Birth and Growth Medical Journal
2026;35(2):61-62. doi:10.25753/BirthGrowthMJ.v35.i2.48083

EDITORIAL

Beyond the Moment: The Lasting Impact of Moral Distress in Neonatal Intensive Care

Joana Machado Morais[1], Carmen Carvalho[2,3]

Neonatal intensive care is characterized by decisions made at the intersection of technological possibility, prognostic uncertainty, and profound human vulnerability. Healthcare professionals caring for critically ill and extremely premature newborns routinely encounter situations in which survival, suffering, and future quality of life must all be weighed when determining what constitutes the newborn's best interests.(1-3) Although advances in neonatal medicine have significantly improved survival rates, they have also intensified the ethical challenges faced by clinicians, frequently resulting in moral distress and its enduring consequences.

Moral distress, first described by Andrew Jameton in 1984, refers to "the psychological distress of being in a situation in which one is constrained from acting on what one knows to be right".[4] Initially associated with nursing, the concept is now widely recognized across healthcare professions.[3] In neonatal intensive care, clinicians frequently encounter dilemmas regarding whether to initiate or continue intensive treatment when survival may involve profound long-term suffering and uncertain quality of life. For many professionals, the tension between their moral judgment regarding the patient's best interests and the care ultimately provided persists beyond the clinical encounter, continuing to influence them long after the immediate decision has been made.

Moral distress is a multifactorial phenomenon influenced by psychological characteristics such as confidence and emotional resilience, as well as external factors including institutional policies and hierarchical structures. Ethically challenging situations, particularly those involving treatment perceived as disproportionate or futile, may further intensify distress. Importantly, identical clinical scenarios may provoke profound moral conflict in one clinician while having minimal impact on another, highlighting the deeply personal nature of moral experience.[3]

A large survey conducted in the United States between 2023 and 2024 reported that approximately two out of every five physicians experienced high levels of work-related moral distress within the preceding two weeks. Female physicians, emergency medicine practitioners, and those working more hours per week were more likely to report moral distress, whereas older or married physicians were less likely to do so. Professional fulfillment demonstrated an inverse relationship with levels of moral distress.[5] Moral distress has been linked to anger, frustration, depression, guilt, and a pervasive sense of powerlessness when facing ethically complex clinical situations.[1,3,6,7]

Recent qualitative research on moral distress among NICU physicians and nurses found that up to 72% of providers encounter morally distressing situations at least monthly.[8] Greater professional experience and ethical understanding may enable clinicians to manage ethically challenging situations more effectively, potentially reducing moral distress. However, increased knowledge and closer exposure to the long-term consequences of extreme prematurity may also heighten awareness of suffering and poor outcomes, thereby increasing moral distress, particularly among experienced NICU staff.[9]

When recurrent moral distress is not adequately acknowledged or supported, it may lead to significant psychological and professional consequences. Although the immediate intensity of distress may diminish once the clinical crisis has resolved, a persistent "moral residue" often remains, contributing to the "crescendo effect" described in the literature. Over time, this cumulative burden may manifest

1. Neonatology Department, Centro Materno-Infantil do Norte, Unidade Local de Saúde de Santo António. 4050-651 Porto, Portugal. u14291@chporto.min-saude.pt
2. Director of Department of Neonatology, Centro Materno-Infantil do Norte, Unidade Local de Saúde de Santo António. 4050-651 Porto, Portugal. carmencarvalho.neo@chporto.min-saude.pt
3. Instituto de Ciências Biomédicas Abel Salazar, Universidade do Porto. 4050-346 Porto, Portugal. carmencarvalho.neo@chporto.min-saude.pt

not only as ethical suffering, but also as emotional exhaustion, cognitive fatigue, and physical burnout.[1,10,11]

Addressing moral distress in neonatal intensive care requires more than individual coping strategies. Transparent communication, shared decision-making, ethics debriefings following exceptionally demanding clinical situations or patient deaths, and strong institutional support may help mitigate the long-term impact of unresolved ethical conflict. Peer support initiatives and access to mental health resources can strengthen clinicians' capacity to navigate ethical challenges.

Equally important is the recognition that conflicting emotions are natural responses to ethically complex care rather than indicators of professional inadequacy. Meaningful change also requires attention to the broader systemic challenges frequently identified by NICU professionals. Inadequate staffing, demanding shift patterns, strained team dynamics, workplace bullying, emotionally difficult interactions with families, and the burden associated with patient death and withdrawal-of-care decisions all contribute to ethical suffering. Creating protected spaces for reflection, promoting narrative medicine, and investing in staff support and ethics education are essential steps toward healthier and more sustainable neonatal intensive care environments.[1,3]

Although moral distress has traditionally been viewed as a negative emotional experience, it may also serve as a catalyst for reflection, professional growth, and ethical development when appropriately acknowledged and addressed. Recognizing moral distress and moral residue as inherent aspects of neonatal intensive care is essential if clinicians are to process these experiences rather than silently carry them forward. In this way, the internal conflict generated by ethically challenging situations may foster deeper reflection, more open discussion of differing perspectives, and more thoughtful decision-making, ultimately contributing to more compassionate and ethically grounded patient care.[6,9] Such transformation reflects the development of moral resilience, defined as the capacity to sustain, restore, or deepen one's integrity in response to moral complexity. However, moral resilience is not solely an individual attribute; it flourishes within healthcare environments that actively promote ethical reflection, mutual support, and a culture of compassionate care.[1,3,10]

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