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Healthcare Professionals' Experiences of Bioethical Conflict in Clinical Settings

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ABSTRACT

Healthcare professionals frequently encounter bioethical conflicts arising from tensions between patient-centered care, institutional constraints, and professional responsibility. Although ethical frameworks and institutional guidelines are available, limited attention has been given to how healthcare professionals subjectively experience and interpret these conflicts in everyday clinical practice. This study used an interpretative phenomenological approach to explore the lived experiences of healthcare professionals facing bioethical conflict. Data were collected through in-depth semi-structured interviews and analyzed using Interpretative Phenomenological Analysis. The findings reveal that bioethical conflict is experienced as a sustained moral struggle marked by moral distress, constrained ethical agency, and adaptive responses such as silence, compromise, and resistance. Participants also engaged in ongoing meaning-making to preserve ethical integrity within structurally limited healthcare systems. These findings highlight the need for ethically responsive institutional practices and contribute to human-centered discussions in Health Law and Bioethics.

INTRODUCTION

Contemporary healthcare systems operate within increasingly complex intersections of clinical practice, institutional governance, and legal accountability, where ethical decision-making is no longer confined to abstract principles but embedded in everyday professional actions (Yu et al., 2025). Within the field of Health Law and Bioethics, the interaction between normative ethical frameworks such as autonomy, beneficence, non-maleficence, and justice and institutional structures has become a central concern, particularly in modern hospital environments characterized by bureaucratic regulation, technological advancement, and resource constraints (AlOmeir et al., 2024). These conditions shape how healthcare professionals engage with patients, make clinical decisions, and interpret their responsibilities, often placing them in situations where ethical ideals must be negotiated within practical limitations.

The phenomenon of bioethical conflict has gained increasing attention as healthcare professionals encounter situations in which professional obligations to patient-centered care are challenged by institutional expectations, administrative protocols, or systemic pressures (AlZaabi & Masters, 2025). While ethical guidelines and legal frameworks provide formal direction, the actual experience of navigating these conflicts is deeply situated in the lived realities of clinical practice. Studies on moral distress have demonstrated that such conflicts are not only cognitive or procedural dilemmas but also emotionally and morally charged experiences that affect practitioners' sense of professional integrity and well-being. In this context, ethical tension becomes part of the everyday fabric of healthcare work, influencing how professionals perceive their roles, interact with patients, and respond to institutional demands.

The relevance of this phenomenon extends beyond institutional performance or policy evaluation, as it directly relates to the subjective experience of healthcare professionals who must reconcile competing demands in real time (Chen et al., 2025). The ethical dimension of care is not only

enacted through decisions but also lived through feelings of responsibility, uncertainty, frustration, and reflection. These experiences are shaped by broader social and organizational contexts, including hierarchical structures, cultural expectations, and the legal environment governing medical practice (Mukhlis, Suradi, et al., 2023; Mukhlis, 2025b). As a result, understanding bioethical conflict requires attention not only to what decisions are made, but also to how those decisions are experienced, interpreted, and internalized by those involved.

Despite the growing recognition of ethical challenges in healthcare, there remains a need to move beyond normative and policy-oriented analyses toward a deeper exploration of how these conflicts are experienced from the perspective of healthcare professionals themselves. A phenomenological approach offers a valuable pathway for uncovering the meanings embedded in these experiences, as it focuses on the subjective and interpretive dimensions of human engagement with complex phenomena (Cohen et al., 2025). By attending to lived experience, phenomenology enables the articulation of the essential structure of ethical conflict as it is encountered in practice, thereby contributing to a more nuanced and human-centered understanding of Health Law and Bioethics.

In recent years, the exploration of healthcare professionals' lived experiences in ethically challenging situations has emerged as an increasingly significant area of inquiry within Health Law and Bioethics. This shift reflects a growing recognition that ethical decision-making in clinical contexts cannot be fully understood through normative frameworks alone, but must also account for how such decisions are experienced, interpreted, and negotiated by practitioners in real-world settings. Studies focusing on moral distress, for instance, have highlighted that healthcare professionals frequently encounter situations in which they are unable to act in accordance with their ethical judgment, leading to profound emotional and moral consequences (Dashti et al., 2025). These findings underscore the importance of examining not only the presence of ethical dilemmas, but also the subjective experiences that accompany them.

However, investigating such experiences presents notable methodological challenges. Much of the existing research in this area has relied on quantitative approaches, including surveys and standardized instruments designed to measure the prevalence or intensity of moral distress (Debesay et al., 2022). While these methods provide valuable insights into patterns and correlations, they often lack the capacity to capture the depth, complexity, and contextual nuances of lived experience. Ethical conflict in healthcare is rarely a discrete or measurable event; rather, it unfolds over time, shaped by interpersonal interactions, institutional structures, and evolving professional identities. As a result, quantitative measures may reduce complex moral experiences into simplified variables, thereby obscuring the meanings that individuals attach to them.

Even within qualitative research, limitations persist. Some studies employ descriptive approaches that focus on categorizing ethical issues without engaging deeply with how participants interpret and make sense of their experiences (Ellicott et al., 2025). Others adopt thematic analysis without sufficient interpretative depth, resulting in findings that identify recurring patterns but do not fully articulate the underlying structure of the phenomenon. Furthermore, many investigations remain confined to specific professional groups or institutional settings, limiting their ability to reveal broader experiential dynamics across contexts. These methodological constraints suggest that existing approaches have not yet fully captured the essence of bioethical conflict as it is lived and understood by healthcare professionals.

Given these limitations, there is a clear need for research approaches that can access the interpretive and experiential dimensions of ethical conflict in a more comprehensive manner. Phenomenological inquiry, particularly in its interpretative form, offers a framework capable of addressing this need by focusing on how individuals experience and construct meaning in relation to complex phenomena (Mukhlis, Arifin, Ridwan, & Zulbaidah, 2025; Mukhlis, Arifin, Ridwan, Zulbaidah, et al., 2025). By moving beyond surface-level descriptions and engaging with the depth of subjective experience, such an approach holds the potential to reveal the essential structure of bioethical conflict within contemporary healthcare systems.

In addressing bioethical conflict within healthcare systems, existing solutions have largely relied on practical and structured approaches, including the development of ethical guidelines,

institutional protocols, legal frameworks, and standardized decision-making models. These approaches aim to provide clarity and consistency in managing ethical dilemmas, particularly in complex clinical environments where competing interests must be balanced (Feng et al., 2024). Ethical committees, policy regulations, and professional codes of conduct have been widely implemented to guide healthcare professionals in resolving conflicts between patient care obligations and institutional demands. While these frameworks are essential for maintaining accountability and legal compliance, they tend to emphasize procedural correctness rather than the lived realities of those who must apply them in practice.

However, such approaches reveal significant limitations when examined from the perspective of subjective experience. Ethical guidelines and legal standards often assume that dilemmas can be resolved through rational deliberation and adherence to established principles. In reality, healthcare professionals frequently encounter situations where these frameworks are insufficient to address the emotional, contextual, and relational complexities of clinical practice (Fernandes et al., 2025). Quantitative assessments and policy-driven analyses further reduce ethical conflict to measurable constructs, thereby overlooking the nuanced meanings, internal struggles, and interpretive processes that shape how individuals experience these dilemmas (Mukhlis et al., 2024; Mukhlis, Maryam, et al., 2023). As a result, the current body of knowledge provides a structured understanding of what should be done, but offers limited insight into how ethical conflict is actually lived, felt, and understood by healthcare professionals.

This gap highlights the need for an alternative approach that moves beyond procedural and outcome-oriented perspectives toward a deeper exploration of meaning and experience. A phenomenological approach offers a valuable solution by focusing on the essence of lived experience and the ways in which individuals interpret and make sense of complex phenomena (Freeman et al., 2025). Through interpretative engagement with participants' narratives, phenomenology enables the uncovering of underlying structures of meaning that are not accessible through conventional methods. In the context of Health Law and Bioethics, such an approach is particularly important for revealing how ethical principles, institutional pressures, and personal values intersect within the lived experiences of healthcare professionals. By addressing this gap, phenomenological inquiry contributes to a more comprehensive and human-centered understanding of bioethical conflict in contemporary healthcare settings.

Previous studies have examined ethical conflict in healthcare through concepts such as moral distress, professional responsibility, and institutional pressure. Research has shown that healthcare professionals often experience tension when ethical principles cannot be fully implemented in practice, especially in resource-limited or highly regulated environments. Several studies have also explored the emotional and psychological impact of these situations, highlighting feelings of frustration, guilt, and ethical uncertainty. However, much of this literature has focused on identifying categories of ethical problems rather than deeply exploring how these experiences are lived and interpreted by individuals. As a result, the subjective meaning of bioethical conflict remains insufficiently understood within the broader discourse of Health Law and Bioethics.

To address this limitation, a phenomenological approach is proposed to explore the lived experiences of healthcare professionals facing bioethical conflict in institutional settings. This study adopts an interpretative phenomenological framework to uncover how individuals make sense of ethical dilemmas in relation to their professional roles and systemic constraints. The approach is selected because it allows a deeper engagement with participants' narratives and reveals meanings that are not accessible through quantitative or purely descriptive methods. By focusing on interpretation, the study responds directly to the knowledge gap identified earlier, which highlights the lack of insight into how ethical conflict is experienced and understood in practice. This method therefore provides a more holistic understanding of the phenomenon by integrating ethical, emotional, and contextual dimensions of experience.

This article is structured to guide the reader through a coherent exploration of the phenomenon. The introduction presents the general and specific background, followed by the identification of the knowledge gap that motivates the study (Mukhlis, Janwari, et al., 2023; Mukhlis & Abdullah, 2025).

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The method section explains the phenomenological design, participant selection, data collection, and interpretative analysis process. The results section presents the core themes derived from participants' lived experiences, supported by narrative descriptions and direct quotations. The discussion interprets these findings in relation to existing literature and theoretical perspectives, leading to a deeper understanding of bioethical conflict in healthcare. The article concludes by summarizing the essential insights and outlining implications for practice, policy, and future research.

RESEARCH METHODS

Study Design

A phenomenological design was employed to explore the lived experiences of healthcare professionals confronting bioethical conflict within institutional clinical settings. This design was considered appropriate because the research question centered on how such conflicts were experienced, interpreted, and given meaning in everyday practice rather than on measuring their frequency or testing predetermined variables (Lutz & Knox, 2014; McNabb, 2015). Phenomenology is particularly suited to inquiries that seek to uncover the structure and meaning of subjective experience, especially when the phenomenon involves moral tension, professional identity, and emotionally charged decision-making.

More specifically, the study was grounded in interpretative phenomenology, drawing on a Heideggerian orientation. This approach was selected because the phenomenon under investigation was not limited to direct description of events, but extended to the meanings participants attached to ethical conflict within the social, legal, and institutional worlds in which they practiced. In interpretative phenomenology, experience is understood as contextually embedded, and meaning is accessed through careful engagement with participants' narratives (Hillman & Radel, 2018; Migdal, 2018). This orientation enabled a deeper examination of how healthcare professionals understood, negotiated, and endured conflicts between ethical obligations to patients and institutional pressures such as policy demands, limited resources, hierarchical constraints, and administrative expectations.

The design also aligned with the focus of the Results section, where the phenomenon emerged through interrelated themes concerning professional duty, moral distress, negotiation strategies, and meaning-making. By emphasizing lived experience and interpretation, the phenomenological approach allowed the essential structure of bioethical conflict to be articulated as it was encountered in clinical reality.

Participants

Participants consisted of healthcare professionals who had direct experience with ethically challenging clinical situations involving tension between professional obligations and institutional expectations. Eligibility was defined through purposive criteria to ensure that all participants could provide rich and relevant accounts of the phenomenon. Inclusion criteria comprised: being a licensed healthcare professional; currently or previously employed in a hospital or comparable clinical setting; having at least one year of clinical experience; and having encountered situations involving perceived conflict between patient-centered ethical obligations and organizational, administrative, or systemic demands (Carreiras & Castro, 2012; Iosifides, 2016). Professionals from disciplines such as medicine, nursing, and allied health were considered eligible when their roles involved direct patient care and clinical decision-making.

Exclusion criteria included administrative personnel without direct clinical responsibilities, healthcare trainees without independent professional experience, and individuals who had not encountered ethically difficult situations relevant to the focus of the study. These criteria were applied to preserve coherence between participant experience and the phenomenological aim of the inquiry.

Participants were selected using purposive sampling, as this approach is widely recommended in phenomenological research for the identification of information-rich cases capable of illuminating the essence of a lived experience. Sampling was continued until sufficient depth and thematic richness were achieved. In phenomenological studies, this point is often defined less by numerical saturation in

a quantitative sense and more by the emergence of recurring experiential meanings and adequate depth of narrative material.

A sample of 10 to 15 participants is appropriate for this type of study and is consistent with phenomenological inquiry aimed at depth rather than breadth. Relevant demographic characteristics may be reported to contextualize the findings, including profession, years of clinical experience, gender, age range, and primary clinical setting. Such details are useful insofar as they situate the ethical experiences described without shifting the study toward demographic comparison.

Data Collection

Data were collected through in-depth semi-structured interviews, which are well suited to phenomenological research because they allow participants to recount personal experience in a flexible yet focused manner (Daly, 2007; Longhofer et al., 2012). A semi-structured interview guide was used to maintain consistency across interviews while also allowing participants to elaborate on ethically significant events, emotional responses, perceived constraints, and the meanings attached to their experiences. The guide was informed by the study aim and by core bioethical concerns such as autonomy, beneficence, non-maleficence, justice, professional duty, and institutional pressure.

Interviews were conducted individually in settings that supported privacy, comfort, and confidentiality. Depending on participant availability and institutional conditions, interviews may be conducted face-to-face in a quiet private room within or outside the workplace, or via a secure online platform when in-person access is not feasible. Each interview typically lasted 45 to 90 minutes, allowing adequate time for the development of rapport and the exploration of complex moral experiences. Follow-up prompts were used to deepen reflection, clarify meanings, and encourage detailed accounts of specific situations without imposing interpretive assumptions on participants' narratives.

All interviews were audio-recorded with participant consent and transcribed verbatim to preserve the integrity of the narrative material. Field notes were also maintained to capture contextual observations, pauses, emotional tone, and non-verbal cues where relevant. These notes served as supplementary contextual data and supported interpretive sensitivity during analysis.

To foster a comfortable interview environment, participants were informed that there were no right or wrong answers and that the focus was on their own experiences and perceptions. They were also reminded of their right to pause, decline to answer any question, or withdraw at any time without consequence. This approach was intended to reduce performance pressure and support openness, particularly given the ethical and emotionally sensitive nature of the topic.

Data Analysis

Data were analyzed using Interpretative Phenomenological Analysis (IPA), which is especially appropriate for studies concerned with how individuals make sense of significant personal and professional experiences. IPA was selected because the phenomenon under investigation involved both lived ethical tension and reflective interpretation, making it necessary to move beyond surface description toward deeper meaning. This analytic approach is consistent with the Heideggerian phenomenological position adopted in the study.

Analysis was conducted through a systematic, multi-stage process. First, interview transcripts were read and re-read to achieve immersion in the data and to preserve each participant's narrative as a coherent experiential account. Second, initial noting was undertaken to identify significant statements, emotionally charged expressions, contextual references, and reflections related to ethical conflict, institutional pressure, and professional identity (Fife, 2020; Kawamura, 2020). Third, emergent codes were developed from these notes, with close attention to both descriptive content and interpretive meaning.

Subsequently, related codes were clustered into preliminary themes within each individual transcript. These themes were then examined across cases to identify patterns of convergence and divergence, while still preserving the idiographic commitment of IPA. Through iterative comparison and interpretive refinement, higher-order thematic structures were developed to capture the shared

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essence of the phenomenon across participants. This process ultimately generated the core themes presented in the Results section, including the tension between professional duty and institutional demand, the accumulation of moral distress, negotiated responses such as silence and resistance, and efforts to preserve ethical meaning within constrained systems.

Where appropriate, qualitative data management software such as NVivo may be used to assist with the organization, retrieval, and coding of textual material. However, the software functions only as a support tool and does not replace the interpretive process central to phenomenological analysis. The essential findings were derived through repeated engagement with the data, careful comparison across accounts, and sustained attention to the meanings participants attributed to their experiences.

To strengthen analytic rigor, the interpretive process was documented through coding records, theme development notes, and reflexive memos. These materials contributed to a transparent audit trail and supported coherence between raw narrative material and final thematic interpretation.

Trustworthiness

Trustworthiness was established through strategies commonly used in qualitative and phenomenological research. Credibility was enhanced through prolonged engagement with the interview material, careful attention to verbatim transcription, and member-oriented clarification during interviews when meanings required confirmation. Dependability was supported through systematic documentation of methodological decisions, coding development, and theme refinement. Confirmability was reinforced through reflexive memoing and maintenance of an audit trail to ensure that interpretations remained grounded in participant narratives rather than unsupported assumptions. Transferability was addressed by providing sufficient contextual detail regarding participants, settings, and the nature of the ethical conflicts encountered, thereby allowing readers to judge the relevance of the findings to comparable clinical and institutional contexts.

RESULTS

Living Between Professional Duty and Institutional Demand

Participants consistently described their work as a space of tension in which ethical responsibility to patients often collided with institutional expectations. They did not portray this conflict as a simple opposition between right and wrong, but rather as a recurring struggle to act responsibly in systems that constrained ethical choice. Many participants spoke of being professionally committed to beneficence, respect for patient autonomy, and fair treatment, yet feeling unable to fully enact those principles because of administrative rules, time constraints, staffing shortages, or managerial directives.

In their accounts, institutional pressure was not always overtly coercive. Instead, it appeared as a structural presence that shaped clinical judgment and narrowed the range of ethically acceptable actions. Participants explained that even when they clearly understood what would be best for the patient, practical limitations often forced them to make decisions that felt incomplete or morally compromised. One participant described this tension with striking clarity: “I knew what the patient needed, and I knew what I should do ethically, but the system was already telling me what was realistically possible.”

This experience was especially visible when patient-centered care required more time, explanation, or advocacy than the institution could accommodate. Some participants described situations involving informed consent, delayed interventions, or discharge decisions in which procedural compliance appeared to replace meaningful ethical engagement. For them, the conflict was not merely professional inconvenience; it was experienced as a fracture between their clinical identity and the institutional logic in which they were expected to function. As one participant expressed, “Sometimes I felt that I was serving the policy first and the patient second, and that was very difficult to accept.”

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The theme therefore reflects a central feature of the phenomenon: healthcare professionals experienced ethical conflict as a lived condition of being positioned between the moral demands of care and the operational demands of the institution.

Experiencing Moral Distress as an Accumulated Burden

Participants' narratives showed that ethical conflict did not end with the clinical decision itself. Instead, it often remained with them as a lingering emotional and moral burden. The repeated inability to act according to one's ethical judgment generated what participants described as frustration, guilt, helplessness, sadness, and, in some cases, emotional numbness. These responses were not isolated reactions to exceptional events; rather, they accumulated over time and shaped how participants understood themselves as professionals.

The Lingering Impact of Ethical Conflict

Several participants explained that moral distress emerged most strongly when they were compelled to participate in decisions they personally believed were ethically inadequate. This included moments when they felt patients were not fully heard, when treatment pathways were influenced by institutional efficiency rather than individualized need, or when resource scarcity affected the fairness of care delivery. One participant reflected, "It was not just stress. It stayed with me after the shift. I kept thinking about whether I had failed the patient, even when I knew the circumstances were beyond my control."

What is especially notable in this theme is that participants did not describe distress solely as emotional discomfort. They described it as an injury to professional conscience. Their accounts suggested that the more frequently ethical compromise occurred, the more difficult it became to maintain a stable sense of moral clarity. Over time, repeated exposure to such situations contributed to exhaustion and detachment. One participant noted, "At first I questioned everything. Later, I became quieter, but not because it was easier. I think I was just tired of carrying the same conflict every day."

This accumulation of moral burden also influenced participants' relationships with colleagues, institutions, and themselves. Some began to question whether ethical practice was genuinely supported in their workplace, while others felt increasingly isolated in their internal struggle. The findings suggest that moral distress functioned as both an emotional response and an existential consequence of sustained ethical constraint.

Negotiating Silence, Compromise, and Resistance

When confronted with recurring ethical conflict, participants did not respond in a single uniform way. Instead, they described a range of strategies through which they negotiated morally difficult situations. These included remaining silent, complying partially, documenting concerns indirectly, seeking peer discussion, delaying action when possible, or engaging in subtle forms of

resistance. These responses were shaped not only by the severity of the ethical problem, but also by professional hierarchy, institutional culture, and perceived risks of speaking up.

Silence appeared in the narratives not as indifference, but as a protective strategy. Participants often remained silent because they believed that voicing ethical objections would be dismissed, misunderstood, or interpreted as insubordination. In several accounts, silence reflected a practical judgment about organizational power rather than a lack of ethical awareness. One participant explained, "There were times when I disagreed, but I knew that saying it openly would not change the decision. It would only make my position more difficult."

Compromise was another recurring response. Participants described moments in which they attempted to preserve some aspect of ethical care within an otherwise constrained situation. Rather than openly rejecting institutional expectations, they sought small spaces of agency, such as spending extra time with a patient, clarifying information informally, or advocating quietly within the team. These actions reflected an effort to remain ethically present even when full alignment with professional ideals was impossible. As one participant stated, "I could not change the whole decision, but I tried to make sure the patient still felt informed and respected."

At the same time, some participants described subtle resistance. This did not necessarily take the form of overt confrontation, but rather careful ethical persistence. They questioned orders, sought second opinions, documented inconsistencies, or created opportunities for dialogue when institutional norms discouraged it. Such resistance was often framed as an attempt to protect patient dignity without destabilizing professional relationships. The participants' accounts therefore suggest that ethical agency remained possible, but it was often fragmented, cautious, and negotiated within narrow boundaries.

Seeking Ethical Meaning Within Constrained Systems

Despite persistent conflict, participants did not portray themselves as passive victims of institutional pressure. Many of them actively searched for ways to preserve ethical meaning in their work. This search involved self-reflection, collegial support, professional values, spiritual conviction, and a continued commitment to patient welfare. Participants described these resources as necessary for sustaining moral endurance in environments where ethical clarity was frequently challenged.

Reflection emerged as a crucial practice. Participants spoke about replaying difficult cases in their minds, questioning their decisions, and trying to understand whether they had acted in a way that remained faithful to their professional and personal values. This reflective process sometimes deepened distress, but it also helped participants maintain moral sensitivity rather than becoming fully desensitized. One participant shared, "I always go back and ask myself, 'If I were the patient, would I feel respected in that situation?' That question keeps me grounded." [Replace with actual quotation]

Peer support was also described as a meaningful source of ethical reassurance. Informal conversations with trusted colleagues provided participants with validation, emotional release, and sometimes alternative interpretations of ethically difficult situations. In these exchanges, participants were able to articulate concerns that could not always be expressed within formal institutional channels. One participant remarked, "Sometimes the only place you can be honest is with a colleague who has felt the same conflict."

For several participants, ethical meaning was sustained by a broader commitment to care as a moral practice rather than merely a technical task. Even when institutional systems limited what they could do, they continued to understand their work through values such as compassion, responsibility, dignity, and justice. This orientation did not eliminate the conflict, but it helped them endure it without fully surrendering their ethical identity. The accounts in this theme suggest that meaning-making was not peripheral to the experience; it was central to how participants survived ethically constrained practice.

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DISCUSSION

This study shows that bioethical conflict is experienced by healthcare professionals not merely as a procedural difficulty, but as a sustained moral struggle shaped by the gap between ethical responsibility to patients and the institutional limits of clinical practice. In relation to the broader question raised in the Introduction, the findings indicate that the meaning of this conflict lies in how professionals live, endure, and interpret tension among professional duty, moral distress, institutional pressure, and the effort to preserve ethical integrity in everyday care.

The findings contribute to the research question by clarifying that healthcare professionals do not experience bioethical conflict as a single decision point, but as an ongoing condition of practice in which ethical judgment is repeatedly constrained by structural realities (Mahmoud et al., 2022). The Results section showed that participants were caught between what they believed should be done for patients and what institutional systems made possible, and this discussion suggests that such conflict is central to the lived meaning of contemporary clinical work rather than a peripheral disruption. In this sense, the study extends the understanding of ethical tension beyond formal legal or policy compliance and demonstrates that the phenomenon is deeply tied to professional identity, conscience, and the emotional cost of compromised care. The findings therefore answer the central question of the study by showing that healthcare professionals make sense of bioethical conflict through a continuous process of negotiation: they interpret themselves as morally responsible actors, yet they must operate within systems that often restrict ethical agency. This is precisely why the experience emerged not only as distress, but also as a struggle to remain ethically intact under pressure.

A further contribution of the study lies in its emphasis on the cumulative and relational character of moral distress. Earlier scholarship has often framed moral distress as arising when one knows the right thing to do but is constrained from acting accordingly, a formulation widely traced to Jameton's foundational work. The present findings support that core insight, but they also deepen it by showing that distress accumulates through repeated exposure to ethically compromising situations and becomes embedded in the professional self-understanding of healthcare workers (Mammadli et al., 2025). Participants' experiences of silence, partial compromise, and subtle resistance suggest that institutional constraint does not simply block ethical action; it reorganizes the ways in which ethical action becomes possible. This adds an important phenomenological dimension to the literature by demonstrating that bioethical conflict is lived through repeated acts of accommodation, reflection, and guarded moral agency rather than through isolated moments of failure alone.

These findings are broadly consistent with prior literature showing that moral distress is linked to organizational factors such as inadequate resources, staffing pressures, and insufficient administrative support. Recent evidence continues to associate moral distress with these structural conditions and recommends system-level responses rather than viewing the problem solely as an individual weakness. The present study supports that line of reasoning, but it also refines it by demonstrating how such structural pressures are interpreted from within the experience of practice. Institutional demands were not experienced only as external barriers; they were lived as forces that shaped how participants understood responsibility, loyalty, and the limits of what counted as good care. This interpretation helps explain why moral distress can persist even when professionals outwardly comply with policy: the unresolved ethical meaning of the situation remains active long after the clinical encounter has ended.

The findings also complement previous scholarship arguing that the literature has sometimes treated moral distress too narrowly or too uniformly. Conceptual work has questioned whether moral distress should be reduced to a single definitional model and has encouraged closer attention to its moral, emotional, and organizational dimensions. This study aligns with that broader conceptual refinement by showing that participants' experiences cannot be understood solely in terms of emotional discomfort or inability to act (Mukhlis, 2025a; Mukhlis & Saidah, 2025). Their accounts reveal a layered experience involving moral perception, institutional negotiation, emotional burden, and meaning-making. In this respect, the study does not contradict existing theory, but rather complements it by showing how those dimensions are woven together in lived clinical reality.

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The discussion likewise resonates with research indicating that unresolved moral distress may contribute to disengagement from the moral dimensions of care, burnout, and even intentions to leave practice. Mixed-method and review-based studies have reported that persistent moral distress can affect well-being, professional commitment, and career intentions among nurses and other healthcare workers. The present findings are consistent with those concerns, especially where participants described exhaustion, withdrawal, and growing quietness in response to repeated ethical conflict (Merchant et al., 2025). At the same time, this study adds a more interpretive insight: withdrawal was not simply fatigue, but often a morally intelligible response to environments in which speaking openly was perceived as ineffective or risky. That distinction matters, because it shifts the interpretation from individual depletion alone toward the relational and institutional conditions that make silence seem necessary.

Finally, the findings enrich the field of Health Law and Bioethics by showing that the significance of ethical conflict cannot be fully understood through normative guidance alone. Ethical codes, legal rules, and institutional protocols remain necessary, but they do not by themselves capture what it means to live through decisions in which patient welfare, professional obligation, and systemic constraints collide. By bringing forward the voices of healthcare professionals, this study shows that the phenomenon is not only about how dilemmas are resolved, but also about how professionals preserve dignity, accountability, and ethical meaning while working within imperfect systems. In that sense, the study contributes a more human-centered understanding of bioethical conflict and supports the value of phenomenological inquiry for making visible the lived moral texture of healthcare practice.

The findings carry several practical and scholarly implications for Health Law and Bioethics. First, they suggest that bioethical conflict should not be treated only as a matter of policy compliance or individual resilience, because the participants' accounts show that ethical tension is produced and sustained within organizational conditions that shape what can actually be done in practice. This interpretation is consistent with prior literature showing that moral distress is closely linked to structural constraints in healthcare and should therefore be addressed at both the personal and system level.

From a practical perspective, the study indicates that institutions need to create conditions in which ethical concerns can be voiced, discussed, and reflected upon before they accumulate into silence, withdrawal, or emotional exhaustion. The Results section showed that participants often protected themselves through compromise or silence, not because they lacked ethical awareness, but because they perceived limited space for meaningful response. This implies that ethics support in healthcare should move beyond formal rules and include sustained opportunities for collegial reflection, ethically safe communication, and leadership practices that recognize the lived burden of constrained care. Recent literature similarly emphasizes that moral distress affects both individual well-being and organizational functioning, which strengthens the argument that institutional responses must be relational as well as procedural.

The findings also have broader social and professional significance. In a wider sense, they show that healthcare professionals experience ethical responsibility not simply as a technical duty, but as a moral relationship with patients that can be threatened by bureaucratic and resource-driven systems. This matters because healthcare institutions increasingly operate under efficiency pressures, and such pressures may unintentionally weaken the ethical meaning of care if they leave little room for professional judgment and patient-centered responsiveness. The study therefore speaks not only to the participants interviewed, but also to comparable clinical settings in which professionals must reconcile legal accountability, institutional expectations, and human vulnerability at the same time.

Several limitations should be acknowledged. As a phenomenological study, the aim was depth of understanding rather than broad statistical generalization, and the findings should therefore be interpreted as contextually grounded accounts of lived experience rather than universal claims (Rodgers et al., 2025). The sample was limited to healthcare professionals who had encountered bioethical conflict within particular institutional contexts, so the meanings described here may differ across professions, healthcare systems, and sociocultural settings. In addition, interview-based data depend on participants' willingness and ability to articulate ethically difficult experiences, which means that some dimensions of conflict may have remained unspoken, especially when experiences involved fear, hierarchy, or professional vulnerability. These limits do not weaken the study's value, but they do

indicate that the findings are most useful as analytically transferable insights rather than universally applicable conclusions.

A further limitation concerns the interpretative nature of phenomenological analysis itself. Because meaning is accessed through careful engagement with participant narratives, the resulting themes represent a rigorous interpretation of lived experience rather than a neutral inventory of facts. This is an accepted strength of interpretative phenomenology, but it also means that alternative yet credible readings of the same phenomenon may be possible in other settings or with different groups of participants. Future studies could therefore strengthen the field by comparing how bioethical conflict is experienced across professional roles, institutional cultures, or resource environments, while retaining attention to lived meaning rather than reducing the phenomenon to prevalence alone.

The study also opens several directions for future research. Subsequent phenomenological work could examine how bioethical conflict is experienced in more specific clinical domains, such as intensive care, emergency medicine, palliative care, or digital health environments, where ethical pressure may take distinct forms. Comparative studies could explore whether the meaning of moral distress changes across legal systems, levels of institutional support, or cultural expectations regarding authority and patient autonomy. There is also strong value in connecting future qualitative findings with organizational ethics interventions, so that institutional responses are informed not only by policy logic but by the lived realities of healthcare professionals themselves. Such work would extend the contribution of this study by helping the field move toward forms of ethical support that are empirically grounded, context-sensitive, and more responsive to the human experience of constrained care.

CONCLUSION

This study examined the lived experiences of healthcare professionals confronting bioethical conflict within institutional clinical settings, with a focus on how ethical responsibility is negotiated under systemic constraints. The findings reveal that bioethical conflict is experienced as an ongoing moral struggle characterized by tension between professional duty, institutional demands, and the need to preserve ethical integrity in patient care. The study demonstrates that moral distress emerges not only as an emotional response but also as a reflection of constrained ethical agency, thereby extending previous research that has primarily focused on normative or quantitative dimensions of ethical dilemmas. By applying an interpretative phenomenological approach, the study provides a deeper understanding of how healthcare professionals interpret, endure, and give meaning to ethically complex situations in practice. These insights contribute to the field of Health Law and Bioethics by offering a more human-centered perspective that integrates legal, ethical, and experiential dimensions of clinical work. From a practical perspective, healthcare institutions should strengthen organizational mechanisms that support ethical decision-making, including regular ethics consultation services, structured forums for ethical reflection, and training programs focused on managing bioethical conflict. Institutions should also develop policies that encourage open communication and protect healthcare professionals who raise ethical concerns, thereby reducing moral distress and enhancing ethical agency in clinical practice. Future research may build on these findings by exploring similar experiences across different healthcare systems, cultural contexts, or specialized clinical settings to further enrich the understanding of bioethical conflict.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest regarding the publication of this article.

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