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SCOPING REVIEW

Moral Distress and Coping Among Nurses in Southeast Asia: A Scoping Review of the Evidence and Its Implications for Oncology Nursing

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Abstract

Background: Moral distress is well documented in oncology nursing, but the evidence comes largely from outside Southeast Asia, a region with a fast-growing cancer burden and constrained nursing workforces.

Objective: To map the extent, nature, and gaps of evidence on moral distress and coping among nurses in the eleven ASEAN member states, with specific attention to oncology, palliative, and end-of-life nursing.

Methods: We followed Joanna Briggs Institute methodology and PRISMA-ScR reporting (registration 652NO26). PubMed, CINAHL, Scopus, and PsycINFO were searched from inception to 10 October 2026, supplemented by Google Scholar, the Thai-Journal Citation Index, Garuda, and reference lists. Two reviewers screened and charted independently, and charted data were verified against the original full texts. No critical appraisal was performed, consistent with scoping review methodology.

Results: Of 336 records identified, 258 unique records were screened and 27 reports were assessed in full. Ten reports met the eligibility criteria: Thailand (n = 4), the Philippines (n = 3), Indonesia (n = 2), and Singapore (n = 1). Only one, a qualitative study of eight senior oncology and palliative nurses in Singapore, sampled oncology or palliative nurses; it addressed value conflict and coping rather than measuring moral distress. System-level constraints and end-of-life care situations were the highest-ranked causes of moral distress in Thai mental health nurses, and moral resilience and moral courage mediated the link between moral distress and moral injury in Filipino nurses. No eligible reports were identified from the other seven ASEAN states.

Conclusions: Evidence on moral distress among nurses in Southeast Asia is sparse, concentrated in four countries, and almost silent on oncology nurses. Priorities include oncology-specific studies with validated, language-appropriate instruments, longitudinal designs linking distress to retention, and evaluation of resilience-building interventions.

Keywords: Moral Distress; Oncology Nursing; Coping; Moral Resilience; Southeast Asia; ASEAN; Scoping Review.

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1. Introduction

Moral distress arises when a clinician identifies the ethically appropriate action but is constrained from taking it by institutional, hierarchical, or resource barriers [1]. The construct has been refined through the notions of moral residue and the crescendo effect [2], and through narrative syntheses that clarify what the term does and does not encompass [3].

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Oncology nursing exposes clinicians to prolonged treatment trajectories, uncertain prognoses, and end-of-life decisions, all recurrent antecedents of moral distress. A meta-analysis of eight cross-sectional studies, including 1,654 oncology nurses, found moral distress of low-to-moderate frequency but high intensity [4]. Qualitative work has explored its sources in oncology nurses [5], and an umbrella review of 19 systematic reviews reported higher moral distress in intensive care, coronary care, and oncology units [6].

This evidence is geographically uneven. In a meta-analysis of 86 papers from 21 countries, Thailand was the only Southeast Asian country represented [7]. An integrative review of moral distress among nurses in developing economies likewise identified a paucity of empirical studies [8].

Southeast Asia comprises eleven ASEAN member states and recorded an estimated 1,146,810 incident cancer cases in 2022, with 2.03 million annual cases projected by 2050 [9]. Nursing workforce shortages are concentrated in low- and middle-income settings [10], and research from Thai hospitals links nurse burnout to nurse-reported quality of care and patient outcomes [11]. These conditions plausibly increase exposure to morally distressing situations in cancer care, but the extent to which this has been studied is unknown.

Coping and resilience are the natural complement to moral distress. The transactional model distinguishes problem-focused from emotion-focused coping [12], while the moral resilience framework describes the capacity to sustain or restore integrity in response to moral adversity [13]. Whether either framework has been applied to Southeast Asian nurses has not been mapped.

We therefore conducted a scoping review to map the evidence on moral distress and coping among nurses in ASEAN member states, with specific attention to oncology, palliative, and end-of-life nursing, and to identify priorities for future research.

2. Methods

2.1. Protocol and Reporting

The review followed Joanna Briggs Institute scoping review methodology [14]. The approach is adapted from the Arksey and O'Malley framework and the Levac et al. refinements [15,16]. Reporting conforms to the PRISMA-ScR checklist [17]. The protocol was registered with the Cavite Medical Center research registry (registration number 652NO26) before data extraction and is available on request.

2.2. Eligibility Criteria

We applied the Population, Concept, Context framework recommended for scoping reviews [18]. The population was nurses (registered, licensed, student, or specialty) practising or training in any of the eleven ASEAN member states (Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, the Philippines, Singapore, Thailand, Timor-Leste, Vietnam). The concept was moral distress or the closely related constructs of moral injury, moral resilience, moral courage, and moral sensitivity, together with coping strategies. Reports on coping with ethically conflicting situations in oncology or end-of-life care were eligible even when the term moral distress was not used. The context was any clinical, academic, or community setting. Primary quantitative, qualitative, or mixed-methods studies published in English in peer-reviewed journals were eligible. Reviews, editorials, letters, conference abstracts, theses, and studies whose participants were not nurses or in which nurse-specific data could not be extracted were excluded. No publication-date restriction was applied.

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2.3. Information Sources and Search

Four bibliographic databases were searched from inception to 10 October 2026: PubMed/MEDLINE, CINAHL (EBSCOhost), Scopus, and PsycINFO (APA PsycNet). The search combined controlled-vocabulary terms (MeSH, CINAHL headings, Scopus index terms, APA Thesaurus terms) with free-text terms for the concept block (moral distress OR moral injury OR moral resilience OR moral courage OR moral sensitivity OR ethical conflict), the population block (nurs*), and the context block (individual ASEAN country names, their adjectival forms, and the phrases “Southeast Asia” and “ASEAN”). The full search strategy for each database is reported in Supplementary Table S1.

Supplementary records came from Google Scholar (first 50 records per query), the Thai-Journal Citation Index (TCI), the Indonesian national database Garuda, and backward citation checking of the reference lists of included reports and of a recent regional systematic review [8].

2.4. Selection of Sources of Evidence

Records were exported to EndNote 21 and duplicates removed. The two authors (NMP, MC) screened titles and abstracts independently against the eligibility criteria. Reports judged potentially eligible by either reviewer went forward to full-text assessment. Both authors then assessed full texts independently. Disagreements were resolved by discussion between the two authors. Interrater agreement at full-text assessment was high (Cohen’s $\kappa = 0.82$).

2.5. Data Charting

A charting form, piloted on two reports and refined, extracted author, year, country, design, setting, sample, instrument, key findings on moral distress or related constructs, and reported coping strategies. The anticipated instruments were established tools: the Moral Distress Scale [19] and its revision [20]. The Measure of Moral Distress for Healthcare Professionals [21] was also anticipated as an instrument in the included reports. Charting was performed by one author and independently double-checked against the original full text by the other author for every included report. Discrepancies, which were minor and concerned the labelling of coping strategies, were resolved by consensus.

Full texts were retrieved through institutional subscriptions, open-access publisher platforms, PubMed Central, and direct author contact. Two reports whose full texts could not be retrieved after these efforts are documented in the PRISMA-ScR flow diagram (Figure 1) and in Supplementary Table S2.

2.6. Synthesis

We mapped the included reports descriptively by country, population, design, instrument, and principal findings on moral distress and coping. Consistent with scoping review methodology [14,17] no critical appraisal or quantitative synthesis was performed. An evidence map by ASEAN member state (Figure 2) summarises what was and was not found.

3. Results

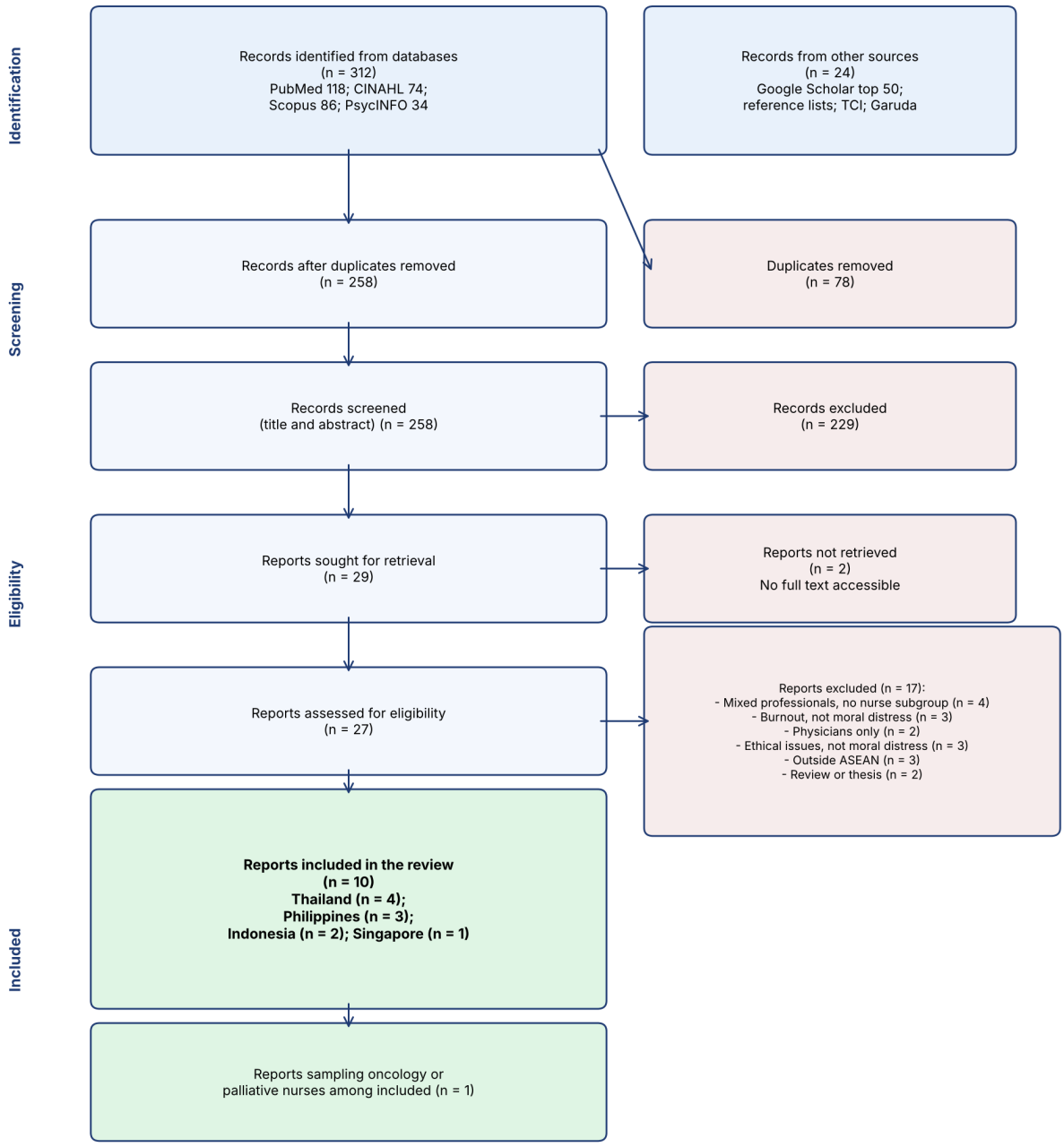
3.1. Study Selection

Database searches returned 312 records (PubMed 118; CINAHL 74; Scopus 86; PsycINFO 34) and supplementary sources added 24, for a total of 336. After removing 78 duplicates, 258 records were screened and 229 were excluded at title and abstract. Twenty-nine reports were sought for retrieval, of which 27 were obtained in full text and 2 were not retrievable. Seventeen

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were excluded at full-text assessment (reasons in Figure 1 and Supplementary Table S2), leaving 10 included reports (Figure 1).

Figure 1. PRISMA-ScR flow diagram of the identification, screening, eligibility assessment, and inclusion of reports.



3.2. Characteristics of Included Reports

The ten included reports were published between 2018 and 2023 and originated from Thailand (n = 4), the Philippines (n = 3), Indonesia (n = 2), and Singapore (n = 1) (Table 1). The four Thai reports comprised a mixed-methods study [22] and a psychometric evaluation of the Thai Measure of Moral Distress for Healthcare Professionals [23]. Two further Thai reports studied mental health nurses [24,25]. The three Philippine reports comprised an online survey of 412

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practising nurses [26]. Two others studied nursing students [27,28]. The two Indonesian reports surveyed emergency department nurses [29] and nurses caring for COVID-19 patients [30]. The Singaporean report interviewed senior oncology and palliative nurses [31].

Table 1. Characteristics of the ten included reports.

Report	Country	Design	Participants	Measures	Key findings
Prompahakul et al., 2021 [22]	Thailand	Convergent parallel mixed-methods	462 survey respondents and 20 interviewees; nurses from two tertiary institutions in a southern province	Moral distress survey; interviews	Top-ranked causes were system-level and end-of-life related. Work unit, considering leaving the position, and episodes in the past year predicted distress.
Prompahakul et al., 2023 [23]	Thailand	Cross-sectional psychometric evaluation	448 registered nurses (of 462 respondents), two tertiary hospitals	Thai MMD-HP	Three factors (system, team, patient/family level); overall Cronbach alpha 0.94. Judged reliable, valid, and useful.
Upasen and Saengpanya, 2021 [24]	Thailand	Qualitative narrative	41 mental health nurses; purposive and snowball sampling	In-depth interviews	Core theme of keeping the patient safe, with five themes including frustration, self-condemnation, and sleeping difficulty.
Upasen et al., 2021 [25]	Thailand	Qualitative narrative	41 mental health nurses; purposive and snowball sampling	In-depth interviews	Six coping strategies: talking to others, positive self-talk, self-efficacy, using training and experience, exercising professional autonomy, and case conference groups.

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Report	Country	Design	Participants	Measures	Key findings
Berdida and Grande, 2023 [26]	Philippines	Online cross-sectional survey with mediation analysis	412 nurses, convenience sample via social media, during COVID-19	Four self-report scales	Distress was negatively associated with resilience and courage and positively with moral injury. Resilience and courage mediated moral distress and injury.
Escolar-Chua, 2018 [27]	Philippines	Descriptive-correlational	293 baccalaureate nursing students	Moral distress, sensitivity, and courage measures	Most students ignored distressing situations to avoid conflict; 79.2% rarely considered quitting. Distress intensity correlated with frequency (r = 0.13) and sensitivity (r = 0.25).
Escolar Chua and Magpantay, 2019 [28]	Philippines	Descriptive qualitative	14 senior nursing students in community health nursing	Qualitative data	Three themes: unprofessional behaviour of some healthcare workers, resulting powerlessness, and differing values of community members.
Widianti et al., 2019 [29]	Indonesia	Cross-sectional descriptive	51 emergency department nurses, one hospital in Bandung	MDS-R	Moral distress tended to be low (mean total score 50.72, SD 43.85). Work experience was significantly associated; intention to quit was not.

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Report	Country	Design	Participants	Measures	Key findings
Arafat et al., 2023 [30]	Indonesia	Cross-sectional descriptive	128 nurses in COVID-19 treatment rooms, Makassar	Moral Distress Scale for Clinical Nurses; demographics	Nurses reported relatively low moral distress despite exposure to morally stressful situations. Undergraduate-educated nurses reported higher distress than those with other training.
Ho et al., 2022 [31]	Singapore	Qualitative interview study	8 senior supportive, palliative, and oncology nurses, National Cancer Centre Singapore	Semi-structured interviews; Ring Theory of Personhood	Three domains: identity formation, conflict between values, beliefs, and professional duties when caring for the dying, and identity refinement. Experience and timely support attenuated the impact.

MDS-R, Moral Distress Scale-Revised; MMD-HP, Measure of Moral Distress for Healthcare Professionals.

3.3. Moral Distress

Across the ten reports, moral distress ranged from low to moderate or high. Two Indonesian reports reported low distress — in emergency department nurses [29] and in nurses caring for COVID-19 patients [30]. The Thai mixed-methods study found moderate to high distress, with system-level and end-of-life care situations ranked highest [22]. The Thai psychometric work supported a three-factor structure of the MMD-HP in Thai nurses [23]. In Thai mental health nurses, distress centred on keeping patients safe and was accompanied by frustration, self-condemnation, and sleeping difficulty [24]. Senior oncology and palliative nurses in Singapore described conflicts between their values and professional duties when caring for dying patients [31]. In the Arafat et al. COVID-19 cohort, moral distress was related to educational background, with undergraduate-educated nurses reporting higher scores [30].

3.4. Moral Injury, Resilience, and Courage

In 412 Filipino nurses surveyed during the pandemic, moral distress was negatively associated with moral resilience and moral courage and positively associated with moral injury; resilience and courage mediated the relationship between moral distress and moral injury [26]. Among Filipino baccalaureate students, distress intensity and frequency correlated weakly ($r = 0.13$) and sensitivity and intensity moderately ($r = 0.25$) [27]. Students in community health

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placements attributed distress to unprofessional behaviour by some healthcare workers and to a resulting sense of powerlessness [28].

3.5. Coping, Resilience, and Cultural Context

Coping was the primary focus of one report. Thai mental health nurses described six strategies: releasing tension by talking to others, positive self-talk, believing in their ability to handle problems, using their training and experience, exercising professional autonomy, and taking part in case conference groups [25]. Moral resilience and moral courage mediated the relationship between moral distress and moral injury in Philippine nurses [26]. The tendency of students to ignore distressing situations to avoid conflict may reflect an avoidant response, although it was not framed as coping [27]. In Singapore, senior oncology and palliative nurses reported that experience and timely support attenuated the impact of difficult experiences [31].

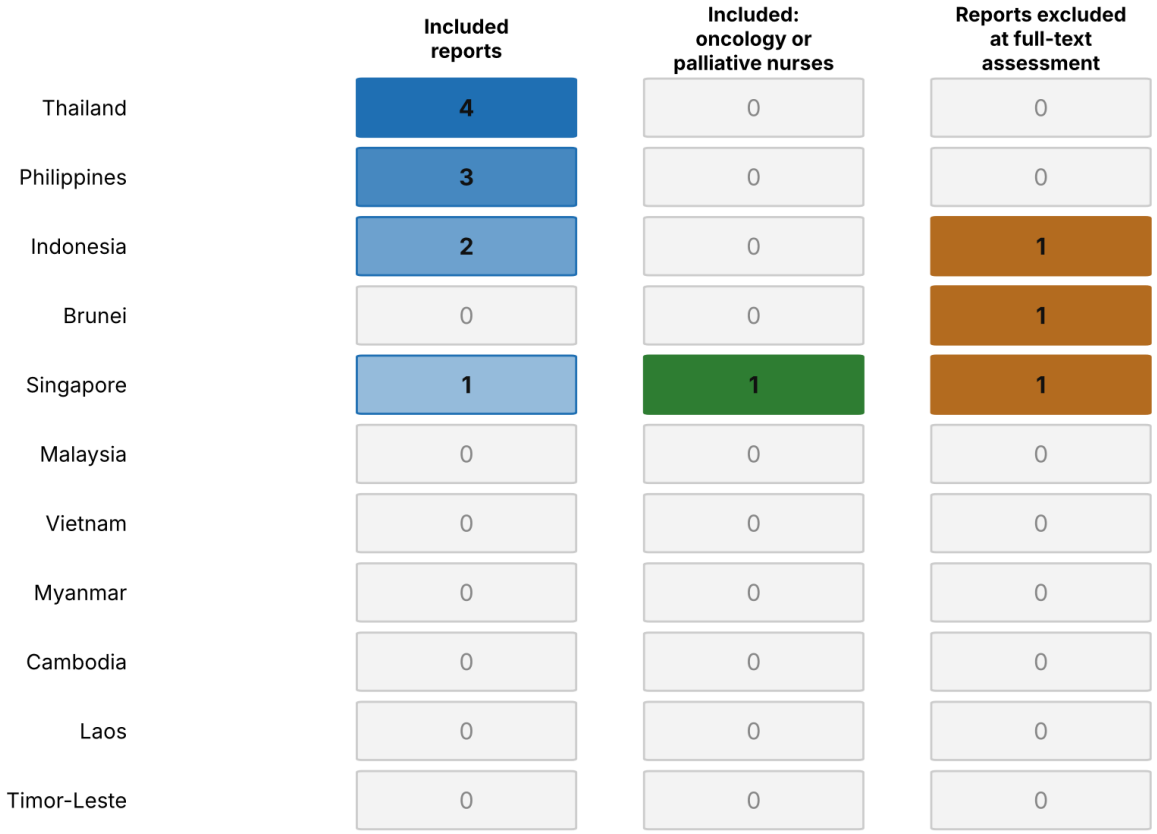
On cultural context, the authors of the Thai psychometric study observed that the southern province studied is predominantly Muslim and that families of different faiths may decide on life-sustaining treatment on religious grounds, which could precipitate moral distress in nurses [23]. The Thai mixed-methods authors likewise proposed that patients' and families' religious perspectives merit further exploration [22].

3.6. Oncology-Specific and Adjacent Evidence

One included report sampled oncology or palliative nurses specifically. It was a qualitative study of eight senior nurses in Singapore that examined coping with caring for the dying through personhood theory and did not measure moral distress [31]. No eligible reports were identified from Brunei, Malaysia, Vietnam, Myanmar, Cambodia, Laos, or Timor-Leste (Figure 2).

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Figure 2. Evidence map of included and excluded reports by ASEAN member state. Cells show the number of reports; the excluded reports are listed in Table 2.



Three oncology-related or ethics-related regional reports were excluded after full assessment (Table 2). A phenomenological study of Indonesian nurse team leaders examined strategies for addressing ethical issues in hospitals [32]. A Bruneian study of oncology nurses examined burnout and psychosocial work factors rather than moral distress [33]. A Singaporean study analysed interviews with oncologists, who are physicians [34].

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Table 2. Oncology-related and ethics-related regional reports assessed in full and excluded.

Report	Country	Population and design	Focus and main finding	Reason for exclusion
Wati et al., 2023 [32]	Indonesia	14 nurse team leaders from seven hospitals; phenomenological	Strategies and challenges in addressing ethical issues in hospitals.	Ethical issues; moral distress construct not examined
Jais et al., 2021 [33]	Brunei	All 63 oncology nurses at the national cancer centre; cross-sectional	Burnout (Maslach Burnout Inventory) and psychosocial factors (COPSOQ II). Better leadership, justice and respect, and rewards were associated with lower emotional exhaustion.	Burnout outcome; moral distress not examined
Rajalingam et al., 2026 [34]	Singapore	12 oncologists at a tertiary cancer centre; secondary analysis of semi-structured interviews	Sources of moral distress and the costs of caring (compassion fatigue, vicarious trauma, secondary traumatic stress, burnout) in medical oncologists.	Physicians, not nurses

4. Discussion

4.1. Main Findings

This review identified ten eligible reports from four of eleven ASEAN member states, and only one sampled oncology or palliative nurses. That report studied value conflict and coping through personhood theory and did not measure moral distress [31]. Evidence on oncology nurses from other regions [4] therefore cannot be assumed to apply to Southeast Asian practice, and the scarcity of regional data is itself the main finding. The pattern mirrors the geographic imbalance reported in meta-analyses that span 86 primary studies but name Thailand as the only Southeast Asian country represented [7].

4.2. What the Regional Evidence Shows

Three signals are consistent across the Thai and Philippine reports. First, system-level and end-of-life care situations are the highest-ranked antecedents in nurses who were asked to rank them [22]. Second, moral injury is empirically distinct from moral distress, and moral resilience and courage mediate the link between them in a large Filipino sample [26]. Third, coping repertoires identified in Thai mental health nurses are predominantly social and professional rather than individual [25]. Whether such strategies apply to oncology nurses is untested, although Singaporean oncology and palliative nurses described a comparable role for experience and support [31]. The two Indonesian reports [29,30] suggest low levels of distress in emergency and COVID-19 wards and point to education and work-experience variables that warrant replication.

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4.3. Implications for Oncology Nursing and Research Priorities

Four priorities follow. First, oncology-specific primary studies in ASEAN cancer centres using validated, language-appropriate instruments such as the Thai MMD-HP [23] and comparable adaptations in Bahasa Indonesia, Vietnamese, and Filipino. Second, longitudinal rather than cross-sectional designs that link moral distress to intention to leave and to actual attrition, which have been linked to nurse-reported quality of care in Thai hospitals [11]. Third, intervention studies evaluating resilience-building programmes [13] in oncology units. Fourth, regional collaboration coupled with research-capacity development in the seven states where no eligible reports were identified.

4.4. Strengths and Limitations

Strengths include an explicit PICo-structured protocol with prior registration, a search of four bibliographic databases supplemented by Google Scholar, regional indexes, and reference-list checking, duplicate independent screening, and duplicate charting with both authors verifying every included report against the original full text. Eligibility was broadened beyond oncology to obtain any regional evidence, and one included report [31] did not name moral distress and was included for its focus on coping with value conflict.

Limitations are the following. The English-language restriction may have missed reports in Bahasa Indonesia, Thai, Vietnamese, and Filipino that are not indexed in English databases; the regional indexes (TCI, Garuda) partially mitigate but do not eliminate this. Two reports were sought but not retrievable (Figure 1, Supplementary Table S2). Consistent with scoping review methodology no critical appraisal was performed [14], and the included body of evidence is small, concentrated in four countries, and predominantly cross-sectional, so the direction and magnitude of effects should be interpreted cautiously.

4.5. Conclusions

Evidence on moral distress and coping among nurses in Southeast Asia is sparse, concentrated in Thailand, the Philippines, Indonesia, and Singapore, and almost silent on oncology nurses. The next generation of regional studies should sample oncology and palliative units, use validated instruments translated into national languages, employ longitudinal designs linking distress to retention, and evaluate interventions that build moral resilience in cancer care teams.

Declarations

Funding: None.

Competing interests: The authors declare no competing interests.

Author contributions: Both authors contributed equally to this research paper.

Data availability: All data generated or analysed during this review are included in this article and its supplementary files. The protocol and the full charting form are available from the corresponding author on reasonable request.

Ethics approval and protocol registration: The review protocol was registered with the Cavite Medical Center research registry (protocol number 652NO26) before data extraction. No human participants were involved.

Use of artificial intelligence: An AI writing assistant (Claude, Anthropic) was used by the authors to help draft and format the manuscript. The authors reviewed all outputs, verified the included and excluded references against the original sources, and take full responsibility for the content, accuracy, and interpretation of this work.

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