Association between moral distress and burnout syndrome at a Palliative Care Unit in federal district—Brazil

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Background: Healthcare professionals face stressful situations, especially in palliative care settings, where they are exposed to ethical dilemmas. This study aims to assess the association between moral distress and burnout syndrome among working at a Palliative Care Unit.

Methods: This is a cross-sectional analytical observational study conducted in a specialized Palliative Care Unit in Brazil. Between June and November 2024, a questionnaire was applied to healthcare professionals, collecting sociodemographic data, the Measure of Moral Distress for Healthcare Professionals-Brazilian version (MMD-HP BR) and the OLdenburg Burnout Inventory (OLBI) scales.

Results: A total of 100 healthcare professionals were included, with a mean age of 39.79±10.23 years. The majority were female (82%), physicians (24%), had no palliative care formation (79%) and worked for less than 11 years (75%). The MMD-HP BR scale ranged from 0 to 309 (median =98), while the OLBI scale ranged from 36 to 65 (median =49). Burnout was associated with age (coefficient β=–0.11, P=0.02) and the intention to leave the job (coefficient β=2.81, P=0.01); however, there was no statistically significant association between burnout and moral distress.

Conclusions: There was no association between moral distress and burnout in our study. This may be due to the interdisciplinary nature of palliative care helping mitigate this impact. Nevertheless, the association between Burnout, professionals' age, and the desire to leave their jobs highlights workforce overload. Broader studies are needed to enhance understanding and help to prevent and control these phenomena.

Keywords: Moral distress; burnout; palliative care

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Introduction

Healthcare professionals face daily stressful situations throughout their work routine, ranging from pre-hospital care to intensive care units. In all scenarios, there is a need for assertive assessment to efficiently manage health issues, while maintaining a humanized approach to provide the most appropriate care for patients.

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It's not different in palliative care settings. Especially due to the close contact that professionals have with patients suffering from serious and often end-of-life illnesses, which expose them daily to psychological and existential dilemmas (1).

Communication difficulties with patients, families, and/or teams, lack of resources, institutional organization, and the performance of potentially inappropriate or futile procedures are triggering and perpetuating factors of these situations (2), which may lead to the occurrence of moral distress and burnout syndrome.

Moral distress was first described in 1984 by the American philosopher and bioethicist Andrew Jameton and refers to the distress experienced by healthcare professionals when they are unable to act according to their moral values or what they believe is ethically appropriate in the context of health care (2,3).

Over the years, it has become evident that moral distress can occur across various health situations, especially in end-of-life care situations where therapeutic futility is present (4).

Core components of moral distress include complicity in technically inappropriate decisions, lack of autonomy, and repeated experiences and risk factors for moral distress can be categorized into patient-related, health unit-related, and system-related levels.

These factors can lead to feelings of anger, frustration, self-depreciation, and sadness, and have been associated with burnout syndrome and the intention to leave the job (5,6).

In palliative care settings, professionals face ethical challenges daily concerning the boundaries between life and death. Palliative care professionals must have communication skills to empathetically address sensitive issues with patients, families, and other team members who may not be open to shared decision-making or discussions about therapeutic adequacy. This places them at higher risk for moral distress (1,7).

Due to the multidimensional nature of moral distress, a comprehensive assessment scale was developed. The most updated version, revised and published in 2019 by Epstein *et al.*, is the Measure of Moral Distress for Healthcare Professionals (MMD-HP), which is applicable across all healthcare disciplines and settings.

In 2023, this scale was validated in Brazil for use in palliative care and named the Brazilian version of the Measure of Moral Distress for Healthcare Professionals (MMD-HP BR), becoming an important tool for assessing moral distress and its outcomes among palliative care professionals. The scale consists of a 28-item questionnaire, with scores ranging from 0 to 432. Higher scores indicate greater moral distress (2).

Burnout was introduced to the scientific community in the 1970s by German psychoanalyst Herbert J. Freudenberger, however, it was psychologist Christina Maslach who expanded the research, identifying high levels of emotional exhaustion, depersonalization, and a reduced sense of professional efficacy—events that typically occur in sequence. This led to the development of the burnout syndrome triad (8).

Since then, studies on burnout syndrome have grown significantly, reinforcing its recognition as a global issue. Burnout can affect any worker, especially those in healthcare, due to frequent exposure to stress, intense human interaction, and high-pressure environments (9). At palliative care settings, burnout is also a common issue, especially the emotional domain, with the prevalence ranging up to 66% according to the literature, and may cause serious consequences at healthcare workforce (10-12).

Due to the intense personal suffering caused by burnout syndrome, affected individuals are more prone to substance abuse, severe depressive episodes, reduced productivity,

Highlight box

Key findings

- No statistically significant association was found between moral distress and burnout syndrome among healthcare professionals working in a specialized palliative care unit.
- Burnout syndrome was associated with younger age and the intention to leave the job.

What is known and what is new?

- Healthcare professionals in palliative care settings are exposed to ethical stressors and have more risk to develop moral distress and burnout syndrome.
- Previous studies have suggested a relationship between moral distress and burnout in different healthcare contexts.
- This is a pioneering study in Brazil. Currently, there are no studies assessing the association between moral distress and burnout syndrome among healthcare professionals working in palliative care services in the country. This highlights the relevance of the present research.

What is the implication, and what should change now?

- Findings highlight workforce overload and the need for preventive strategies to reduce these phenomena, such as training in communication and bioethics during academic formation, stronger integration between ethics committees and clinical teams, regular interdisciplinary meetings, and psychological support programs can help reduce the incidence of moral distress and burnout syndrome.

absenteeism, and the desire to quit their jobs (9,13).

The most common scale to assess burnout syndrome was developed by Maslach, named the Maslach Burnout Inventory (MBI). Despite its popularity, the MBI has limitations: (I) it treats "professional efficacy" as a core domain of burnout syndrome, although it may be a consequence; (II) it includes both positively and negatively framed items, which may introduce bias; and (III) it is not free (14).

To address some of these limitations, Evangelia Demerouti developed the Oldenburg Burnout Inventory (OLBI) in 1999, being validated in Brazil and Portugal in 2019 by Sinval *et al.* This scale comprises two domains—exhaustion and disengagement—and consists of 15 items. Each item is assessed using a Likert-type scale with responses ranging from 1 (strongly disagree) to 5 (strongly agree). Similar to MMD-HP, higher OLBI scores means higher levels of burnout (13).

This study aims to evaluate the frequency of Moral Distress and its association with Burnout Syndrome among healthcare professionals working in the multidisciplinary team of the Palliative Care Unit at the Hospital de Apoio de Brasília, affiliated with the Health Department of the Federal District. We present this article in accordance with the STROBE reporting checklist (available at https://apm.amegroups.com/article/view/10.21037/apm-2026-1-0016/rc).

Methods

This is a cross-sectional analytical observational study conducted in a specialized Palliative Care Unit at the Hospital de Apoio de Brasília in the Federal District, part of the Brazilian Unified Health System.

Participants included professionals from the multidisciplinary team—both staff and palliative care residents—working in the Palliative Care Service at Hospital de Apoio de Brasília. Inclusion occurred after proper explanation and signing of the informed consent form. Professionals on leave during data collection or those who declined participation after clarification were excluded.

Evaluation parameters

Between June and November 2024, a questionnaire was administered via Google Forms® to collect the following data: age, sex, race, marital status, religion, education level, profession, employment status (public servant or resident), training in palliative care (lato sensu postgraduate course, residency, master's, doctorate), years of experience in Palliative Care, total weekly working hours, weekly working hours specifically in Palliative Care, and length of service at the support hospital.

After data collection, using the same platform, the MMD-HP BR and OLBI scales were administered. The MMD-HP and OLBI scales were used with permission from their respective copyright holders.

Ethical aspects

This study was conducted in accordance with the Declaration of Helsinki and its subsequent amendments. The study was approved by the Research Ethics Committee of the Fundação de Ensino e Pesquisa em Ciências da Saúde, affiliated with the Health Department of the Federal District (No. 79188624.6.0000.5553).

Statistical analysis

The dependent variable "OLBI Scale", which measures levels of burnout among healthcare professionals, was analyzed using a Generalized Linear Model with a normal distribution (15). Normality of data distribution was verified using the Shapiro-Wilk (P=0.35), Kolmogorov-Smirnov (P=0.80), and Anderson-Darling (P=0.32) tests, all indicating approximate normality. Therefore, a Generalized Linear Model with a normal distribution was appropriate to assess statistical associations between predictors and burnout.

All statistical analyses were performed using R® software (version 4.4.1).

Results

Of the 124 staff members and residents working in the Palliative Care Service at Hospital de Apoio de Brasília, 100 (80.65%) participated in the study. The mean age of participants was 39.79±10.23 years (mean ± standard deviation), with the majority being female (82%). The three most common professions were physicians (24%), nursing technicians (18%), and nurses (17%), and 71% of participants were public employees. Seventy-nine participants reported no formal training in Palliative Care; among those with training, 12 reported postgraduate education, three reported residency training, one reported a master's degree, and one reported a doctoral degree in the field.

The median length of employment at the institution was 4 years, which was also the median duration of experience in Palliative Care. The interquartile range for length of service at HAB was 1 to 11 years. More than half of the participants worked 40 hours per week or more. Additional sociodemographic data are presented in *Table 1*.

Regarding the MMD-HP BR scale, participants' scores ranged from 0 to 309 points, with a median of 98 points and an interquartile range between 58.75 and 153.50 points (*Table 2*).

Regarding the OLBI scale, scores ranged from 36 to 65 points, with a median of 49 points and an interquartile range between 46 and 53 points (*Table 3*).

Both univariate and multivariate analyses showed that the variables significantly associated with burnout were age (β coefficient =–0.11, P=0.02) and the response to the first question of the MMD-HP BR scale, "yes, I have considered leaving, but I have never left" (β coefficient =2.81, P=0.01). Other variables, including sex, race, marital status, religion, educational level, profession, employment status, length of service, experience in Palliative Care, formal training in Palliative Care, and workload, did not show statistical significance (*Tables 4,5*).

The diagnostic analysis of the residuals from the multivariate model showed that the model meets the assumptions of normality, homoscedasticity, and

Table 1 Sociodemographic and occupational characteristics of healthcare professionals (n=100)

Variables	Results
Age (years)	39.79±10.23
Sex	
Female	82%
Male	18%
Race/color	
White	59%
Mixed race	35%
Black	6%
Marital status	
Married	50%
Divorced	9%
Single	36%
Stable relationship	4%
Widowed	1%
Religion	
Agnostic	9%
Atheist	2%
Catholic	44%
Spiritist (Brazilian spiritualist doctrine)	18%
Evangelical	20%
Umbanda (Afro-Brazilian syncretic religion)	3%
Other	4%

Table 1 (*continued*)

Table 1 (*continued*)

Variables	Results
Educational level	
High school	2%
Incomplete undergraduate	3%
Undergraduate	23%
Postgraduate	31%
Residency	25%
Master's	13%
Doctorate	3%
Profession	
Physician	24%
Nurse	17%
Nursing technician	18%
Other	41%
Employment status	
Resident	29%
Public service employee	71%
Palliative Care formation	
Postgraduate/residency/other	21%
None	79%
Length of service at institution (years)	4 [1–11]
Time working in Palliative Care (years)	4 [1–10]
Work shifts	
1 shift	6%
2 shifts	74%
3 shifts	20%
Total weekly workload	
20 h	12%
40 h	40%
>40 h	48%
Hours worked in Palliative Care	
<20 h	8%
20 h	20%
>20–<40 h	2%
40 h	38%
>40 h	32%

Data are presented as mean ± standard deviation or median [Q25–Q75] unless otherwise specified.

Table 2 MMD-HP BR score summary

Data	Results
Minimum score	0
Maximum score	309
Median	98
Q25	58.75
Q75	153.50
Question 1: Have you ever abandoned or considered leaving a job position due to moral distress?	
No, I have never considered leaving or quitting a position	37%
Yes, I have considered leaving, but never did	45%
Yes, I have left a position	18%
Question 2: Are you currently considering leaving your job position due to MD?	
Yes	83%
No	17%

MD, moral distress; MMD-HP BR, Measure of Moral Distress for Healthcare Professionals-Brazilian version.

Table 3 OLBI PT & BR version—score summary

Data	Results
Minimum score	36
Maximum score	65
Median	49
Q25	46
Q75	53

OLBI, Oldenburg Burnout Inventory; PT & BR version, Portugal and Brazilian version.

independence, reinforcing the validity of the results obtained (*Figures 1-4*).

Discussion

This is a pioneering study in Brazil. Currently, there are no studies assessing the association between Moral Distress and Burnout Syndrome among healthcare professionals working in palliative care services in the country. This highlights the relevance of the present research.

Patient-related factors, as well as those involving caregivers, healthcare teams, institutional organization, and professional's personal values, are associated with moral distress in the palliative care context (7).

Given that palliative care professionals face ethical dilemmas daily, especially related to end-of-life decisions and the appropriateness or futility of certain interventions, moral distress may occur more frequently—particularly in settings where the palliative care team lacks autonomy (1,2).

The current literature emphasizes the strong association between moral distress and burnout syndrome, especially among professionals who score highly for emotional exhaustion and have already considered leaving their jobs (16-18).

Although the overall MMD-HP BR score did not show a statistically significant association with burnout syndrome, the specific response "yes, I have considered leaving but never did" (question 1 of MMD-HP BR) was significantly associated with burnout syndrome (P=0.01), which supports existing literature.

In terms of healthcare professional and family/caregiver interaction, the lack of advanced care planning, insufficient

Table 4 P values—univariate models

Variable	P value
Age	0.03
Sex (male)	0.29
Race/color	
Mixed race	0.93
Black	0.74
Marital status	
Divorced	0.86
Single	0.14
Stable relationship	0.58
Widowed	0.37
Religion	
Atheist	0.22
Catholic	0.51
Spiritist (Brazilian spiritualist doctrine)	0.26
Evangelical	0.29
Other	0.20
Umbanda (Afro-Brazilian syncretic religion)	0.25
Educational level	
High school	0.92
Incomplete undergraduate degree	0.65
Completed undergraduate degree	0.71
Postgraduate degree	0.91
Residency	0.50
Master's degree	0.58
Profession	
Dentist	0.49
Nurse	0.94
Pharmacist	0.57
Physiotherapist	0.62
Speech therapist	0.95
Physician	0.70
Nutritionist	0.73
Psychologist	0.67
Nursing technician	0.86
Nutrition technician	0.86
Occupational therapist	0.59

Table 4 (*continued*)

Table 4 (*continued*)

Variable	P value
Employment status	
Public service employee	0.08
Length of service at the institution	0.17
Time working in Palliative Care	0.34
Total time working in Palliative Care	0.48
Palliative care formation	
Postgraduate degree	0.80
Board certification	>0.99
Residency	0.74
Master's degree	0.29
No formation	0.79
Work shifts	
Morning & night	0.63
Morning & afternoon	0.70
Morning, afternoon & night	0.71
Afternoon	0.83
Afternoon & night	0.71
Total weekly workload	
20 h	0.49
40 h	0.09
Hours worked in Palliative Care	
>40 h	0.11
40 h	0.26
>20–<40 h	0.45
<20 h	0.56
MMD-HP BR score	0.48
MMD-HP BR Question 1	
Yes, I have considered leaving but never did	0.02
Yes, I have left a position	0.55
MMD-HP BR Question 2	
Yes	0.22

MMD-HP BR, Measure of Moral Distress for Healthcare Professionals-Brazilian version.

communication about care goals, and unfamiliarity with palliative care principles can lead to the rejection of palliative approaches and increase moral distress among palliative care providers (7,19).

Interdisciplinarity is a core component of palliative care teams, requiring inclusive communication and shared goal setting to reduce emotional burden, professional disengagement, and fragmentation of care—key principles

Table 5 P values—multivariate models

Data	Estimate (β coefficient)	P value
Intercept	52.3671959	<0.001
Age	−0.1129287	0.02
MMD-HP BR Question 1		
Yes, I have considered leaving, but never did	2.8119648	0.01

MMD-HP BR, Measure of Moral Distress for Healthcare Professionals-Brazilian version.

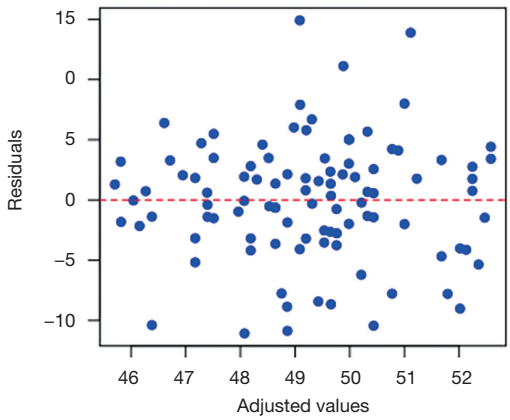

Figure 1 Residuals *vs.* adjusted values.

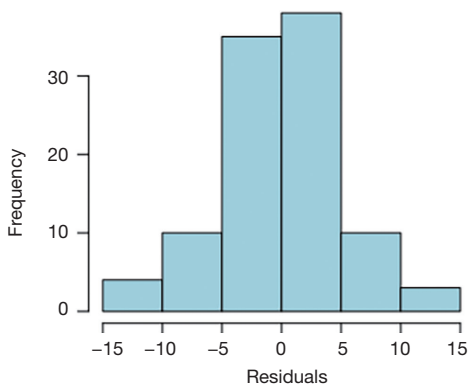

Figure 2 Histogram of residuals.

of palliative care (17,18). In this context, clinical decision-making is distributed across multiple professionals, promoting collective responsibility in ethically challenging situations.

This collaborative structure may help explain the absence of a statistically significant association between moral distress and burnout observed in our study. In contrast to more hierarchical settings, such as intensive care units, where decision-making is often centralized and non-physician input may be limited (19,20), palliative care teams tend to foster greater professional autonomy, open communication, and mutual support. These factors may buffer the impact of moral distress, preventing it from translating into burnout, even when ethically challenging

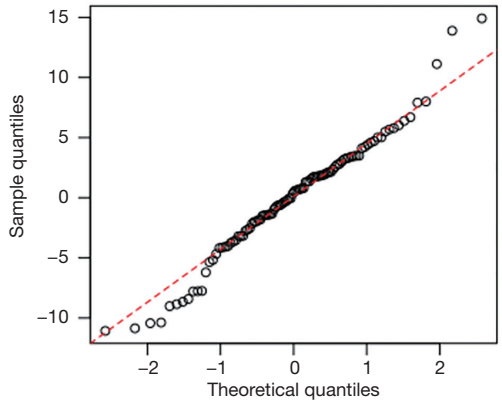

Figure 3 Q-plot of residuals.

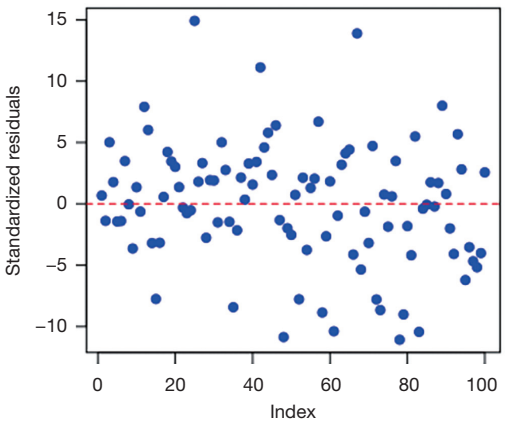

Figure 4 Standardized residuals *vs.* Index.

situations are present.

Regarding age, younger professionals may be more emotionally vulnerable due to developmental factors, which can impair coping mechanisms during stressful events (20). Combined with ageism from senior staff who equate youth with inexperience, this may contribute to higher burnout syndrome levels among younger individuals (21-23).

Given the complexity of these two phenomena, a multidimensional institutional approach is essential. Strategies such as training in communication and bioethics during academic formation, stronger integration between ethics committees and clinical teams, regular interdisciplinary meetings, and psychological support programs can help reduce the incidence of moral distress and burnout syndrome (7,24,25).

The main limitations of this study include the lack of standardized cut-off points for moral distress and burnout syndrome in the MMD-HP BR and OLBI scales, respectively, and the fact that this is a single-center study, which may limit the understanding of causal factors, outcomes, and the development of policies aimed at reducing the prevalence of these conditions in palliative care settings.

Conclusions

In palliative care settings—especially those primarily handling end-of-life patients—the presence of interdisciplinary practices may mitigate the relationship between moral distress and burnout syndrome, empowering professionals and reinforcing their autonomy more effectively than in other healthcare environments.

Nevertheless, the observed moral distress and burnout syndrome levels should not be overlooked. The association

between burnout syndrome, younger age, and the intent to leave work underscores the physical, psychological, and social burdens faced by these professionals.

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Footnote

Reporting Checklist: The authors have completed the STROBE reporting checklist. Available at https://apm.amegroups.com/article/view/10.21037/apm-2026-1-0016/rc

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Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. This study was conducted in accordance with the Declaration of Helsinki and its subsequent amendments. The study was approved by the Research Ethics Committee of the Fundação de Ensino e Pesquisa em Ciências da Saúde, affiliated with the Health Department of the Federal District (No. 79188624.6.0000.5553). Written informed consent was obtained from all participants prior to their inclusion in the study.

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