Moral distress was first defined as knowing the right thing to do when policy constraints do not allow for appropriate choices (Jameton, 1984). A more recent definition of moral distress implies that healthcare workers make an active choice not to follow their conscience (Kalvemark, Hoglund, Hansson, Westerholm, & Arnetz, 2004). Moral distress is the psychological response to knowing the appropriate action but being unable to act (Schluter, Winch, Holzhauser, & Henderson, 2008). The constraints that may lead to moral distress can be grouped into three categories: clinical situations (e.g., providing futile care), internal constraints (e.g., feelings of powerlessness, lack of knowledge), and external constraints (e.g., lack of communication, inadequate staffing, staff competency) (Hamric, Borchers, & Epstein, 2012). Research in this area is important because many nurses leave their place of employment or the profession itself as a result of moral distress (Davis, Schrader, & Belcheir, 2012; Elpern, Covert, & Kleinpell, 2005; Ferrell, 2006; Huffman & Rittenmeyer, 2012; Schluter et al., 2008; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012). Helping nurses recognize moral distress and identify strategies for its management are important to the nurse, patient, and healthcare facility. Unrecognized and untreated moral distress can lead to lower quality of care and decreased patient satisfaction (De Villers & DeVon, 2013; Gutierrez, 2005; Huffman & Rittenmeyer, 2012; Schluter et al., 2008; Varcoe et al., 2012).

The purpose of the current study was to examine the level of moral distress in nurses who work in oncology units irrespective of experience in oncology or the specific unit. Nurses must be aware of the existence of moral distress and find ways to reduce potential emotional problems.