et al*.[23] (2020)	Ethical conflicts experienced by nurses in geriatric hospitals in South Korea: “if you can’t stand the heat, get out of the kitchen”	13 nurses (South Korea)	Phenomenological study	- Encountering ethical conflicts can lead to various forms of psychological distress among nurses, including frustration, helplessness, anger, or outrage. - These distressful emotions can exacerbate challenges in managing ethical conflicts. - A lack of clear ethical guidelines or rules can intensify anxiety due to uncertainty and reduce nurses' organizational commitment and quality of care. - It can result in the resolution of the conflict between nurses' personal emotions and their role in supporting patients' families when facing family cruelty.

Contd...

Table 1: Contd...

Code	Author (Year)	Research Design	Sample (Country)	Research design	Research results
R12	Kaufman[24] (1997)	Construction and practice of medical responsibility: dilemmas and narratives from geriatrics	(The United States)	Case story	- Sometimes, clinical decisions are a form of resistance to structural forces and established routines. These dilemmas have the potential to trigger and strengthen moral indignation against a system that obstructs individuals' sense of responsibility.
R13	Laabs[25] (2005)	Moral problems and distress among nurse practitioners in primary care	71 nurse practitioners (The United States)	Descriptive study design	- Some individuals engage in unethical behavior, and nurses feel powerless to influence their actions. - Nurses attempt to rectify moral issues but lack the resources, such as time or finances, to bring about change.
R14	Langley *et al*.[26] (2015)	Moral distress experienced by intensive care nurses	100 ICU nurses (South Africa)	Exploratory and descriptive design	- Professionally, nurses might display reluctance to engage with patients' families, restrict care, or resort to absenteeism or leave the unit, hospital, or profession due to moral outrage.
R15	Laabs[27] (2007)	Primary care nurse practitioners' integrity when faced with moral conflict	23 nurse practitioners (The United States)	Glaser and Strauss grounded theory	- Nurses feel distressed and outraged due to what they view as unethical actions by others. - Instead of internalizing these negative emotions, they direct them toward the individuals or entities they hold accountable for their moral transgressions. - The experience of outrage can compromise the integrity of nurse-patient relationships. - Nurses believe they are personally responsible for rectifying perceived moral wrongs and have the capability to do so.
R16	Liu *et al*.[28] (2021)	Psychometric properties of the ethical conflict in nursing questionnaire critical care version among Chinese nurses: a cross-sectional study	248 nurses (China)	A cross-sectional study	- The range of emotional responses, from moral outrage to moral indifference in descending order, leads to the failure to develop strategies aimed at mitigating moral conflicts and enhancing the nursing work environment.
R17	Maffoni *et al*.[29] (2019)	Healthcare professionals' moral distress in adult palliative care: a systematic review	(Italy)	A systematic review article	- The internal moral experiences of an individual contribute to job burnout, compassion fatigue, and feelings of moral distress.
R18	Milliken and Uveges[30] (2022)	Nurses' ethical obligations toward unvaccinated individuals	(The United States)	Case story	- Nurse burnout arises along with moral outrage due to the continuous rise in the COVID-19 census in the intensive care unit, coupled with being understaffed. - Colleagues' discussions at the nurses' station about unvaccinated patients and families expressing disappointment regarding vaccination choices contribute to the burden perceived by nurses within the healthcare system.
R19	O'Haire and Blackford[31] (2005)	Nurses' moral agency in negotiating parental participation in care	9 nurses (Australia)	Grounded Theory	- Moral outrage serves to empower nurses within the hospital environment. - It can hinder their negotiation abilities. - It can also lead to a decrease in the quality of childcare.
R20	O'Mara *et al*.[32] (2011)	Will moral outrage stand up? Distinguishing among emotional reactions to a moral violation	10 nurses (The United States)	A randomized clinical trial (RCT)	- The catalyst for the initiation of moral action involves seeking revenge and compensation on behalf of a third party who has been harmed.

Contd...

Table 1: Contd...

Code	Author (Year)	Research Design	Sample (Country)	Research design	Research results
R21	O'Mara[33] (1999)	Communication and conflict resolution in emergency medicine	(The United States)	Case report	- There is a heightened necessity to enhance communication methods and management approaches to address conflicts. - The demand for nurses to engage in collaborative interdisciplinary educational and research initiatives relating to departmental matters is on the rise.
R22	Pike[34] (1991)	Moral outrage and moral discourse in nurse-physician collaboration	(The United States)	Case report	- Nurses come to the realization that they are at times the sole caregivers. - They observe that physicians also experience moral dilemmas and deep caring for patients, similar to nurses, but often deal with them in isolation. - Collaboration breaks down in situations requiring rational, innovative, and compassionate care during ethical dilemmas. - The lack of cooperation between nurses and physicians affects not only patient care, but also their own well-being. - Properly managed moral outrage can foster shared qualities like joint decision-making and responsibility, which can remove limitations and promote cooperative moral dialogue between nurses and physicians, ultimately leading to elevated care.
R23	Rushton[8] (2013)	Principled moral outage: an antidote to moral distress?	(The United States)	Case report	- Moral outrage can result in taking action or choosing not to act, both of which leave behind a lingering painful aftermath from morally distressing situations. - The nurse cannot make a correct prioritization or choice between conflicting moral principles.
R24	Rushton and Thompson[6] (2020)	Moral outrage: Promise or peril?	(The United States)	Case report	- The prolonged activation of the nervous system in hyperarousal mode can trigger a release of stress hormones, leading to feelings of being overwhelmed, depleted, apathetic, persistently anxious, or reactive—often termed as "autopilot." - Operating on autopilot can result in failing to make conscious, respectful, and meaningful choices aligned with one's values and commitments. - This mode can erode empathy, cooperation, and clear thinking, leading to destructive behaviors instead of seeking solutions. - The inability to pause and reflect before reacting can hinder the capacity to respond thoughtfully and consider countervailing values. - Expressing moral outrage can take the form of written or spoken protests, blaming wrongdoers, accusing motives, aggressive behaviors, or inciting violence. - Shared experiences of moral outrage can unite individuals in solidarity against threats to their personal or professional identities, values, beliefs, or integrity. - Moral outrage can serve as a signal for physicians to address violations or injustices, driven by altruistic concern for others' welfare.

Contd...

Table 1: Contd...

Code	Author (Year)	Research Design	Sample (Country)	Research design	Research results
					- The buildup of negative emotions can intensify and contribute to a "moral contagion," affecting and spreading to others. - The need arises to engage in principled moral analysis, exploring various alternative actions aligned with one's values, such as speaking up, negotiation, conscientious objection, and silent witness. - There can be a tendency to justify anger towards others by framing emotions as morally valid or using self-serving posturing to protect one's moral identity. - The allure of self-righteous indignation can divert attention from personal responsibility when expressing moral outrage.
R25	Rothschild and Keefer[35] (2017)	A cleansing fire: Moral outrage alleviates guilt and buffers threats to one's moral identity	(The United States)	Review of 5 Experimental studies	- Moral outrage can act as a driving force behind favorable social results, such as endorsing political initiatives, engaging in protests, and seeking retribution for moral wrongs on behalf of those who have been wronged.
R26	Rushton[36] *et al*. (2013)	A framework for understanding moral distress among palliative care clinicians	(The United States)	Case story	- Experiencing moral injury, moral outrage, burnout, or acute secondary stress can result from failing to manage personal or moral distress, leading to physical, emotional, and mental exhaustion due to prolonged exposure to emotionally challenging situations. - Taking principled compassionate actions involves leveraging the force of moral outrage to make difficult decisions, confronting morally compromising situations despite resistance, and opposing them in a fair and measured manner.
R27	Thomas *et al*.[37] (2021)	COVID-19 and moral distress: A pediatric critical care survey	(The United States)	Exploratory survey	- The presence of colleagues who are self-centered and display unprofessional behavior can lead to a fracture in team cohesion. - Health-care professionals are grappling with challenges to their professional identities, roles, expectations, and academic connections due to moral outrage, particularly during the COVID-19 pandemic.
R28	Udén *et al*.[38] (1995)	The stories of physicians, registered nurses, and enrolled nurses about ethically difficult care episodes in surgical care	20 physicians, 19 registered nurses (Sweden)	Ricoeur's (1976) phenomenological hermeneutics	- Moral outrage can have negative effects, including increased workload and job burnout, especially when dealing with complex care problems. - On the positive side, moral outrage can also lead to a desire for increased interaction among individuals.
R29	de Vyver[39] (2016)	Promoting prosociality: Testing the potential of moral elevation and moral outrage	(United Kingdom)	Review of 5 Experimental studies	- Individuals demonstrate a readiness to participate in collective actions in response to unfair treatment, whether it affects individuals within their group (in-group) or those outside their group (out-group). - This encourages individuals to support others, such as Rushton, and to take a stand against injustices that do not directly affect themselves.

Contd...

Table 1: Contd...

Code	Author (Year)	Research Design	Sample (Country)	Research design	Research results
R30	Woods *et al*.[40] (2015)	Researching moral distress among New Zealand nurses: A national survey	412 registered nurses (New Zealand)	The cross-sectional survey	- When trying to uphold moral principles in oppressive situations, individuals may experience a compromise of their integrity.
R31	Wolf and Zuzelo[41] (2006)	"Never Again" stories of nurses: dilemmas in nursing practice	(The United States)		- Difficulty in forgetting distressing clinical situations when circumstances at work compel individuals to engage in actions that contradict their moral beliefs - Proneness to experiencing moral outrage when facing similar challenging situations, particularly those that are problematic and intolerable - Persistence of negative emotions like anger, shame, and guilt concerning the decisions and actions of certain healthcare providers - Struggling with impaired performance and psychological imbalance - Inability to sustain the ability to provide quality patient care and remain in nursing when feeling a lack of proper control over patient situations - Loss of respect of nurses towards physicians who have violated ethical principles
R32	Wong[42] (2020)	Beyond burnout: Looking deeply into physician distress	(Canada)	Case story	- Allowing unchecked or driven moral outrage, often fueled by unmet (often unconscious) need, anger, or self-aggrandizement, to escalate into contagious conflicts and perpetuate the dynamics of the dramatic triangle involving the roles of persecutor, victim, and rescuer. - Physicians may become apathetic in response to moral outrage, viewing it as a deliberate act of indifference and denial in the face of others' suffering or harmful situations.
R33	Wilkinson[43] (1989)	Moral distress: A labor and delivery nurse's experience	(The United States)	Case story	- Nurses experiencing moral outrage, rejection, disillusionment, hostility, and despair may provide different and less effective care. - Nurses who are highly conflicted and dissatisfied may struggle to establish a positive atmosphere and build relationships that prioritize their patients' well-being.
R34	Wilson and Puckett[44] (2011)	Effects of moral outrage on child welfare reform	(The United States)	Case story	- Attempt to terminate or demote staff, supervisors, or managers who have made errors of judgment and moral violations, often driven by persistent media attacks on management teams - The effort to satisfy public demands for accountability, particularly in cases involving a child's death - An attempt to manage a media crisis which can lead to a risk-aversive organizational culture as a survival strategy, where avoiding blame becomes a primary objective - A failure to thoroughly understand the multifaceted causes of ethical decision-making errors

Table 2: Consequences of moral outrage among clinical nurses

Themes	Sub-themes
Mental exhaustion	Feelings of anxiety (R4, R8)
	Feelings of emotional exhaustion (R4)
	Feelings of frustration (R5, R11, R8, R31, R21, R33)
	Feeling outraged and distressed (R15)
	Feelings of depression and suicidal ideation (R6)
	Pre-traumatic stress disorder (PTSD) (R6, R24, R20, R21, R22)
	Feelings of disillusionment with the reality of health care services (R7)
	Feelings of inadequacy (R13)
	Feelings of isolation (R22)
	Distressing feelings (R9, R24, R23)
	Feelings of being overwhelmed (R24)
	Feelings of worthlessness (R34)
Nurses' callousness	Emotional hardening and reduced empathy (R3)
	Feelings of role conflict (R4)
	Feelings of helplessness (R11)
	Diffusion of responsibility (R12)
	Compassion fatigue (R17)
	The inability to respond thoughtfully and consider countervailing values (R24)
	Loss of integrity in pursuing moral actions (R23, R30)
	Low professional respect (R31)
Job burnout	Reduced job satisfaction (R4)
	Poor job performance (R4)
	Desire to quit job (R5, R14, R31)
	Limited organizational commitment (R11)
	Absenteeism in the workplace (R14)
	Financial constraints and insufficient time to address ethical violations (R14)
	Job burnout (R17, R28)
	Experiencing chronic boredom at work (R17-R18)
	Low quality of care (R11, R19)
Failure in interpersonal relationship	Fostering resentment and humiliation in the nurse-patient relationship (R3)
	Lack of empathy for ethical solutions (R22)
	Lack of capacity for social interaction (R22)
	Reluctance to engage in moral discussions with specialists and head nurses (R22)
	Reluctance to engage with patients' families (R14)
	Challenges in interdisciplinary cooperation (R24, R22, R3)
	Inability to negotiate patient conditions (R24, R22, R19)
	Breakdown in team cohesion and interaction (R4, R10, R27, R33)
Risk-aversive managers	Attempts to fire staff instead of understanding the multifaceted causes (R34)
Moral degradation	Inclinations toward revenge (R20)
	Inability to recognize ethical dimensions (R8)
	The loss of moral conscience (R9)
	Poor social skills (R10)
	Selfish behavior for personal gain (R24)
	The loss of respect of nurses toward physicians (R31)
	Instances of dual moral behavior in clinical contexts (R32)
	Indifference toward moral issues (R16, R24)
	Lack of correct prioritization of conflicting moral principles (R23)
	Challenges in managing ethical conflicts (R11)
Altruistic approach	Whistleblowing to expose moral issues (R1)
	Compassionate actions by adhering to principles (R10)
	Increased protective involvement (R11)
	Initiatives to reinstate moral standards and moral courage (R15)
	Endeavors to compensate and advocate for injured individuals (R20)
	Clarifying reasons behind violations of moral principles (R24)
	Taking principled compassionate actions (R26)
Professional solidarity	Participation in interdisciplinary educational and research initiatives (R21)
	Vocal opposition to violence in written or verbal forms (R24)
	Sharing experiences of moral outrage across diverse social groups (R27, R25)
	Collective unity to address moral outrage (R24, R29)
	Reinforcement of team identity (R27)

social interaction,[34] including reluctance to engage in moral discussions with specialists and head nurses,[34] the patient's families,[26] and even the patients.[15] Therefore, they lost the ability to negotiate patient conditions,[6,31,34] have cooperative interdisciplinary relationships,[6,15,34] and address ethical concerns.[34] MO can also lead to a breakdown in team cohesion and interaction, ultimately fostering resentment[16,22,43,37] and humiliation within the nurse–patient relationship.[15]

Moral degradation

Moral degradation, synonymous with amorality, encompassed the loss of moral conscience,[21] apathy toward moral issues,[6,28,42] inclinations toward revenge,[32]

ethical degradation in social skills,[22] unethical reactions including selfish behavior for personal gain,[6] deficient ethical practice, and inability to recognize ethical dimensions,[20] and instances of dual moral behavior in clinical contexts.[42] Moreover, they could not make correct prioritizations or choices between conflicting moral principles.[8]

Risk-aversive managers

Managing a media crisis can lead to a risk-averse organizational culture as a survival strategy, where avoiding blame becomes a primary goal. In this regard, there is no attempt to fully understand the multifaceted causes of ethical decision-making errors, especially in severe consequences of ethical violations such as the death of a child, among managers.[44]

Altruistic approach

Altruistic nurses demonstrated compassion by adhering to principles that safeguard patient safety, integrity, and wellbeing.[22] Nurses also sought solutions to MO, including whistleblowing to expose moral issues,[13] endeavors to compensate and advocate for injured individuals,[32] initiatives to reinstate moral standards and moral courage,[27] and clarifying the reasons behind violations of moral principles.[6] Thus, compassionate actions[36] and increased protective involvement for affected individuals were prominent across these actions.[23]

Professional solidarity

Furthermore, professional solidarity entailed increased nurse participation in interdisciplinary educational and research initiatives,[33] investigation of MO experiences across diverse social groups to address threats to identity, values, professional beliefs,[35,37] collective unity to address MO,[6,39] vocal opposition to violence or aggression in written or verbal forms,[6] and reinforcement of team identity.[37] Occasionally, positive consequences manifested as an altruistic approach and professional solidarity.

Discussion

This scoping review summarizes current knowledge of the consequences of MO among nurses in clinical settings. The multidimensional nature of MO outcomes among nurses can be illustrated by the identified themes in the examined articles, whose evaluation could lead to the emergence of effective actions.

One of the main negative consequences of MO was the occurrence of mental exhaustion. In this regard, Clark *et al*.[49] highlighted that nurses may experience moral distress when faced with unnecessary patient suffering and feel that they are not doing enough morally to address these challenges. This distress may escalate over time and in specific circumstances and contexts, resulting in moral residue and injury. Hamric[20] mentioned that this moral distress could sometimes turn into MO and cause anger, despair, depression, and anxiety in moral dilemmas. Moreover, Phelps *et al*.[50] emphasized that the relationship between moral injury and the feeling of anger, mediated by a sense of betrayal by leaders, teams, and organizations, the existence of injustice once others have violated one's moral rules, and shame, when a person has violated one's moral code, might be cyclical signs of an impending mental disorder as well as a psychotic break with organizations. In the study by Dodek *et al*.,[51] higher moral distress in nurses was also associated with less scope for decision-making and social support, along with more psychological stress and pressure. Moreover, some studies revealed that nurses working in ambulatory care units could sometimes undergo more psychosomatic disorders due to their mental experience of stress and workload.[41,52] Kesbiç and Boz correspondingly stated that going through challenging caregiving moments in a difficult work environment and its cost could raise compassion fatigue as one of the symptoms of mental exhaustion.[53] However, another survey established that a high workload during the COVID-19 crisis could positively enhance the performance of nurses.[54] A review of these studies made it possible to understand the importance of psychophysical well-being in nurses during moral challenges, such as MO.

Additionally, the study results showed that nurses' callousness, failure in interpersonal relationships, and moral degradation were other negative consequences of MO. In this regard, Hsiao Ying stated that callous nurses exhibit cruelty, indifference, and moral confusion, which can lead to job burnout.[55] Corley highlighted that MO was often a short-term avoidance behavior in reaction to the suffering of others.[56] Jones-Bonofiglio emphasized that individuals in the line of reasoning between right and wrong could experience moral confusion and job burnout.[57] The limitations of ethical actions among nurses may manifest as internal barriers such as the lack of confidence, timidity, fear, insecurity, and inferiority, or external barriers like attention to authority, physicians' orders, hospital policy, and threats of legal action.[6] Despite this, Hakimi *et al*.[58] indicated that nurses may exhibit moral indifference in unethical work environments, including feelings of discouragement, normalization, surrender, and self-justification. Moreover, Ghazanfari *et al*.[59] conversely added that nurses with MO could have independence and even motivation to cope with moral problems but less moral distress. Rushton and Thompson suggested that focusing on tone of voice, rather than MO practice as a coping strategy, could lead to more effective ethical analyses, such as speaking, conscientious objection, and negotiation.[6] They noted that the dynamics of interpersonal interactions in the cooperation between nurses and physicians with principled MO could empower them. This mutual trust and respect could enable integrated care, fostering creativity, optimism, energy, and constructive action in addressing moral

dilemmas.[6] It can be concluded that nurses' callousness, characterized by moral disengagement, can have negative consequences for patient care. However, by developing principled moral orientation and fostering cooperative relationships between nurses and physicians, healthcare professionals can effectively navigate moral dilemmas and provide integrated care.

However, the positive consequences of MO could manifest in the form of an altruistic approach and professional solidarity. Some studies have already highlighted this, praising MO as a positive force for promoting positive social outcomes through behaviors such as support for political actions, participation in protests, and the desire to hold moral offenders accountable on behalf of innocent victims.[8,35,37] Additionally, some studies have noted that MO could be identified after nurses felt moral distress when subverting patient support measures.[8,13,60] In addition, Batson *et al*.[14] pointed out that motivation stemming from MO can drive individuals toward moral standards or principles. Furthermore, Haahr also indicated that experiencing MO may result in individuals seeking organizational support and further training to overcome internal and external barriers arising from fear.[61] Rushton and Thompson suggested that MO could help individuals identify the sources of their anger, motivate them to take responsible action, and foster courage in challenging strict moral boundaries.[6] On the other hand, Koçak (2021)[22] found that MO can positively predict interdependence in relationships during the COVID-19 pandemic. Holtz *et al*. emphasized that moral integrity, solidarity, and the distinction between individual and social values are significant aspects of moral resilience in professional settings.[62] However, Rushton and Thompson cautioned that external restrictions, such as imposed policies and attitudes related to nursing home care, legal constraints, and organizational threats, may sometimes counteract collective moral actions fueled by MO. This is because it can trigger excessive arousal in individuals, leading to a conflict between ignoring moral violations and experiencing constant anxiety.[6] The review study by Haahr *et al*. also highlighted ethical challenges faced by nurses of all age groups, complicating the navigation of professional values, standards, and organizational structures, thereby increasing stress and uncertainty in seeking support.[61] Thus, while external restrictions and organizational threats may hinder collective moral actions driven by MO, resulting in elevated stress and challenges in seeking support, individuals must strive to strike a balance between taking responsible action and managing the emotional and physiological consequences of their MO within professional roles.

The scoping review discussed in this study has a few limitations. Unlike systematic reviews, it did not formally evaluate the quality of the studies included in the analysis. However, a systematic review would not have been suitable for this research question as most of the studies had a qualitative design. Further exploration of nurses' practices and attitudes in various countries is also necessary to present a more diverse representation as many existing studies primarily focus on specific European nations. To enhance comprehension in future research, examining cultural, legal, and organizational differences between countries is beneficial to understanding how to measure the impact of these outcomes on nurses' mental health, job satisfaction, turnover intention, and patient safety.

Conclusion

This review has identified the multifaceted consequences of MO among nurses with negative and positive outcomes. While MO can lead to mental and emotional exhaustion, strained relationships, and a sense of moral degradation, it also has the potential to foster altruism, professional solidarity, and resilience. It is crucial for healthcare organizations to recognize and address the negative consequences of MO among nurses, while also fostering a supportive work environment that encourages positive growth and resilience in the face of moral challenges. By promoting ethical leadership, self-care strategies, and opportunities for moral reflection, healthcare organizations can mitigate the negative effects of MO and promote positive outcomes for both nurses and the patients they care for. Finally, further research is needed to explore nurses' experiences regarding MO among different health care professionals in hospitals.

Acknowledgments

All authors contributed to the conception and design of the study. The authors would like to thank the research deputy of the Semnan University of Medical Science for supporting the research.

Financial support and sponsorship

Nil.

Conflicts of interest

Nothing to declare.

References

1. Inocian EP, Cruz JP, Saeed Alshehry A, Alshamlani Y, Ignacio EH, Tumala RB. Professional quality of life and caring behaviours among clinical nurses during the COVID-19 pandemic. J Clin Nurs 2021. doi: 10.1111/jocn.15937.
2. Haidt J. The moral emotions. Handbook of Affective Sciences. Oxford University Press; 2003. p. 852-70.
3. O'Mathúna D, Smith J, Zadvinskis IM, Monturo C, Kelley MM, Tucker S, *et al*. Ethics and frontline nursing during COVID-19: A qualitative analysis. Nurs Ethics 2023;30:803-21.
4. Crockett MJ. Moral outrage in the digital age. Nat Hum Behav 2017;1:769-71.
5. Zembylas M. Encouraging moral outrage in education: A pedagogical goal for social justice or not? Ethics Educ 2021;16:424-39.
6. Rushton CH, Thompson L. Moral outrage: Promise or peril? Nurs Outlook 2020;68:536-8.

7. Nordam A, Torjuul K, Sørlie V. Ethical challenges in the care of older people and risk of being burned out among male nurses. J Clin Nurs 2005;14:1248-56.
8. Rushton CH. Principled moral outrage: An antidote to moral distress? AACN Adv Crit Care 2013;24:82-9.
9. Sinclair S, Raffin-Bouchal S, Venturato L, Mijovic-Kondejewski J, Smith-MacDonald L. Compassion fatigue: A meta-narrative review of the healthcare literature. Int J Nurs Stud 2017;69:9-24.
10. Toronto CE, Remington R. A Step-by-Step Guide to Conducting an Integrative Review. Springer; 2020.
11. Kutcher AM, LeBaron VT. A simple guide for completing an integrative review using an example article. J Prof Nurs 2022;40:13-9.
12. Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, *et al*. PRISMA extension for scoping reviews (PRISMA-ScR): Checklist and explanation. Ann Intern Med 2018;169:467-73.
13. Andersen SL, editor Patient advocacy and whistle-blowing in nursing: Help for the helpers. Nurs Forum. Wiley Online Library; 1990.
14. Batson CD, Kennedy CL, Nord LA, Stocks E, Fleming DYA, Marzette CM, *et al*. Anger at unfairness: Is it moral outrage? Eur J Soc Psycho 2007;37:1272-85.
15. Dudzinski DM. Moral outrage toward willfully unvaccinated COVID-19 patients. J General Internal Med 2022;37:2070-1.
16. Fry ST, Harvey RM, Hurley AC, Foley BJ. Development of a model of moral distress in military nursing. Nurs Ethics 2002;9:373-87.
17. Georges JJ, Grypdonck M. Moral problems experienced by nurses when caring for terminally ill people: A literature review. Nurs Ethics 2002;9:155-78.
18. Godshall M. Coping with moral distress during COVID-19. Nursing 2021;51:55-8.
19. Hallaran AJ, Edge DS, Almost J, Tregunno D. New nurses' perceptions on transition to practice: A thematic analysis. Can J Nurs Res 2023;55:126-36.
20. Hamric AB. Moral distress in everyday ethics. Nurs Outlook 2000;48:199-201.
21. Johnstone MJ. Poor working conditions and the capacity of nurses to provide moral care. Contemp Nurs 2002;12:7-15.
22. Koçak L. Moral outrage, intolerance of uncertainty and relational interdependence during the covid-19 pandemic: A social psychology research. J Fam Couns Educ 2021;6:57-73.
23. Kim M, Oh Y, Kong B. Ethical conflicts experienced by nurses in geriatric hospitals in South Korea: "If You Can't Stand the Heat, Get Out of the Kitchen". Intern J Environm Res Public Health 2020;17:4442.
24. Kaufman SR. Construction and practice of medical responsibility: Dilemmas and narratives from geriatrics. Cult Med Psych 1997;21:1-26.
25. Laabs CA. Moral problems and distress among nurse practitioners in primary care. J Am Acad Nurs Pract 2005;17:76-84.
26. Langley GC, Kisorio L, Schmollgruber S. Moral distress experienced by intensive care nurses. South Afr J Crit Care 2015;31:36-41.
27. Laabs CA. Primary care nurse practitioners' integrity when faced with moral conflict. Nurs Ethics 2007;14:795-809.
28. Liu Y, Cui N, Zhang Y, Wang X, Zhang H, Chen D, *et al*. Psychometric properties of the ethical conflict in nursing questionnaire critical care version among Chinese nurses: A cross-sectional study. BMC Nurs 2021;20:1-11.
29. Maffoni M, Argentero P, Giorgi I, Hynes J, Giardini A. Healthcare professionals' moral distress in adult palliative care: A systematic review. BMJ Supp Palliat Care 2019;9:245-54.
30. Milliken A, Uveges MK. Nurses' ethical obligations toward unvaccinated individuals. AACN Adv Crit Care 2022;33:220-6.
31. O'Haire SE, Blackford JC. Nurses' moral agency in negotiating parental participation in care. Intern J Nurs Prac 2005;11:250-6.
32. O'Mara EM, Jackson LE, Batson CD, Gaertner L. Will moral outrage stand up?: Distinguishing among emotional reactions to a moral violation. Eur J Soc Psych 2011;41:173-9.
33. O'Mara K. Communication and conflict resolution in emergency medicine. Emerg Med Clin N Am 1999;17:451-9.
34. Pike AW. Moral outrage and moral discourse in nurse-physician collaboration. J Professional Nurs 1991;7:351-62.
35. Rothschild ZK, Keefer LA. A cleansing fire: Moral outrage alleviates guilt and buffers threats to one's moral identity. Motiv Emot 2017;41:209-29.
36. Rushton CH, Kaszniak AW, Halifax JS. A framework for understanding moral distress among palliative care clinicians. J Palliat Med 2013;16:1074-9.
37. Thomas TA, Davis FD, Kumar S, Thammasitboon S, Rushton CH. COVID-19 and moral distress: A pediatric critical care survey. Am J Crit Care 2021;30:e80-98.
38. Udén G, Norberg A, Norberg S. The stories of physicians, registered nurses and enrolled nurses about ethically difficult care episodes in surgical care. Scand J Caring Sci 1995;9:245-53.
39. de Vyver JV, Abrams D. Promoting third-party prosocial behaviour: The potential of moral emotions. Intergroup Helping (39) and the international library of bioethics(57) 2017:349-68.
40. Woods M, Rodgers V, Towers A, La Grow S. Researching moral distress among New Zealand nurses: A national survey. Nurs Ethics 2015;22:117-30.
41. Wolf ZR, Zuzelo PR. "Never again" stories of nurses: Dilemmas in nursing practice. Qual Health Res 2006;16:1191-206.
42. Wong AM. Beyond burnout: Looking deeply into physician distress. Can J Ophthalmol 2020;55:7-16.
43. Wilkinson JM. Moral distress: A labor and delivery nurse's experience. J Obstet Gynecol Neonatal Nurs 1989;18:513-9.
44. Wilson D, Puckett A. Effects of moral outrage on child welfare reform. Arch Pediatr Adolesc Med 2011;165:977-8.
45. Elo S, Kyngäs H. The qualitative content analysis process. J Adv Nurs 2008;62:107-15.
46. Kuckartz U, Rädiker S. Analyzing Qualitative Data with MAXQDA. Springer; 2019.
47. Lincoln YS, Guba EG. Naturalistic inquiry. California: Sage Publications; 1985.
48. Kyngäs H, Kääriäinen M, Elo S. The trustworthiness of content analysis. In H. Kyngäs, K. Mikkonen, & M. Kääriäinen (Eds.), The application of content analysis in nursing science research. Springer.2020;41-8.
49. Clark P, Crawford TN, Hulse B, Polivka BJ, Resilience, Moral Distress, and Workplace Engagement in Emergency Department Nurses. West J Nurs Res 2021;43:442-451.
50. Phelps AJ, Dell L, Murray K. Moral injury and anger in the workplace. Anger at Work: Prevention, Intervention, and Treatment in High-Risk Occupations. American Psychological Association; 2021. p. 81–110. doi: 10.1037 / 0000244-004.
51. Dodek PM, Norena M, Ayas N, Wong H. Moral distress is associated with general workplace distress in intensive care unit personnel. J Crit Care 2019;50:122-5.
52. Werner NS, Bültmann M, Möckel L. Perceived stress, workload and psychosomatic complaints in inpatient and outpatient care nurses. Pflege 2022. doi: 10.1024 / 1012-5302/a000901.
53. Kesbiç Ş, Boz İ. Experiences of perinatal nurses regarding compassion fatigue and compassion satisfaction:

A phenomenological study. J Psychosom Obstet Gynecol 2022;43:359-67.

54. Pourteimour S, Yaghmaei S, Babamohamadi H. The relationship between mental workload and job performance among Iranian nurses providing care to COVID-19 patients: A cross-sectional study. J Nurs Manag 2021;29:1723-32.
55. Hsiao Ying T. Taiwanese cancer patients' view of 'not-good nursing': Reflections based on Viktor Frankl's ideas. J Japanese Nurs Ethics 2023;15:53-61.
56. Corley MC. Nurse moral distress: A proposed theory and research agenda. Nurs Ethics 2002;9:636-50.
57. Jones-Bonofiglio K. Health Care Ethics through the Lens of Moral Distress. The international library of bioethics 2020;82:21-38.
58. Hakimi H, Joolaee S, Ashghali Farahani M, Rodney P, Ranjbar H. Moral neutralization: Nurses' evolution in unethical climate workplaces. BMC Med Ethics 2020;21:1-10.
59. Ghazanfari MJ, Emami Zeydi A, Panahi R, Ghanbari R, Jafaraghaee F, Mortazavi H, *et al*. Moral distress in nurses: Resources and constraints, consequences, and interventions. Clin Ethics 2022;17:265-71.
60. Davidson PM, Padula WV, Daly J, Jackson D. Moral Outrage in COVID19—Understandable but not a Strategy. Wiley Online Library; 2020. p. 3600-2.
61. Haahr A, Norlyk A, Martinsen B, Dreyer P. Nurses experiences of ethical dilemmas: A review. Nurs Ethics 2020;27:258-72.
62. Holtz H, Heinze K, Rushton C. Interprofessionals' definitions of moral resilience. J Clin Nurs 2018;27:e488-94.