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Determination the Level of Moral Distress Among Critical Care Units Nurses'

A Thesis

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Partial Fulfillment of the Requirements for the Degree of Master in
Nursing Sciences**

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بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

﴿وَقُلْ رَبِّ أَدْخِلْنِي مُدْخَلَ صِدْقٍ وَأَخْرِجْنِي
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نَصِيرًا﴾

صدق الله العظيم

(سورة الاسراء: آية 80)

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Dedications

With great love and respect I dedicate this work to:

The one who gave away everything and took nothing, to the one I have none than him, to the most sacrificed example, the one who no matter I do I never pay him back, my great father.

The one, I never forget, to the one who can take the place of all others but her place no one else can take, my mother.

Sisters and brother for support and encouragement.

Everyone who helped me.

Researcher ...

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Abstract

Background: Critical care nurses face several moral challenges due to frequent involvement in palliative and end-of-life care, heavy workloads, close patient contact, uncertainty in clinical decision-making, and conflicts with other healthcare professionals. Unresolved ethical disputes may result in moral distress. Moral distress is a bad feeling and a psychological unease which can produce harmful effects on patients, nurses, and organizations.

Objectives: To determine the level of moral distress among nurses in critical care units.

Methodology: Quantitative descriptive study - cross-sectional design is selected to carry out this study to determine the level of moral distress among critical care units' nurses at AL-Hillah Teaching Hospitals. From the period between 9th of November-2022 to 1st June-2023. A non-probability- purposive sample were selected to carry out the study, which consist of (250) nurses who work in the critical care units. In order to collect data, the specific tool prepared, which divided into three parts; the first part consists of demographical characteristics, the second part includes employment characteristics, and the third part is the moral distress scale that consists of three domains. The validity is obtained by (12) experts, while the reliability calculated as (0.80), which is statistically acceptable.

Results: The result this study indicated that the majority of the study sample, 129 (51.6%), was male, 225(90%) were between the ages of (20-30) age group, and most of the study sample, 126 (50.4%) was bachelor degree, 131(52%) was married. The finding recorded moderate moral

distress level among critical care unit nurses. No significant relationship was found between the nurse's moral distress and working place.

Conclusions: Nurses working in critical care units have a moderate level of moral distress.

Recommendations: The study recommended planning and implementing educational programs such as offering ethical workshops and courses about ethics for critical care nurses to explain the concept and to identify the coping strategies which can be used to decrease moral distress.

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List of Abbreviations

<i>Items</i>	<i>Meaning</i>
AACN	American Association of Critical Care Nurses

ANA	American Nursing Association
CCU	Critical Care Unit
EMS	Emergency Medical Services
ICU	Intensive Care Unit
MD	Moral Distress
NICU	Neonate Intensive Care Unit
N	Population
US	United States

List of Statistical Abbreviations and Symbols

<i>Items</i>	<i>Meaning</i>
df	Degree of freedom
F	Frequency
MS	Mean Score
n	Sample size
P. value	Probability value
r	Personal correlation coefficient
SD	Stander Deviation
SPSS	Statistical Package for the Social Sciences
%	Percentage
K	Number of groups
MSE	Mean squares errors
MSR	Mean of squares residual
SSE	Sum of squares errors
SSR	Sum of squares residual

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Chapter One

Introduction

Chapter One

1.1. Introduction:

Critical care units (CCUs) are dedicated to saving the lives of patients who are critically ill or in need of life-sustaining assistance. They provide continuous intensive monitoring by the most technological advanced support that health care team can offer, dealing directly one-on-one contact with patients, becoming the main source of information for family members and struggle with decisions about the appropriateness of aggressive care, all these factors create stressful work environment which may effect quality of care (Hassan *et al.*,2013).

Nurses are more likely than other healthcare workers to encounter ethical dilemmas because of their continual activity, heavy workloads, and difficulty providing patient care. This is so because nurses must decide what is moral in various situations. Organizational barriers, including a lack of support from the authorities, a shortage of time, administrative laws and practices, and medical authority, have been laid in place because it is impossible to do the right thing, which would create moral distress among nurses (Nassehi *et al.*, 2019).

Moral distress (MD) is a major, highly prevalent problem in the nursing profession. In fact, moral distress is defined as a painful feeling and a psychological disequilibrium felt by the nurses when they are not able to do what they believe to be right. In other words, someone with moral distress knows what is morally correct but cannot put that knowledge into practice due to organizational constraints (Gallagher, 2010).

It's a distressing condition that can significantly impact nurses psychologically and physically. Some of the psychological symptoms that

nurses could experience include decreased self-esteem, loss of integrity and feelings of anger, anxiety, fear, sadness, numbness, frustration, depression, misery and guilt. while, physical symptoms include loss of appetite, nausea, diarrhea, forgetfulness, fatigue, exhaustion, stomachaches, muscle tension, migraines and heart palpitations (Deschenes & Kunyk 2020). These occurrences can result in nurses' disappointment with other people, dissatisfaction with work, decreased moral sensitivity, and ultimately low-quality nursing care delivery, which can eventually cause nurses to leave their job. This can also negatively impact nursing practice, patient treatment success, and nurses' performance and well-being, affecting the quality and quantity of nursing care (Ebrahimi *et al.*, 2015).

In the course of their everyday work, nurses experience ethical challenges, such as making decisions about patient care that go against the patient's expressed desires, aggressive or ineffective treatment of terminal patients, problems with informed consent, working with inefficient physicians and nurses, adhering to institutional policies, performing unnecessary testing on critically ill patients, and lying to patients. These decisions limit ethical decision-making and may interfere with the patient's needs, leading to moral distress (Hassan *et al.*, 2013).

Almost all nurses go through moral distress at some point in their careers. Still, because of the difficulties they face at work, nurses who work in intensive care units appear to be more susceptible to experiencing MD. Critical care nurses face several moral challenges due to frequent involvement in palliative and end-of-life care, heavy workloads, close patient contact, uncertainty in clinical decision-making, and conflicts with other healthcare professionals. Unresolved ethical conflicts not only create job dissatisfaction,

but may also trigger burnout syndrome in nurses (Emami *et al.*, 2022 and Park *et al.*, 2015).

Healthcare professionals rarely consider what MD may mean for patients and their families, nor do they fully understand how they view moral issues that directly and indirectly concern them. Hospital environment is stressful, and feelings of vulnerability and loss of control are often unbearable for some patients and their families as they make difficult treatment decisions for themselves or their loved ones, particularly at end-of-life or with other emotionally charged issues (Ulrich, 2020).

Critical care nurses must understand MD and its negative effects on giving patients the best care possible and take a leadership role in their units to address this issue with their employing institution and develop strategies to lessen the impact of moral distress. These strategies should be based on the best available evidence, various interventions have been proposed, such as education and training, clinical ethics consultations, and supportive interventions like debriefing and based stress reduction (Huffman & Rittenmeyer, 2012).

There are three levels of intervention needed in cases of moral distress: a patient-level intervention to bring team members together for frank discussion; a unit-level intervention to identify changes needed to prevent or minimize such situations in the future; and an organization-level interference to examine practices that threaten the ethical integrity associated with healthcare personnel. To create an environment where professional nurses can carry out their responsibilities without compromising their integrity, organizational structures must be addressed, specifically regarding interprofessional collaboration (Ay *et al.*, 2019 and Epstein & Hamric, 2009).

1.2. Importance of the Study

Moral distress has been fairly well documented in critical care populations, medical-surgical nurses, and nurses in various general practice settings in the United States and Canada. Additionally, psychiatric nurses in Ireland and Japan have been confirmed to have it. A lot of the time, aggressive or useless end-of-life care, unsafe or lack of staffing, and incompetent staff or providers are linked to moderate to high or extreme degrees of moral anguish (O'Connell, 2015). As a result, these major adverse consequences have an impact on the nurse's capacity to cope, which eventually results in reduced self-worth and the inability to provide effective patient care. Accordingly, research revealed that 35% of individuals had moral distress a minimum of once per month and that 27% had left a previous position due to moral distress (Davis, 2012).

According to American studies, between 25% and 50% of nurses likely to leave their positions because of their incapacity to deal with MD. As a result, nurses cannot cope with MD and require more efficient interventions (Ghazanfari, *et al.*, 2021). Furthermore, highest levels of moral distress were related to the skill of health care providers and following family requests to continue life support, also known as futile care. So, the nurses were considering leaving their existing jobs because they were suffering from high levels moral distress (Fernandez-Parsons *et al.*, 2013).

This problem has been acknowledged as a critical concern within the nursing profession in New Zealand due to the rising pressure on nurses to adapt to changing working conditions and medical practices. It is thought to occur when nurses are aware of ethical principles but are hindered from acting morally

due to internal or external obstacles. Typically, these restrictions contain institutional and personal aspects (Woods, 2015).

In Ethiopia, nurses who experienced higher levels of MD. They had poor communication among teams, insufficient staffing, a sense of being powerless over decisions, and incorrect care delivery (Berhie *et al.*, 2020).

Nurses in Iran face various difficulties, such as a lack of staff, decreased job satisfaction, poor social standing, and variations in theory and practice. This can lead to poor decisions as a result of job stress. Intensive care unit (ICU) nurses have to make and perform many moral decisions on a daily basis. Still, individuals are not always able to behave by their own beliefs, leading to moral distress (Borhani *et al.*, 2015).

The negative effects of moral distress on patients' lives included pain, a prolonged death, an undignified death, quantity rather than quality of life, incorrect care, a long hospital stay, disrespect, being unable to spend time with loved ones, and false hope. Critical care nurses consequently felt negative emotions such as frustration, rage, grief, psychological exhaustion, helplessness, pain, anxiety, disappointment, depression and physical exhaustion. If they do not cope with their moral distress appropriately, they may leave their jobs. Because nurses frequently acknowledge that they have little to no authority in their organizations and believe that they cannot manage the moral distress situation (Choe *et al.*, 2015).

Nurses in Turkey ICU may feel unappreciated, lacking in autonomy and motivation, or not see themselves as part of the team due to factors such as working in shifts with few other nurses in unsuitable physical environments, having insufficient opportunities for promotion, receiving inadequate pay,

experiencing inequality, having an unclear job description, and being subjected to unsuitable institutional and health policies (Karagozoglu *et al.*, 2015).

1.3. Problem of Statement

The statement of the study: is to determination the Level of Moral Distress Among Critical Care Units Nurses’.

Institutional and clinical moral problems exist in the practice of critical care. It was found that nurses' lack of decision-making autonomy caused them to act immorally in situations involving cardiopulmonary resuscitation, futility of end-of- life treatments, preventable deaths, and decisions regarding sharing information with the patient or family. The behavior of the nursing personnel was improper and at odds with their values (Aram *et al.*, 2018).

Ethics are essential to this profession since nurses frequently encounter huge numbers of sick people and their mortality, which puts them at a high risk of emotional conflict. Ethical practice is an essential part of nursing care, and nursing's present and future depend on the evolution of moral competence. Going against one's moral principles may cause moral distress (Salari *et al.*, 2022).

Nurses more attuned to the ethical dimensions of care may be more at risk for moral distress since these nurses see the moral dimensions of nursing being neither respected, discussed, nor managed (Hamric *et al.*, 2006).

Individuals deliberate and make moral judgements about what they consider to be the most acceptable action or behavior in a given set of circumstances. If they are frustrated in their desire to act in accordance with moral choice, due to perceived personal and organizational constraints, they may experience moral distress (St Ledger *et al.*, 2013).

During their daily activities, nurses are constantly faced with situations requiring knowledge and skills in the field of professional ethics and moral decision-making. Moral distress in nursing profession is one of the most prevalent phenomena (about 50%) that may cause psychosocial problems in nurses (Abbasi *et al.*, 2019).

Nurses in the ICU experienced moderate moral distress. It is still a very real worry for nurses who work in intensive care settings. To ensure patient safety and efficient care delivery, nurses must develop and practice their clinical decision-making skills (Al-Turfi, & Al-Jubouri, 2022).

In this study, the moral distress level was compared to critical units, and we believe that the highest moral distress rate can be found in the intensive care unit because the high mortality rates in the ICU department compared to other departments, the ICU team faces the most significant risk factor that drives moral distress, which is the end of- life decision. This may be due to shortage of therapeutic facilities, prevention of prolonging the patient's suffering, or the choice to save patients who have a higher probability of survival compared to other patients with low survival probability due to bed occupancy shortage (AlQahtani *et al.*, 2021). Wherefore, moral distress is one of the major issues in intensive care units (ICUs) that requires immediate and extensive attention (Abumayyaleh *et al.*, 2016). Various studies have shown that nurses' moral distress in the ICU can lead to negative outcomes in patients such as pain, death, prolonged hospitalization, and disrespect. It can also result in a sense of disability in ICU nurses, which affects their quality of life and occupation (Choe *et al.*, 2015).

Multiple and complex responsibilities ICU nurses for critically ill patients will increase the severity of moral distress because in ICUs, despite

physical pressure, nurses face intense psychological stress. They often encounter critical situations when they are supposed to make ethical decisions in caring for and treatment of patients, so that their confrontation with these critical moments may increase their moral distress (Shafipour *et al.*, 2015). The aim of this study is to explore the moral distress issue as a multi-dimensional phenomenon which may affected nurses in critical care unit. Gap of study focused in an attempt to identify the level of moral distress among nurses working in critical care units and provide knowledge about the moral distress concept because the nurses have little or no knowledge related to moral distress. So, they need to be cognizant of the concept of moral distress and recognize those symptoms that may result from prolonged work-related stressors, especially those that evolve from moral and ethical situations. It is vitally important for nursing management to recognize the stressors that the staff may be under and to investigate provisions that may be needed to deal with these issues. Focus on negative effects of moral distress are multidimensional that may affect nurses and cause physical and psychological problems as well as affecting job retention, job satisfaction, and quality of care.

1.3.1. Research Question:

- 1- Is working with complicated cases increases moral distress level?
- 2- Is there correlation between selected demographics (age, gender, education, years of experience, and years of experience in the critical care unit) and the level of moral distress?
- 3- Is the organization policy act as a factor to increase moral distress level among critical care nurses?

1.3.2. Objectives of the Study:

The objectives of the present study include the followings:

- 1- To determine the level of moral distress among nurses in critical care units by using Corley moral distress scale.
- 2- To identify the demographical and employment characteristics of the study sample.
- 3- To compare the level of moral distress among nurses related to their working area.
- 4- To find out the relationship between moral distress level and some variables related to demographical and employment characteristics (age, gender, years of experience, education qualification).

1.4. Definition of the Terms

1.4.1. Determination:

Theoretical definition:

It is a quality that makes people continue trying to find the magnitude value or quantity of something by calculation (Sudhakar, 2018).

Operational definition:

The process of fixing or computing moral distress levels among nurses at critical care unit.

1.4.2. Level:

Theoretical definition:

An instrument for establishing a horizontal line or scale measures amount, quantity and quality (Zghair *et al.*, 2018).

Operational definition:

It is a horizontal line measurement used to assess moral distress among nurses at critical care units.

1.4.3. Moral Distress:**Theoretical definition:**

It is a serious problem in nursing, which contributes to feelings of loss of integrity and dissatisfaction in the work environment. It occurs when an ethical action should be taken but fell to act upon it (Urden *et al.*, 2013).

Operational definition:

It is a painful experience for critical care units when they know the correct ethical action, which should be taken but not allowed due to administration obstacles or institutional policy.

1.4.4. Nurse:**Theoretical definition:**

A professional person who maintain, promote, restore health and well-being, and work to prevent illness according to his/her scientific background (Romano & Pangaro, 2014).

Operational definition:

A professional person who responsible to cover critical patients' needs and maintain proper healthy environment during his/her admission in the intensive care unit.

Chapter Two

Review of literature

Chapter Two

Review of Literature

The purpose of this chapter is to provide an overview of the relevant literature pertinent to this study. A computer-aided literature search was performed to find research studies and article about moral distress concept. This review will discuss the theoretical framework which obtain the scientific background of the interested phenomena.

Reviewing Related Literature of Moral Distress Concept

2.1. Historical Review:

In the late 1970s, when healthcare ethics theory and practice started to take develop, with an increasing consensus about how ethical principles should govern healthcare delivery. Andrew Jameton, the first to evaluate nurses' experiences with moral dilemmas, observed that ethical problems in hospitals might be divided into three categories: moral uncertainty, moral dilemmas, and moral distress. When Jameton first described moral distress, he said that it when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action (Ulrich & Grady 2018).

Jameton asserted that moral distress was distinct from moral conflict since, at the very least, there was always the appearance of a choice in a moral conflict, meaning that there may be more than one 'correct' course of action. In the 1990s, Liaschenko added to the discussion by resurrecting a number of the contextual or external arguments, claiming that nurses experience moral distress or outrage and loss of integrity when attempting to act morally in oppressive circumstances (Woods *et al.*, 2015).

The terms "moral" and "distress" are common words in ordinary English, but the expression moral distress is an artistic term. The phrase was initially used in 1984 to describe an issue that was noticed in nursing practice, and it has since existed virtually entirely in the context of medical and bioethical literature (Campbell *et al.*, 2016).

Practicing nurses often make ethical judgements, while carrying out their tasks, even though they may not be aware of it. They must choose their own moral conduct in a number of situations involving suffering is a decision that nurses must make. Owing to their peculiar position in the healthcare power structure, and because of their employing institutions, physicians, other nurses, patients, and patients' families -nurses are especially prone to suffer moral distress (Wilkinson, 1987).

Wilkinson (1989) affirms that nurses' likelihood of successfully handling moral distress decreases as the amount of moral anguish they face at work increases. If they continuously fail in trying to handle the pressure, their personality suffers, their professional connections at work deteriorate, and they lose self-confidence. The nurse feels as though no one values their opinion, that they have been humiliated and defeated. If they keep failing, they will just perform what is necessary, leading to worse patient care and thinking about leaving their jobs and profession altogether (Mareš, 2016).

The Gallup organization has been conducting polls to evaluate how ethical and trustworthy various professions are for the past 25 years. In 2015, for the fifteenth consecutive year, nurses were recognized as having the greatest levels of integrity and morality among the mentioned professions (Gallup, 2015). Since the Gallup survey first appeared in it in 1999, nurses have topped it every year with the exception of 2001, after firemen were added as a result to

their service during and following the eleventh September attacks (Jones, 2010), while a dynamic process in nursing is currently in motion, which has the potential to both jeopardize the nurse's personal and professional safety and lower the public's perception of nurses as moral actors. Moral distress, which often leads to compassion fatigue, can have a detrimental effect on one's mental and physical well-being, retention, job satisfaction, and the ability to deliver competent, high-quality patient care (Johnson, 2016).

According to Corley's (2002) theory, that moral distress among nurses occurs when the nurse knows what is best for the patient but that course of action conflicts with what is best for the organization, other providers, other patients, the family, or society as a whole. Thus, moral distress occurs when the internal environment of nurses their values and perceived obligations are incompatible with the needs and prevailing views of the external work environment. To resolve conflicts between the internal and external settings, it is important to clarify values and have effective communication skills. Moral discomfort can be disastrous and cause nurses to consider quitting their jobs, but it can also have a positive effect by raising nurses' knowledge of ethical issues (Epstein & Delgado, 2010).

Pendry (2007) provided a more contemporary definition of moral distress as the physical or emotional suffering that is experienced when restrictions (internal or external) prevent one from following the course of action that one believes is right. Olson (1998) asserts that moral anguish is organizationally created and linked to how people perceive the ethical climate at work (Allari & Abu-Moghli, 2013).

The American Association of Critical-Care Nurses (AACN) identified MD as a significant issue in nursing and created its own definition

and stance on the subject. Moral distress, when a nurse is aware of the morally right course of action but is unable to do so, leading to an incompatible behavior with their personal and professional ideals. The AACN policy position states that moral anguish is a significant but usually disregarded issue in healthcare workplaces (AACN, 2004).

McCarthy, Deady, and Repenshek analyzed existing accounts of moral anguish critically, tracing the idea back to Aristotle and Williams. Repenshek disagrees with Jameton's description of MD, arguing that it is crucial to make the distinction between moral discomfort and moral distress, in which nurses might feel pressured to take actions that compromise their professional integrity, but their subjective beliefs about what ought to happen don't materialize (McCarthy, 2013).

2.2. Theoretical Framework:

The Mary Corley (2002) moral distress theory was chosen as a theoretical framework for this investigation. It aims to explain what transpires when a nurse encounters moral distress because they are either unable to act or feel incapable to act as a moral agent for the patient. The context of the theory speaks to the internal and external perceptions of the nurse. The external perceptions concern the work environment, situations that create the ethical conflict and perceived constraints. According to the moral distress theory, institutional constraints are a primary factor contributing to moral distress. The nurses' psychological reactions, such as feelings of perceived helplessness or self-doubt, are related to their internal perceptions. The theory uses moral principles to help people deal with ethical dilemmas they may face in the healthcare setting. The patient, nurse, and organization are all impacted by moral distress. (figure 2.1) shows Model of Corley's Theory of Moral Distress

(Corley, 2002 and Wilson, 2017). The moral thoughts and perspectives for a theory can be pointed as the following:

2.2.1. Individual Perspective:

The moral distress theory assumes that nurses are moral people who do a moral profession. It identifies eight interconnected, non-linear moral notions, including commitment, sensitivity, autonomy, sense-making, judgment, conflict, competency, and certainty. Within the theory, propositions illustrate how the concepts and their relationships have an impact on behavior and results. Following is a thorough explanation of each of the theory's ethical concepts (Showalter, 2020).

2.2.1.1. Moral Sensitivity:

A capacity to understand ethical conflict, exhibit an intuitive and contextual comprehension of the patient's precarious position, and the awareness of the moral consequences of decision taken on the person's behalf are all examples of moral sensitivity. A key point regarding moral sensitivity is that nurses who have a high level of moral sensitivity `experience less moral distress. Nurses with moral sensitivity who lack moral competency are more likely to experience moral distress (Gonzalez, 2016).

2.2.1.2. Moral Commitment:

Moral commitment is defined as the nurse's loyalty to patient care and the guiding values. Moral commitment also implies a nurse's readiness to defend the patient or take risks for the patient. High levels of moral commitment are associated with both an increase in moral competence and a decrease in moral suffering (Showalter, 2020).

2.2.1.3. Moral Autonomy:

Moral autonomy is the capacity and liberty to make decisions on behalf of the patient. The feeling of moral autonomy may cause the nurse to feel a sense of responsibility to take the morally correct action on behalf of the patient (Corley, 2002).

2.2.1.4. Moral Sense-Making:

The ability of the nurse to organize a meaning or make sense of a moral situation or encounter is referred to as make sense of a moral situation, which is similar to the concept of sensitivity. High moral commitment, competence, and sense-making nurses are more likely to have less moral distress (Corley, 2002 and Showalter, 2020).

2.2.1.5. Moral Judgment:

Moral judgment is the capacity of nurses to analyze all relevant factors in an immoral event and select the most effective course of action. The nurse might consider a range of ethical concerns when making moral judgements. Nurses who exhibit high levels of moral decision-making, competence, and commitment are more inclined to act morally with integrity and experience fewer moral distress (Wilson, 2017).

2.2.1.6. Moral Conflict:

Moral conflict is an issue where competing moral principles conflict over what is the ethically appropriate course of conduct. Its six distinguishing characteristics are autonomy, suffering and discomfort, freedom of choice, advocacy, principles, and connection. The nurses are susceptible to encounter ethical challenges when they believe they are representing the interests of their patients, have the freedom to make decisions, have few options, feel their

morals are being compromised, or they have a professional interaction with patients who are in pain and suffering (Corley, 2002).

2.2.1.7. Moral Competency:

It is the capacity to make morally sound judgments, morally acceptable decisions, and morally acceptable actions. High morally competent nurses are sure that the moral choices they make are the right ones (Corley, 2002 and Showalter, 2020).

2.2.1.8. Moral Certainty:

It is a strong feeling of ethical contentment that prompts nurses to put themselves in harm's way, both personally and professionally, in order to act on the 'rightness' of that conviction. Nurses are more likely to sense moral certainty and suffering less moral distress if they have a high level of moral commitment, moral competence, and moral autonomy (Corley, 2002).

2.2.2. Organizational Perspective:

The concepts in the previous section only touch on one aspect of moral distress from the perspective of the individual. It has been held that institutional constraints result in moral distress, hence suggestions from an organization standpoint are provided in this portion (Corley, 2002).

1- Nurses who feel their workplace is more productive and who have an elevated level of satisfaction with their job in terms of ethics would have lower MD.

2- Nurses will have less MD if they have positive connections with their coworkers, patients, managers, the health care institution, and doctors.

3- Nurses may experience low MD if they have more control over their working environment and are hence more inclined to act to remedy ethical difficulties.

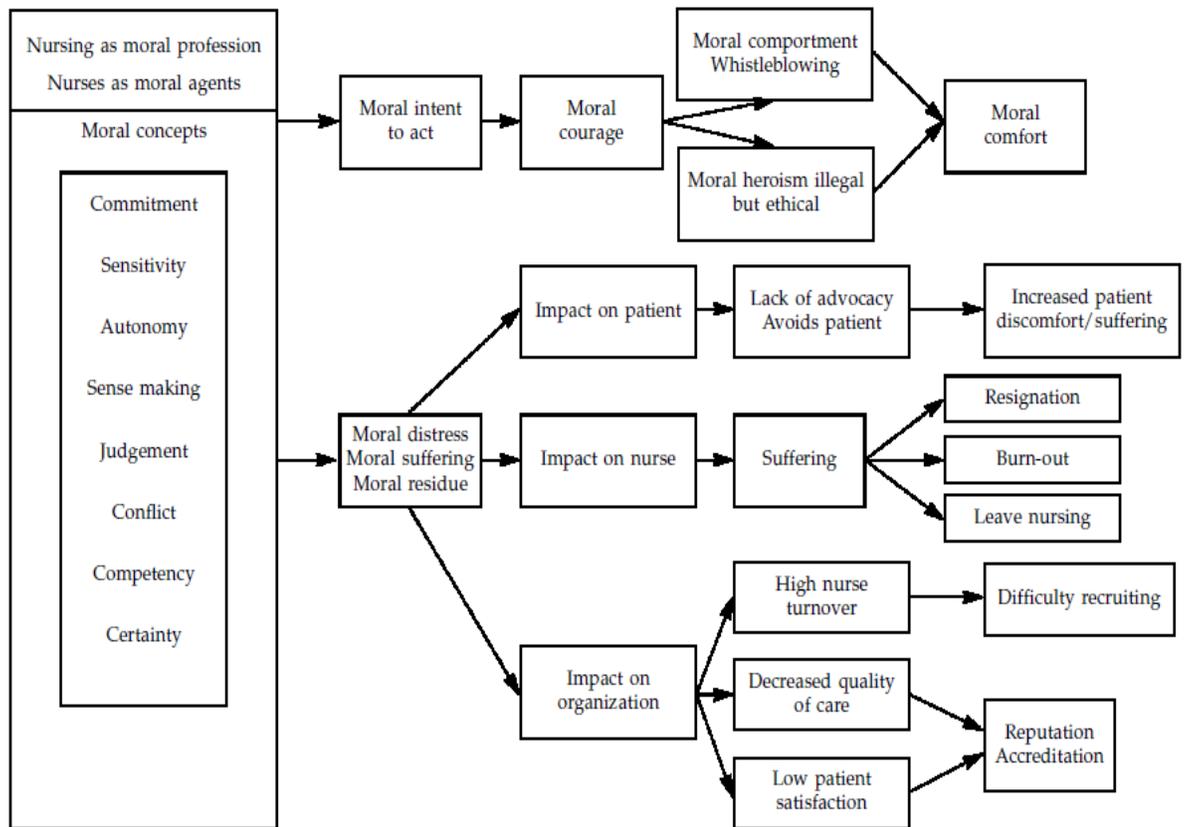


Figure (2.1): Model of Theory of Moral Distress Adapted from Nurse Moral Distress: A Proposed Theory and Research Agenda (Corley, 2002).

2.3. Definitions Moral Distress:

Distress is defined as suffering that affects one's mind and body, as well as sadness or discomfort. The negative aspects of distress imply a need to assist or save the individual. The need for help is now much more urgent. The definition of the word "moral" is relating to the principles of right or wrong in behavior sanctioned by or operative on one's conscience or ethical judgment, which establishes the background for the concept (Johnson,2016).

The phenomena of MD have been well documented in the nursing field. It can be characterized as a type of distress that develops if an individual is cognizant of the morally correct thing to do however is unable to fulfil that commitment. The organization, nurses, and patients are all impacted by moral

distress. Patient suffering will increase when the nurse is unwilling to speak out for the patient and evasion behavior takes place. Unrelieved moral distress compromises a nurse's integrity and self-confidence (Ragavadu, 2016).

Moral distress is distinct from other forms of stress as well as similar conditions like burnout, exhaustion brought on by compassion, and psychological suffering. MD is special due to the fact it entails the transgression of an individual's fundamental ethical principles, has the potential to damage one's sense of personal integrity, and may threaten one's moral identity (Weinzimmer, 2014).

Moral distress, in at its heart, is a form of pain that results from "challenges to, threats against, or violations of professional and individual integrity" (Thomas & McCullough, 2015).

2.4. Factors Affecting Moral Distress:

The elements that contribute to MD in nurses can be broken down into three categories: internal (personal), clinical (about patients), and external (system policies and interactions with colleagues). Each of these elements is crucial in encouraging the growth of MD in nurses.

2.4.1. Clinical Situations:

Moral distress is a common issue for nurses in clinical situations, when they recognize the morally appropriate action to take but feel constrained from doing so due to various factors including giving unwarranted or ineffective treatment; not getting adequate informed consent; working with caregivers who are not as competent as care requires; lack of consensus on a potential treatment plan; lacking continuity of healthcare; having incompatible responsibilities; having an excessive workload; and using resources inappropriately (Hamric *et al.*, 2012).

Clinical basic reasons of MD often involve end-of-life situations, such as maintaining life support when it is not in the patient's best interest, starting lifesaving measures that would only prolong death, continuing aggressive care, providing insufficient pain relief, accelerating the death process, providing false hope to a patient or their family, lack of truth-telling, and disregard for patient wishes (Rawas,2019 and Mealer & Moss, 2016).

2.4.2. Internal Factors:

Internal attributes are one's moral judgment-related values, beliefs, and personality traits. Since they are particular to each person, when nurses encounter comparable moral conflict circumstances, they may all experience different levels of distress, if any. Thwarted moral activities, such as feelings of helplessness that may arise in reaction to external events, are other significant internal precursors of moral distress (Deschenes et al., 2020).

Internal constraints arise from the inability to maintain a healthy mental and emotional perspective when encountering difficult patient care experiences. These include individual character traits such as nurse's conscience, ethical competence, perceived powerlessness, lack of understanding, self-doubt, excessive fear, Lack of awareness about other treatment options, high moral sensitivity, a deficit of assertiveness, social conditioning to follow others and conflicts with religious or spiritual beliefs (Karakachian & Colbert, 2017 and Booth, 2020).

2.4.3. External Factors:

The external limitations that restrict a nurse's ability to behave in a certain situation include inadequate staffing and rising turnover, policies and priorities that conflict with patient care needs, insufficient medical supplies and equipment, nurses who are not involved in decision-making, following family

wishes of patient care for fear of litigation , compromised patient care due to insurance pressure or legal threats, inadequate end-of-life communication, inappropriate use of resources, excessive administrative work, the perception of a lack of support from administrators, and rigid policies (Ledoux, 2015 and Ghazanfari *et al.*, 2022).

Another external attribute of moral distress working with coworkers who are not as competent as the patient care requires, Poor teamwork and communication, inefficient healthcare professionals, noticing mistakes in practice, and working in a hierarchical environment that is restrictive. These external attributes of moral distress can be very upsetting for nurses, because they frequently get angry when forced to follow directions from a superior. Healthcare providers' inability to communicate effectively can lead to misunderstandings and conflicting care objectives (Prompahakul & Epstein 2020).

2.5. Effect of Moral Distress on the Nurses:

These effects can be explained as the following:

2.5.1. Personal or Intrinsic Manifestations:

Moral distress affects a nurse's personality, capacity for work and ability to remain on the same unit. The repercussions of moral distress on nurses' physical and psychological health could be significant.

2.5.1.1. Psychological Effect of MD:

Nurses who encounter MD may experience a variety of adverse emotions, including feelings of helplessness or being overpowered, advocacy that is unsuccessful, anger, guilt, sadness, frustration, depression, misery, dismay, sorrow, grief, embarrassment, helplessness, and hopelessness, as well as fear, disgust, discouragement, anxiety, bitterness, cynicism, resentment, or

sarcasm, shock, confusion, emotional exhaustion, or withdrawal (Ay *et al.*, 2019).

It can have a significant impact on a nurse's behavior, causing problems with thinking (such as forgetfulness), nightmares, lash outs at others, addictive behaviors (alcohol, drugs, gambling), controlling behaviors, avoidance, agitation, aggression, victim behaviors, excessive crying, feelings of shame and isolation, inability to fall asleep soundly, reluctance to discuss the subject in public or poor social communication, disengagement or depersonalization, and horizontal or vertical violence (Rushton *et al.*, 2016).

Nurses may feel less spiritually well due to moral discomfort. In addition to causing spiritual distress, which can lead to a crisis of faith, diminished moral sensitivity, loss of meaning, deterioration of moral integrity, loss of confidence, self-blame, self-doubt, self-disappointment, and a loss of self-worth, as well as a disconnect from their jobs or communities and a decline in self-esteem (Rushton *et al.*, 2016).

2.5.1.2. Physical Effect of MD:

1. Neurological System Effect:

This issue in nursing can have neurological effects, including migraines headaches, hyperactivity, difficulty falling asleep, forgetfulness, numbness, shivering (Dalmolin *et al.*, 2012).

2. Gastrointestinal System Effect:

Effects of moral distress on the gastrointestinal system can vary from person to person and may depend on the severity and duration of the moral distress. The MD can cause stomach troubles, nausea, vomiting, diarrhea or constipation, throat pain, fatigue, exhaustion. The nurse also may suffer from

loss of appetite, unplanned weight gain or loss. Change may occur in foot habits (Deschenes & Kunyk, 2020).

3. Musculoskeletal System Effect:

The MD may have a significant impact on a nurse's musculoskeletal system. Nursing workers experience a high prevalence of musculoskeletal pain due to the pace of work, time pressure, and understaffing, particularly in the low back and neck-shoulder regions (Ramos *et al.*, 2016).

2.5.2. Professional or Extrinsic Manifestation:

The nursing profession is severely harmed by MD. The ability of the nurse to cope and deliver excellent patient care may be impacted by moral anguish. Moral distress has also been linked to lower job satisfaction and higher turnover, burnout, which can affect the working environment, employee morale and morale. Coworkers' signs of burnout include unwillingness to return to work and patient care, emotional and physical detachment from others, and leaving the job. This contributes to the already acute nurse shortage (Davis *et al.*, 2012).

Nursing staff members are reluctant to go to work or work fewer hours after experiencing moral distress to escape the circumstance. Some nurses have experienced moral distress, which has made it difficult for them to continue working on the same unit, in the same hospital, or even in the nursing profession (Wiegand & Funk 2012). In addition, there is assumed that nurses responded to moral distress in one of three ways: by avoiding morally difficult situations, by voicing their worries about such situations, or by altering the workplace environment. Breaking the cycle of moral suffering might not be possible by leaving one's job and career behind. This could exacerbate the effects of moral distress, as leaving a job can result in financial issues. Leaders

in the healthcare industry as well as the workplace itself are also affected (Rautanen *et al.*, 2018).

This issue negatively affects the relationships with coworkers and patients, which lowers job satisfaction. Additionally, absenteeism and low workplace morals have been connected to moral distress, which affects patient care (Russell, 2012).

Nursing staff constitutes the single largest group of healthcare workers, and their absence has a detrimental impact on both the quantity and quality of patient care. A failure to properly handle MD can lead to burnout, disinterest, and avoiding patients and situations that cause moral suffering. As a result, there might be an increase in patient morbidity and, in some situations, mortality (De Villers & DeVon, 2013).

2.5.3. Effect of Moral Distress on the Patient and Family:

Effect of moral distress on nursing practice and situations causing nurses to experience moral distress have detrimental effects not only on nurses but also on patients and families. Negative patient outcomes include suffering, increased pain, longer hospital stays, disrespect, inability to spend time with family, decreased quality of care, unsuitable care, delayed therapy and prolonged hospitalization. The majority of the effects on the family were similarly detrimental, including pain, being unprepared, feeling overburdened, sadness, guilt, financial load, exhaustion, worry, rage, and being unable to spend time by the patient's bedside (Silva, 2015 and Wiegand & Funk 2012).

2.5.4. Effect of Moral Distress on the Organization:

The has a deleterious effect on organizations. Moral distress and the feelings that go along with it can result in high nurse turnover, poor patient

satisfaction, nurses leaving the field, and a shortage of nurses. These effects can make it difficult to hire new employees and have an impact on the organization's reputation or accreditation (Reeder, 2020).

2.6. Types of Moral Distress:

2.6.1. Initial Moral Distress:

The feelings of Anxiety, anger, and frustration that people feel in response to institutional barriers, interpersonal conflicts, and disagreements with others about values (Jones, 2020).

2.6.2. Reactive Moral Distress:

The distress that persists after the event has passed and involves lingering feelings about one's failure to act on the initial distress (d & Hutchinson, 2015). In addition, this reactive distress, also called as moral residue, has been linked to reactions including crying, depression, nightmares, heart palpitations, diarrhea, and migraines. It has also been linked to a loss of one's own moral identity as well as long-term negative effects (Nassehi *et al.*, 2019).

2.7. Moral Distress Crescendo and Moral Residue:

Moral distress is a complex concept that presents as a situation develops but can also persist long after it is resolved. It is known as moral residue, and many nurses can recall the situation in great detail. There is a concern that moral residue builds with each exposure to morally distressing situations, known as the crescendo effect, as shown in (figure 2.2). There is evidence to suggest that higher levels of moral distress, and presumably moral residue, can result in burnout or intentions to quit a job or even a practice (Trautmann, 2015).

The invisible residue of morality left behind from earlier experiences is built upon with each occurrence of moral distress. Moral residue eventually builds up and has an effect on both one's personal and professional life in an uneven pattern of development. Anxiety, sadness, patient avoidance, and burnout follow as a result of each distinct episode of moral discomfort that adds to the moral residue (Reuvers, 2017).

The crescendo effect is a theoretical model describing the interaction between moral distress and moral residue over time. It is caused by repeated incidents of moral distress, which creates a new baseline level for an individual's moral distress and increases the intensity of subsequent incidents. Root causes persist, moral residue grows, and it finally reaches a crescendo because the person has accumulated so much distress and unresolved moral difficulties that reconciliation is impossible. (Burston & Tuckett 2013).

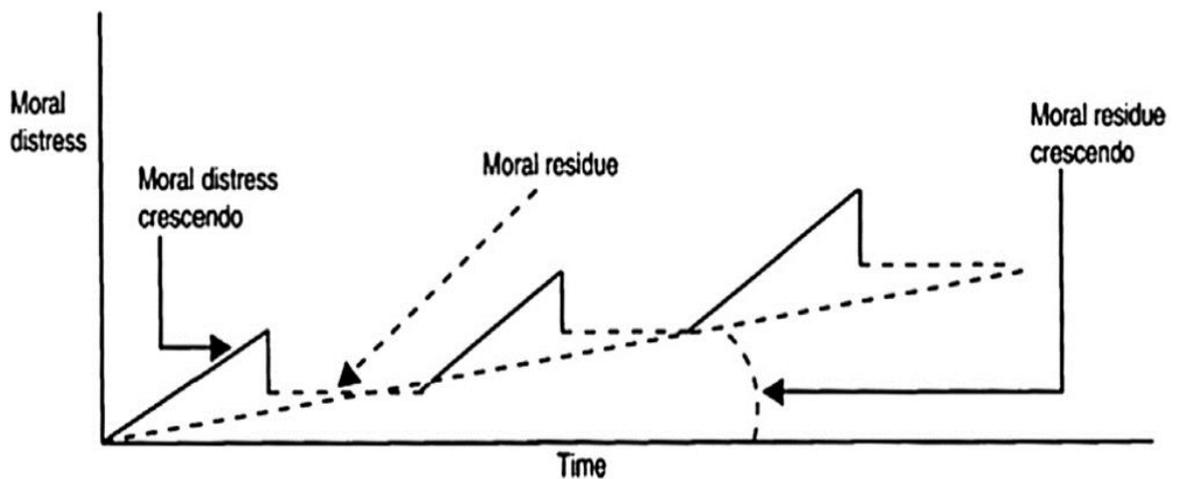


Figure (2.2): Shows the cumulative harmful impacts of moral suffering on an individual. There are always more residues after a moral distress, which is negative for a nurse's psychological well-being. Solid lines indicate moral distress, dotted lines indicate moral residue adopter from (Mareš, 2016).

2.8. Moral Distress Intervention:

The American Association of Critical Care Nurses developed standard framework known as (4A's) represent a processing tool designed to promote positive alteration in difficult situation, the change process occurs in stages, as shown in (figure 2.3) (Molazem et al.,2013):

First stage (ask): The nurse asks him/herself whether the stress he/she feels is a sign of moral distress or just a feeling of suffering. This stage's goal is to determine whether the nurse is going through moral distress.

Second stage (affirm): The nurse makes sure that moral distress is there by participation his or her feelings to others and promising to decrease them.

Third stage (assess): The nurse determines the source of moral distress, which may be environmental or personal, measures the severity of stress, and gets ready for the act stage.

Last stage (act): The nurse makes efforts on a personal and professional level and uses multiple strategies to lessen moral distress, even though it is typical for nurses to regress to earlier stages, it is important that they act and make an effort to uphold their personal integrity as they go into the act stage.

The American Nursing Association (ANA) Code of Ethics (2015), Provision five provides distinct points about moral distress and affirmation. suggested by (Gonzalez, 2016) as the followings:

- 1- Moral regard is consistent with one's moral value and respect, reaching to oneself and encompassing safety and health promotion.
- 2- Just as they do for their patients, nurses must support foster and preserve their own well- being and health, and leaders in nursing should encourage this in their organizations.

3- Nurses should promote moral conversation and communicate one's moral point of view as a duty to oneself as moral actors.

4- Nursing staff must be treated with respect and must never put up with abuse; maintaining integrity is a self-regarding duty.

5- Nurses must continuously assess their own performance in order to preserve competence and pursue excellence in practice.

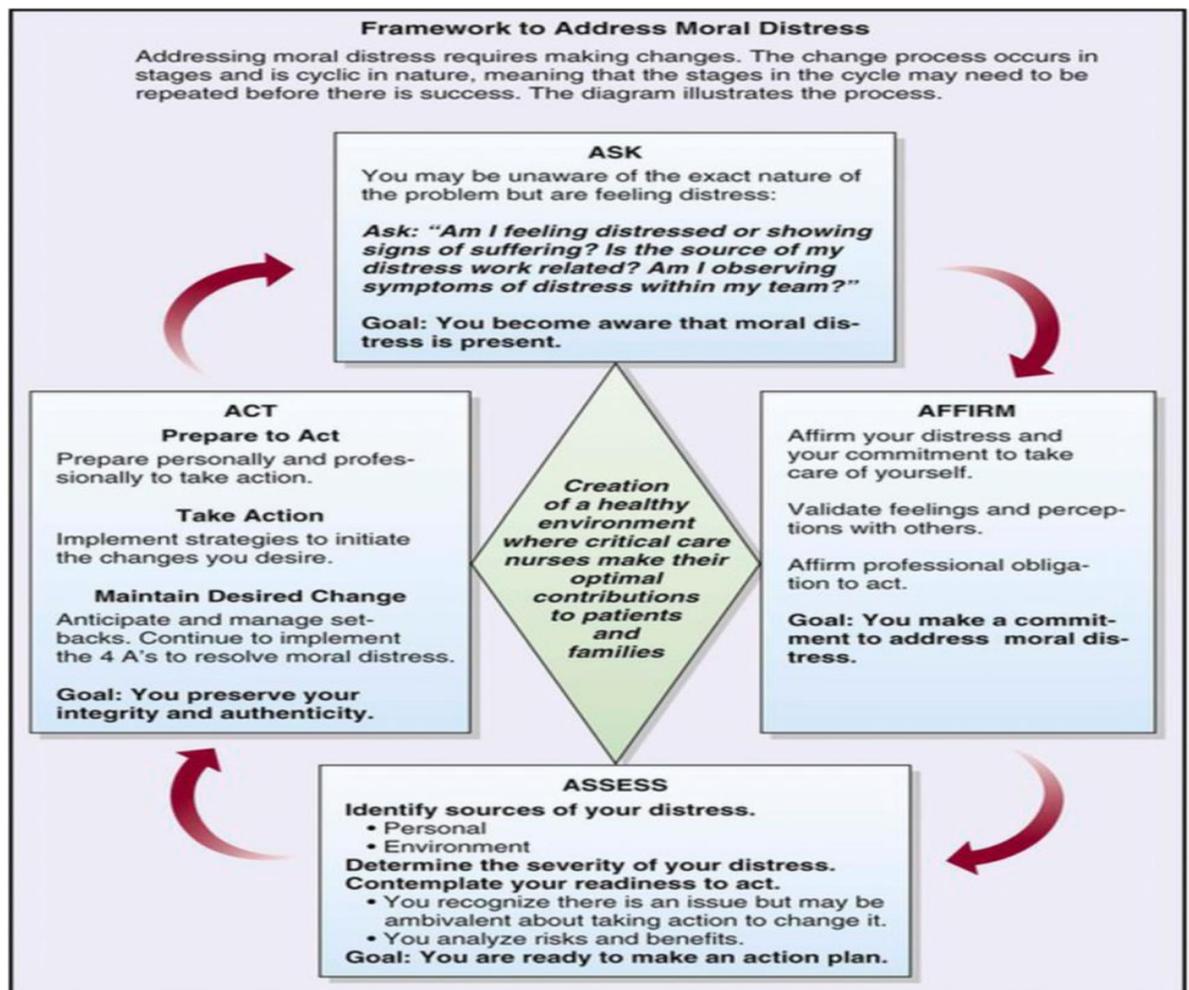


Figure (2.3): American Association of Critical Care Nurses (AACN) 4 A's to rise above moral distress adopted from Semler, 2022.

2.9. Strategies to Alleviate Moral Distress amongst Critical Care Nurses:

Nurses must maintain and enhance working conditions to reduce morale difficulties and make the workplace more comfortable for nurses. Moral

distress can have a significant impact on patients, families, and care management plans, so providers must go beyond recognizing it and develop effective ways to address it. This will ensure that nurses are able to provide appropriate treatment (Mills & Cortezzo, 2020).

2.9.1. Role of Nurses to Alleviate Moral Distress:

Nurses must use coping mechanisms to stop and minimize the signs of moral anguish. Individual moral distress can be reduced by taking care of oneself. Self-care could involve taking extra breaks and setting aside time for oneself. Exercise, rest, spiritual work, meditation, watching films, socializing with family and friends, getting adequate nutrition, getting enough sleep, talking about their feelings with peers, and forming a moral support group are some strategies that may help nurses cope with moral distress or at least lessen its negative effects (Ghazanfari *et al.*, 2022).

Nursing staff workers may benefit from having the chance to address their problems with other nurses. Managers should offer chances that encourage nurses to speak with colleagues and to communicate their perspectives on the situation in order to recognize the moral components and lessen the stress associated with it. Getting nurses to express their ethical worries can help them become more capable of handling challenging circumstances and feelings (De Veer *et al.*, 2013).

2.9.2. Role of Organization in Moral Distress Alleviation:

Strategies that have been identified in reducing or preventing moral distress suggested by Ragavadu, (2016) as the followings:

2.9.2.1. Continual education to raise healthcare workers' understanding of moral distress.

2.9.2. 2. Creating an environment that supports nurses in raising ethical questions to empower them to address concerns.

2.9.2.3. Bringing specialists from many fields together, such as during clinical rounds to talk about patients' objectives.

2.9.2.4. Having unit-based ethical mentors to help deal with problems sooner rather than later and offering the experience of ethics specialists to discreetly aid in assessing a situation from multiple viewpoints.

2.9.2.5. Holding family meetings to make sure they are informed about the patient's condition and any potential changes to the treatment plan, such as hospice care.

2.9.2.6. Provide staff counselling services to help with dealing with upsetting circumstances that might cause moral distress.

Health care system can lessen moral distress in staff by providing policies based on best practices, improving communication systems, creating a supportive and empowering environment, creating methods and policies to guide morally challenging care, and providing means for treating morally difficult situations (Pijl-Ziebe *et al.*, 2008).

Organizations should prioritize providing adequate infrastructures and equipment, ongoing education initiatives, and educational interventions addressing moral distress. These initiatives include offering ethical workshops, facilitating discussion opportunities, helping patients cope with ethical conflicts, hiring more nurses to lessen the workload, and providing enough time for rest. Nursing staff members need to respect each other in order to reduce moral distress (Ay *et al.*, 2019).

2.10. Previous Studies

2.10.1. First Study:

This study published by (Ale *et.al.*, 2022), under the title "Moral Distress among Nurses Working in a Teaching Hospital"

Moral distress referred to the cognitive-emotional dissonance that arises when one feels compelled to act against one's moral requirements. Moral distress has a deleterious effect on patients, nurses, and organizations which results in decreased job satisfaction, increased turnover, and withdrawal from a job, and developing physical and psychological symptoms. The aim of this study is to assess the moral distress among the nurses in Chitwan Medical College Teaching Hospital. A descriptive, cross-sectional research design was conducted among 114 nurses of Chitwan Medical College Teaching Hospital by use probability, stratified random sampling technique.

The results of this study showed that majority of nurses (82.5%) experienced mild moral discomfort, while 17.5% experienced severe moral distress. Moral anguish was substantially correlated with the father's job ($p=0.035$). Interestingly, a statically significant connection between responders using government health insurance services and moral anguish was found ($p=0.013$). The researcher concluded a serious moral distress affects less than one in five nurses, but it can have serious consequences. Because of this, a particular program must be set up by hospital admission for nurses to reduce the moral distress.

2.10.2. Second Study:

The study carried out by (Giannetta *et.al.*, 2022), under the title "Moral Distress Scores of Nurses Working in Intensive Care Units for Adults Using Corley's Scale: A Systematic Review"

This research aims to describe the severity and frequency of moral anguish as measured by Corley's moral distress instruments experienced by nurses in ICUs. The results revealed moderate level of moral distress among nurses working in ICUs. The findings of this systematic review confirm that there are a lot of triggers of moral distress related to patient-level factors, unit/team-level factors, or system-level causes. Beyond the triggers of moral distress, this systematic review showed some correlates of moral distress: those nurses working in ICUs with less work experience and those who are younger, female, and intend to leave their jobs have higher levels of moral distress. This systematic review's findings show a positive correlation between professional autonomy, empowerment, and moral distress scores. Additionally, nurses who feel supported by head nurses report lower moral distress scores. This review could help better identify which professionals are at a higher risk of experiencing moral distress, allowing the early detection of those at risk of moral distress, and giving the organization some tools to implement preventive strategies.

2.10.3. Third Study:

The study carried out by (Zabetian *et.al.*, 2019) under the statement, "Investigation of Moral Distress in Nurses of Jahrom Hospitals in 2018". Stressors in the nursing profession that have an adverse effect on nursing employees. One of these tensions is the moral distress associated with various aspects of ethical issues. The purpose of this study was to Investigation of Moral Distress in Nurses of Jahrom Hospitals in 2018. A descriptive cross-sectional study was conducted on 145 nurses from educational and therapeutic hospitals in Jahrom in 2018. The instrument of the study included a demographic questionnaire and Corley's Moral Distress Scale (MDS). The results of this study showed that mean score of moral distress of nurses was 2.77 ± 0.68 .

Accordingly, the moral distress of 8.3% of nurses present in the research was very low, the moral distress of 31% of them was low, the moral distress of 44.8% of them was moderate, the moral distress of 13.1% was high and the moral distress of 2.8% was very high. There was a significant relationship between gender, work experience and moral distress of nurses ($p < 0.05$). The study concluded that the mean of moral distress of nurses was reported at a relatively desirable level. Therefore, more accurate planning and training workshops can increase the moral distress of nurses.

2.10.4. Fourth Study

This study conducted by (Hiler *et al.*, 2018) under the title "Predictors of Moral Distress in a US Sample of Critical Care Nurses". The research aimed to investigate the associations between the level of moral distress, job environment, and the security of patients in a national sample of critical care nurses. A descriptive correlational design was used. The study cohort comprised a sample of critical care nurses in the United States who had at least 1 year of work experience in an adult intensive care unit. There were 328 nurses providing critical care, and 56% of them had fewer than 20 years of experience as registered nurses. An adverse perception of the working environment and patient safety were merely correlated with moral distress. In this sample, there were statistically significant associations between participant age, practice setting, and work satisfaction and moral distress. The research revealed that critical care nurses' moral distress may be decreased through changes to organizational elements, such as the creation of positive work environments that foster collegial connections.

2.10.5. Fifth Study:

This study conducted by (Lusignani *et al.*, 2017) under the statement "Moral distress among nurses in medical, surgical and intensive-care units".

Moral distress among nurses compromises their ability to provide optimal patient care and may cause them to leave their job. A cross-sectional questionnaire survey of 283 registered nurses was conducted to evaluate the frequency, intensity and levels of moral distress. A revised version of the Moral Distress Scale (MDS-R) was used. The objective of the study to assess the frequency, intensity and level of moral distress perceived by nurses working in medical, surgical and intensive care units. The study findings showed the highest level of moral distress was associated with the provision of treatments and aggressive care that were not expected to benefit the patients and the competency of the health-care providers. Multivariate regression showed that nurses working in medical settings, nurses with lower levels of experience working in medical, surgical or intensive care settings, and nurses who intend to leave their job experienced the highest levels of moral distress. The present study indicates that nurses experience an overall moderate level of moral distress.

2.10.6. Sixth Study:

This study conducted by (vaziri *et al.*, 2015) under the title " Moral Distress among Iranian Nurses". The research aimed to describe the moral distress among Iranian registered nurses. In this study, no relationship between the degree of moral distress and any of the demographic information was discovered in this investigation. The range of the mean moral distress score, from 3.56 to 5.83, indicates mild to severe moral suffering. Working with unsafe levels of nurse staffing was the item with the highest mean score. The item giving medication intravenously to a patient who has refused to take it had the lowest mean score. The most morally distressed nurses were those who worked in EMS and NICU units. The researchers concluded a higher degree of moral distress is observed among nurses who work in health care systems.

Summary

The phenomena of MD have been well documented in the nursing field. It can be characterized as a type of distress that develops if an individual is cognizant of the morally correct thing to do however is unable to fulfil that commitment. The organization, nurses, and patients are all impacted by moral distress (Ragavadu, 2016). MD is special due to the fact it entails the transgression of an individual's fundamental ethical principles, has the potential to damage one's sense of personal integrity, and may threaten one's moral identity (Weinzimmer, 2014).

Moral distress can result from clinical situations, internal constraints, and external factors. Clinical situations, such as unnecessary treatment, inadequate pain relief, false hope, and incompetent caregivers, can trigger moral distress (Mealer & Moss, 2016). Internal constraints, such as lack of understand, self-doubt, excessive fear, lack of awareness about other treatment, social conditioning to follow others and conflicts with religious or spiritual beliefs (Karakachian & Colbert, 2017). External constraints, such as inadequate end-of-life communication, inappropriate use of resources, excessive administrative work, the perception of a lack of support from administrators, and rigid policies (Ghazanfari et al., 2022).

The effects of moral distress include loss of self-worth, interference with personal relationships, psychological and behavioral symptoms, and feelings of powerlessness, hopelessness, and lack of support. Sustained moral distress can have long-term residual effects, causing individuals to compromise themselves and betray their beliefs and values (Rushton *et al.*, 2016).

Moral distress has also been linked to lower job satisfaction and higher turnover, burnout, which can affect the working environment, employee morale and morale (Davis *et al.*, 2012).

Nurses can reduce moral distress by practicing self-care strategies like exercise, rest, and socializing. The healthcare system can reduce moral distress by implementing best practices, improving communication, creating a supportive environment, and providing methods for handling morally challenging care (Ghazanfari *et al.*, 2022 and De Veer *et al.*, 2013).

Chapter Three

Methodology

Chapter Three

Methodology

The following pages offer the systematic steps of the study including study design, administrative arrangement, study setting, study sampling, criteria of the study, questionnaire of study, rating and scoring, validity, pilot study, the reliability of the research questionnaire, ethical consideration, collection of data and method of data collection.

3.1. Study Design:

Quantitative descriptive study - cross sectional design is selected to carried out this study to determination the level of moral distress among nurses in critical care units' at AL-Hillah Teaching Hospitals. From the period between 9th November – 2022 to 1st June – 2023.

3.2. Administrative Agreements:

Administrative arrangements were made to make it easier for the study to determine the level of moral distress among nurses working in critical care units. The project was first presented as a seminar by the researcher on November 9, 2022, in order to get the formal approval of the postgraduate program College of Nursing/ University of Babylon. As a second phase, a process of obtaining ethical permission from a research ethical committee-college of nursing was completed (Appendix: A), and the Ministry of Health provided a formal agreement for the collection of the study's data. For the purpose of facilitating data collection, the Babylon Health Department's training and development center which referred to the critical care units at Marjan Teaching Hospital, Imam Al-Sadiq Teaching Hospital, and Al-Hillah Teaching Hospital (Appendix: C1-C2-C3-C4).

3.3. Study Setting:

This study was conducted in the critical care units at Al- Hillah Teaching Hospitals, which includes the following:

1- Marjan Teaching Hospital which established to receive Babylonian since (1957), the total capacity of the hospital is (316) bed. The study was conducted in the following workplaces: coronary care unit consists of (16) beds and emergency unit consists of (34) beds.

2- Imam AlSadiq Teaching Hospital, this hospital established to receive Al-Hillah city citizen from (2015), the total capacity of the hospital is (492) bed. The study was conducted in the following workplaces: "intensive care unit consists of (20) beds, coronary care unit consists of (15) beds and emergency unit consists of (38) beds".

3- Al – Hillah Surgical Teaching Hospital, established to provide the health services from (1972), the total capacity of the hospital is (447) bed. The study was conducted in the following workplaces: intensive care unit consists of (17) beds and emergency unit consists of (27) beds.

3.4. Study Sample:

Non-probability- purposive sample, the study target population was (588) nurses who work in the critical care units in Al – Hillah teaching hospitals. The sample size has been determined using Richard Geiger's equation (Abdelhady,2019), bringing the total number of nurses (250) into the sample.

The equation Richard Geiger.

“ $d = 0.05$, $z = 1.96$, $N = \text{population}$, $n = \text{sample size}$ ”

$$n = \frac{\left(\frac{z}{d}\right)^2 \times (0.50)^2}{1 + \frac{1}{N} \left[\left(\frac{z}{d}\right)^2 \times (0.50)^2 - 1 \right]}$$

Table (3.1) Distribution of the study sample according to selected setting

No	Hospital Name	frequency	%
1.	Imam Al Sadiq Teaching Hospital	108	43.20%
2.	Al-Hillah Surgical Teaching Hospital	118	47.20%
3.	Marjan Teaching Hospital	24	9.60%
Total		250	100%

3.4.1. Inclusion Criteria:

1. Nurses working at critical care units in Al-Hillah Teaching Hospitals.
2. Nurses agreed to take part in this study.
3. Nurses having at least one year of critical care unit experience.

3.5. Questionnaire of Study:

To achieve the study's objective, a specific questionnaire was created after an extensive evaluation of related literature in the topic of interest phenomena. The questionnaire was divided into three parts (Appendix: F).

Part I: Demographic Characteristics:

The demographic data part consists of (5) items, which include the following: age, sex, educational qualification, marital status, residency.

Part II: Employment Characteristics:

This part that include (4) items: "years of employment in the field, working place, years of experience in a specific work place, working shift".

Part III: Moral Distress Scale:

This part includes the moral distress scale. This scale was originally developed by Mary Corley in 2001 to measure the moral distress (Corley et al., 2001). The permission was obtained to use the scale from the author (Corley) by Email and then translated into Arabic (Appendix: D). It contains 30 items that divided into (3) domain: health care team conflict (12) items, caring conflict (6) items, organizational conflict (12) items.

3.6. Rating and Scoring:

The items were appraised and scored using the following patterns: five points Likert scales were utilized to rate and measure moral distress domain components that scored as (Never=1), (Rarely=2), (Sometimes=3), (Often=4), (Always=5). So that the cutoff point was according to the following: Low = (1-2.60); Moderate = (2.61-3.40); High = (3.41-5). Cut off points for nurses' scores for moral distress level: Low = (30-70), Moderate = (71-110), High = (111-150).

3.7. Validity:

Content validity of the instrument is obtained by panel of (12) experts from multidisciplinary field, who have not less than 10 years of experience in their specialty. Changes and modification performed according to the advises and opinion of the expert in order to reach the proper degree of understanding, clearness and relevance questionnaire to facility data collection to carry out the study objectives. The experts distributed related to their working place as: two experts from College of Nursing in Baghdad University / Ministry of Higher

Education and Scientific Research, three experts from College of Nursing in Karbala University / Ministry of Higher Education and Scientific Research, seven experts from College of Nursing in Babylon university / Ministry of Higher Education and Scientific Research (Appendix: G).

3. 8. Pilot Study:

The pilot study is conducted up on 25 nurses in the (coronary care unit and emergency unit) selected from Marjan Teaching Hospital carried out between 20 to 21 February 2023, nurses who participated in the pilot study were excluded from the study sample, a pilot study was conducted to accomplish the following purposes:

3.8.1. To ensure that the questionnaire for the study was intelligible and clear, the questionnaire items were all clear and easy to understand.

3.8.2. To determine the questionnaire's reliability.

3.8.3. To determine how much time each participant will need to finish the questionnaire items, the average time taken to complete the questionnaire was between (10-12) minutes.

3.8.4. To identify the nature of any challenges that the researcher may have encountered.

3.9. The Reliability of the Research Instrument:

Determining the study questionnaire, the alpha correlation coefficient (r) was used to determine the internal consistency of the research instrument using the “statistical package for social science software (IBM SPSS) version 26”.

The reliability results for the questionnaire were computed for the scale it was 0.80, which was statistically acceptable.

Table (3.2): Reliability statistic

Cronbach's Alpha			N	%
0.803	Cases	Valid	25	100.0
N of items		Excluded ^a	0	0
30		Total	25	100.0
a. Listwise deletion based on all variables in the procedure				

3.10. Ethical Consideration:

In order to retain the ethical consideration to complete the study, the researcher make sure to introduced himself to the respondents. The participants' verbal consent was obtained by the researcher after she made it clear that their participation was voluntary and assured them that all information would be kept private.

3.11. Data Collection:

Using a questionnaire (Arabic version) and self-report procedures with nurses, data was gathered after the cooperation and approval of hospitals administration. The researcher visited the nurses in different shifts (morning and evening). The researcher introduced herself and clarify the purpose of the study to the participants in order to get their verbal agreement and distributed the questionnaire to them. The participants fill out the form and offer an answer (nurses). The participants' answers a questionnaire, independently. Each self-report takes nearly (10 to 15) minutes. Data gathering took place throughout the span of time about (21) days, it started from 23 February to 15 March 2023.

3.12. Statistical Analysis:

In order to determine the study's results, data are examined for this study using statistical methods and the “statistical package for the social science” (SPSS) program version 26.

3.12.1. Descriptive Statistical:

The following parameters were calculated using descriptive statistics to explain demographical and item responses:

3.12. 1.A. Frequencies and Percentage

It is used to calculate the description of demographic characteristics and employment characteristics in the tables (4.1), (4.2).

$$\text{Percent (\%)} = \frac{F}{n}$$

Where:

% = percent.

F = frequency

3.12.1.B. Mean

It is used to estimate the value of the data in the tables (4.3), (4.4), (4.5), (4.6), 4.7). {Mean (\bar{X}) = $\frac{\sum Xi}{n}$ }

3.12.1.C. Standard Deviation

The standard deviation (SD) is calculated according to the following formula

$$SD = \frac{\sqrt{\sum_{i=1}^n (xi - \mu)^2}}{n}$$

Where n = Number of replicates

xi = Replicate i

\bar{x} = Mean of replicates

3.12.2. Inferential Statistic:

3.12.2.A. Correlation Coefficient

It was used to determine the association between moral distress of the nurses and demographic characteristics and employment characteristics in the tables (4.9), (4.10). The correlation coefficient was computed according to the following formula:

$$r = \frac{n(\sum xy) - (\sum x)(\sum y)}{\sqrt{\{n\sum x^2 - (\sum x)^2\}\{n\sum y^2 - (\sum y)^2\}}}$$

3.12.2.B. One Way ANOVA

Analysis of variance (ANOVA) for equality of Means (testing for coincidence when the mean's parameter is different). It was used to determine the differences between nurses' moral distress level and their work place in the table (4.8).

Source of Variance	Degree of Freedom (d.f.)	Sum of Square (S.S)	Mean of Square (M.S.)	F
Between Group	k-1	SSR	MSR=SSR/(k-1)	F = $\frac{MSR}{MSE}$
Within Group (Error)	k(n-1)	SSE	MSE=SSE/(k(n-1))	
Total	nk-1			

df: degree of freedom **k:** number of groups **n:** number of samples

SSR: Sum of squares residual

SSE: Sum of squares errors

MSR: Mean of squares residual

MSE: Mean of squares errors

Chapter Four

Results

Chapter Four

Results

This chapter presents the collected data after statistical management as structured tablets, to make it further scientific and logical interpretation in order to meet the study objectives.

Table (4.1): Descriptive statistic of nurses related to their demographical data.

Variables	Categories	Frequency	Percent
Sex	Female	121	48.4
	Male	129	51.6
	Total	250	100.0
Age	20-30 years	225	90.0
	31-40 years	16	6.4
	41-50 years	9	3.6
	Total	250	100.0
Education Qualification	secondary school nursing	28	11.2
	Diploma	95	38.0
	Bachelor	126	50.4
	Post graduate	1	.4
	Total	250	100.0
Marital status	Married	131	52.4
	Single	116	46.4
	Divorced	2	.8
	Separated	1	.4
	Total	250	100.0
Residency	Urban area	173	69.2
	Rural area	77	30.8
	Total	250	100.0

Table (4.1) revealed that most of nurses 225(90%) were between (20-30) years of age group, 129 (51.6%) were male, while most of the participant

126 (50.4%) were bachelor holder. Related to marital status, 131 (52.4%) of the participants were married and 173 (69.2%) were urban residency.

Table (4.2): Descriptive statistic of nurses related to their employment characteristics.

Variables		Frequency	Percent
Years of employment in the field	1-10 years	232	92.8
	11-20 years	13	5.2
	21-30 years	5	2.0
	Total	250	100.0
Working place	Emergency unit	129	51.6
	Intensive care unit	88	35.2
	Coronary care unit	33	13.2
	Total	250	100.0
Years of experience in a specific work place	1-5 years	231	92.4
	6-10years	11	4.4
	11-15 years	4	1.6
	16-20 years	4	1.6
	Total	250	100.0
Working shift	Morning	72	28.8
	Evening	178	71.2
	Total	250	100.0

Table (4.2) shows that the most of the participate in the study 232 (92.8%) were between (1 to 10) years of employment in the field, the higher percentage of the study sample 129 (51.6%) were working at emergency unit ,231(92.4%) were (5 years or less than 5 years) of experience in the intensive care units, related to working shift the result recorded 178(71.2%) were evening.

Table (4.3): Moral distress level of the critical care nurses related to health care team conflict domain

Items		Frequency	Percent	Mean	Score	Level
Assist the physician, if you think they're caring the patient incompetently.	Never	117	46.8	1.95	58	Low
	Rarely	45	18.0			
	sometimes	73	29.2			
	often	13	5.2			
	Always	2	.8			
	Total	250	100.0			
Dealing with various levels of nurses that I find "unsafe" work with them	Never	140	56.0	1.67	50	Low
	Rarely	62	24.8			
	sometimes	41	16.4			
	often	4	1.6			
	Always	3	1.2			
	Total	250	100.0			
If the dying patient asks about dying, heed the family's request that they not talk about death with him.	Never	61	24.4	2.81	86	Moderate
	Rarely	52	20.8			
	sometimes	56	22.4			
	often	36	14.4			
	Always	45	18.0			
	Total	250	100.0			
Follow the directions given by the physician to avoid talking up death when a dying patient asks about it.	Never	74	29.6	2.82	85	Moderate
	Rarely	46	18.4			
	sometimes	40	16.0			
	often	30	12.0			
	Always	60	24.0			
	Total	250	100.0			
When a patient asks you for the truth, follow the physician's requests and don't tell him.	Never	38	15.2	3.14	94	Moderate
	Rarely	42	16.8			
	sometimes	69	27.6			
	often	49	19.6			
	Always	52	20.8			
	Total	250	100.0			

Continue table (4.3)

follow the doctor's instructions to avoid discussing Code status to patient with the family once they become incompetent.	Never	42	16.8	3.28	98	Moderate
	Rarely	34	13.6			
	sometimes	54	21.6			
	often	52	20.8			
	Always	68	27.2			
	Total	250	100.0			
witness without taking action when health care providers disrespects the patient's dignity.	Never	189	75.6	1.44	43	Low
	Rarely	25	10.0			
	sometimes	25	10.0			
	often	8	3.2			
	Always	3	1.2			
	Total	250	100.0			
When no one will decide not to invest, continue to invest in patients with permanent injuries who are kept on ventilators.	Never	39	15.6	3.78	113	High
	Rarely	21	8.4			
	sometimes	30	12.0			
	often	26	10.4			
	Always	134	53.6			
	Total	250	100.0			
follow with family desires to maintain life, even if it is not in the patients' best interests,	Never	37	14.8	3.71	111	High
	Rarely	22	8.8			
	sometimes	36	14.4			
	often	36	14.4			
	Always	119	47.6			
	Total	250	100.0			
Carry out a job task for which I lack the necessary qualifications.	Never	193	77.2	1.36	41	Low
	Rarely	32	12.8			
	sometimes	19	7.6			
	often	5	2.0			
	Always	1	.4			
	Total	250	100.0			
Perform the procedure when the patient is not fully informed about the procedures they are about to undergo.	Never	30	12.0	3.02	90	Moderate
	Rarely	44	17.6			
	sometimes	92	36.8			
	often	60	24.0			
	Always	24	9.6			
	Total	250	100.0			

Continue table (4.3)

follow the family's wishes even if I disagree with them.	Never	74	29.6	2.54	76	Low
	Rarely	56	22.4			
	sometimes	62	24.8			
	often	26	10.4			
	Always	32	12.8			
	Total	250	100.0			
General mean and sum score				2.626	78	Moderate

Score: low level =30-70 , moderate level =71-110, high level =111-150

Table (4.3) indicated that moral distress level of the study sample related to health care team conflict domain recorded low score in the following items (1,2,7,10 and 12), while item (3,4,5,6 and 11) recorded moderate level, the others remain items (8 and 9) recorded high level. The overall level of moral distress was recorded moderate score (78).

Table (4.4): Moral distress level of critical care nurses in relation to caring conflict

Items		Frequency	Percent	Mean	Score	Level
Follow the physician's request regarding unneeded exams and therapies for terminally ill patients.	Never	37	14.8	2.93	88	Moderate
	Rarely	52	20.8			
	sometimes	84	33.6			
	often	45	18.0			
	Always	32	12.8			
	Total	250	100.0			
Start intensive life-saving measures when I believe they will just hasten death.	Never	8	3.2	4.39	131	High
	Rarely	8	3.2			
	sometimes	27	10.8			
	often	42	16.8			
	Always	165	66.0			
	Total	250	100.0			
Follow the physician's instructions regarding unneeded tests and treatments.	Never	28	11.2	3.38	101	Moderate
	Rarely	35	14.0			
	sometimes	67	26.8			
	often	53	21.2			
	Always	67	26.8			
	Total	250	100.0			

Continue table (4.4)

Prepare an old patient with a terminal disease who is on a respirator for surgery to remove a lump, if needed.	Never	21	8.4	3.84	115	High
	Rarely	21	8.4			
	sometimes	50	20.0			
	often	44	17.6			
	Always	114	45.6			
	Total	250	100.0			
Prepare an old man who suffers from severe dementia and a "No Code" for surgery to place a gastrostomy tube if needed.	Never	37	14.8	3.33	100	Moderate
	Rarely	31	12.4			
	sometimes	59	23.6			
	often	58	23.2			
	Always	65	26.0			
	Total	250	100.0			
Provide the medication intravenously if the patient has reject to take orally.	Never	39	15.6	3.35	100	Moderate
	Rarely	23	9.2			
	sometimes	60	24.0			
	often	68	27.2			
	Always	60	24.0			
	Total	250	100.0			
General mean and sum				3.536	106	High

Score: low level =30-70 , moderate level =71-110 , high level =111-150

Table (4.4) indicated that moral distress level of the study sample related to caring domain recorded moderate mean score in the following items (1,3,5 and 6). while item (2 and 4) recorded high level. The overall level of moral distress were recorded high (3.536±1.266).

Table (4.5): Moral distress level of critical care nurses related to organizational conflict domain

Items	Frequency	Percent	Mean	Score	Level	
Work in a setting where the staffing levels are so low that the care is insufficient.	Never	75	30.0	2.54	76	Moderate
	Rarely	50	20.0			
	sometimes	64	25.6			
	often	37	14.8			
	Always	24	9.6			
	Total	250	100.0			

Continue table (4.5)

To improve their skills, allow medical students conduct harsh procedures on patients.	Never	112	44.8	2.18	65	Low
	Rarely	47	18.8			
	sometimes	49	19.6			
	often	18	7.2			
	Always	24	9.6			
	Total	250	100.0			
Assist medical professionals who are procedures on a patient when CPR has failed.	Never	19	7.6	3.86	116	High
	Rarely	20	8.0			
	sometimes	46	18.4			
	often	56	22.4			
	Always	109	43.6			
	Total	250	100.0			
Provide better care for those who can afford to pay than those who cannot	Never	131	52.4	2.22	67	Low
	Rarely	18	7.2			
	sometimes	45	18.0			
	often	26	10.4			
	Always	30	12.0			
	Total	250	100.0			
Ignore circumstances when patient abuse by caregivers may be occurring.	Never	84	33.6	2.50	75	Moderate
	Rarely	42	16.8			
	sometimes	69	27.6			
	often	26	10.4			
	Always	29	11.6			
	Total	250	100.0			
Ignore conditions where I believe patients have not received enough information to ensure informed consent.	Never	72	28.8	2.48	74	Moderate
	Rarely	46	18.4			
	sometimes	87	34.8			
	often	29	11.6			
	Always	16	6.4			
	Total	250	100.0			
Although a patient has a lot of learning needs, discharge him once his stay has reached its maximum duration according to the "diagnostic related grouping (DRG)".	Never	120	48.0	1.91	57	Low
	Rarely	61	24.4			
	sometimes	49	19.6			
	often	11	4.4			
	Always	9	3.6			
	Total	250	100.0			

Continue table (4.5)

Obey orders or institutional rules to stop the patients treatment if they are no longer able to pay.	Never	76	30.4	2.62	79	Moderate
	Rarely	44	17.6			
	sometimes	58	23.2			
	often	43	17.2			
	Always	29	11.6			
	Total	250	100.0			
when I notice that nurse colleague makes an error in medication and doesn't report it, I take no action.	Never	102	40.8	2.33	70	Low
	Rarely	46	18.4			
	sometimes	48	19.2			
	often	25	10.0			
	Always	29	11.6			
	Total	250	100.0			
Help the physician who administers a exams or treatment without obtaining the patient's informed consent.	Never	58	23.2	2.74	82	Moderate
	Rarely	50	20.0			
	sometimes	77	30.8			
	often	30	12.0			
	Always	35	14.0			
	Total	250	100.0			
Give just intravenous hemodynamic stabilizing medication during a code without compression or intubation procedure.	Never	126	50.4	1.96	58	Low
	Rarely	51	20.4			
	sometimes	47	18.8			
	often	10	4.0			
	Always	16	6.4			
	Total	250	100.0			
Obey the instructions given by the physician not to discuss the status of the code with the patient.	Never	64	25.6	2.88	86	Moderate
	Rarely	38	15.2			
	sometimes	61	24.4			
	often	37	14.8			
	Always	50	20.0			
	Total	250	100.0			
General mean and sum				2.518	75	Moderate

Score: low level =30-70, moderate level =71-110, high level =111-150

Table (4.5) shows that most of the items of moral distress level related to organizational conflict domain recorded low level (2,4,7,9 and 11), and while items (1, 5, 6, 8,10 and 12) recorded moderate level, while remain item(3)

recorded high level and the overall mean score of this domain were moderate (2.518±1.313).

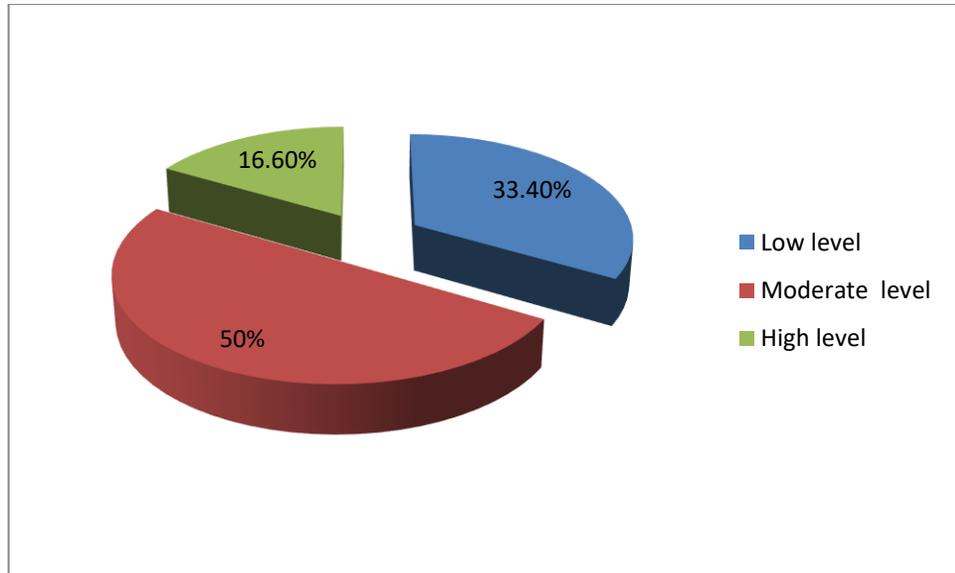


Figure (4.1): The distribution of moral distress level of the nurses in the critical care units.

This figure shows the distribution of the study sample (critical care unit nurses) related to their moral distress level.

Table (4.6): Critical care unit nurses level related to moral distress domain

Levels	Mean	Level
Moral distress level related to health care team conflict	2.626	moderate
Moral distress level related to caring conflict	3.536	High
Moral distress level related to organizational conflict	2.518	low
general mean	2.893	Moderate

Low level =1-2.60 , moderate level =2.61-3.40 , high level =3.41-5

Table (4.6) shows that critical care nurses who participated in the study recorded moral distress due to conflict which presented with health care team and patients caring domain.

Table (4.7): Nurses moral distress level with regards to their working place (n=250)

Work place	n	Mean	Std. Deviation	Level
Emergency unit	129	2.73	.463	Moderate
Intensive care unit	88	2.81	.415	Moderate
Coronary care unit	33	2.79	.350	Moderate
Total	250	2.77	.433	Moderate

Low level =1-2.60 , moderate level =2.61-3.40 , high level =3.41-5

Table (4.7): This table present that the critical care unit who work in different critical units recorded moderate moral distress level.

Table (4.8): Analysis of variance for the difference's between nurses' moral distress level and their work place.

Working place	Source of variance	Sum of Squares	df	Mean Square	Statistics	Sig.
Moral distress level	Between Groups	.595	1	.595	1.156	.284
	Within Group	98.279	191	.515		
	Total	98.478	192			

Findings demonstrated that there were no significant differences in Nurses moral distress with regards working place.

Table (4.9): Correlation between overall moral distress of the nurses and their demographical characteristics.

Parameter	r	P .value
Sex	.073	.253 NS
Age	-.116	.056 S
Educational qualification	-.077	.226 NS
Marital status	.098	.121 NS
Residency	.015	.818 NS

r: person correlation, P: probability

NS: Non-significantly at probability- value > 0.05 , S: Significantly at probability- value ≤ 0.05

This table (4.9) shows that there is no significant between the moral distress level and their demographical characteristics related to (Sex, educational qualification, marital status, residency) in $P \leq 0.05$, while significant founded between moral distress level and their age.

Table (4.10): Relationship between overall moral distress of the nurses and their employment characteristics

Parameter	r	P .value
Years of employment in the field	-.072	.258 NS
Working place	.070	.268 NS
Years of experience in a specific work place	-.117	.056 S
Working shift	-.029	.653 NS

r: person correlation, P: probability

NS: Non-significantly at probability- value > 0.05 , S: Significantly at probability- value ≤ 0.05

This table (4.10) shows that there is no significant between the moral distress level and their employment characteristics related to (years of employment in the field, working place, working shift) in $P \leq 0.05$, while significant founded between the moral distress level and the years of experience in a specific work place.

Chapter Five

Discussion

Chapter Five

Discussion

This chapter offers an analysis and logically discussion of the findings with the assistance of the pertinent literatures and a focus on the researcher's perspective. The interpretation of the results in this chapter will be provided methodically in accordance with the objectives of the study.

Part I: Demographical Features of Study Population:

During the data analysis path, the results in (Tab.4.1.) point out, that (51.6%) were male, this finding in the same line with a study carried out, in Iran related to relationship between autonomy and moral distress in emergency nurses their finding recorded that most of the sample (52.6%) were male (Abdolmaleki *et al.*, 2018).

The majority of the participants are in the age group (20-30) years old within (90%). These findings are supported by study conducted by (Molazem, 2022), who found in his study that the most of nurses employed in the critical care units (48.9%) were in the age group (20-30) years old. Also, this finding agreed with the result of (Sirilla, 2014), who stated that the age of the study sample is within the age group of (20-29) years.

Regarding the educational qualification most of the sample (50.4%) were bachelor degree. This result is similar with the findings of (Wilson *et al.*, 2013) who found that (82.9%) of nurses employed in the critical care units were bachelor holder.

Critical care unit receive complicated conditions, the internal environment of such units commonly stressful related to fast turnover of patient, critical intervention, immediate decisions which effected by changing patients'

condition, for this reason they should have many competences such as assess, treat and monitor any changes which providing their basic care. Male nurses can tolerate the overload and working under pressure which sometimes need physical strength. The results show that most of the sample (52.4%) were married, this finding of the current study is agreed with (Asgari *et al.*, 2019) who found that (85.2%) of nurses were married.

According to the residency most of the sample (69.2%) were from urban area.

Part II: Employment Characteristics of the Sample:

Table (4.2) Regarding to the years of employment in the field the majority of the sample have (1-10) years of employment in nursing. This finding agree with a study accomplished by (Villaroman *et al.*, 2021), who find the majority of ICU nurses (79%) of were with experience between (1-5) years respectively. The results show that the most of nurses who participant in the study have (≤ 5) years of experience in critical care units. This finding agreed to a study established by Gonzalez,2016, who stated that (70%) of nurses had less than 5 years of experiences in critical care units, according to Benner the (2-5) years working give the person the ability to solve problems, judgment and decision making which make him / her to extended to provide comprehensive care to complex cases.

The result shows that the higher percentage of the study sample (51.6%) were working at emergency unit, this result disagree with study by Soleimani *et al.*, 2019 who found that most of the sample (30.1%) were working in intensive care unit, difference in the results may be related to the hospital policy, as the number of nurses in the emergency unit was more than in other departments. The capacity and turn off in the emergency department are major factors which determine the number of the personnel's (team member) who receive patient and provide care. The capacity of the emergency department

which used a setting to collect the data were AL- Hilla Teaching Hospital (27) beds, Imam Al Sadiq Teaching Hospital (38) beds, and Marjan Teaching Hospital (34) beds while, for this reason the nurses who work in this area are more in number than the other departments

Regarding working shift of nurses, the results shows the highest percentage (71.2%) were working evening shift, because nurses who had experience for one year or more were majority in the evening shift. Locally policy which followed at hospitals in Al- Hilla City were planned to divide the day work (24hrs) to two shift (morning 6hrs and evening-night shift 18hrs) for this reason the number of nurses on duty in the evening shift were more than the morning one.

Part III: Moral Distress Level of the Study Sample:

Moral distress grading which presented in table (4.3), recorded moderate level related to team conflict, this result agreed with the results of study which carried out by (Ramathuba & Ndou, 2020), who found that ethical disputes frequently arise in healthcare settings, particularly in intensive care units. Health workers must deal with these challenges such a lack of resources, poor staff-to-family communication, and poor decision-making in low resource environments that cause moral distress and depersonalization, from point of nurses during daily duty caring many responsibilities related to patient care, comfortability, and doing their best to cover his/her needs, dealing which different cases with different age group and educational level needs time, effort and many competences. Moreover dealing with family members who join the patient in his/her admission to the hospital especially critical care units, they need special communicates skills to make them aware to the health status and several times need to take decision to direct treatment or determine the

management. All these situations produce stressful environment for health team members and the nurses specially.

Table (4.4) This table shows that the most items related to caring conflict were represented high level regarding moral distress, this result are similar to study carried out by (Hassan et. al., 2013) who found the high level of moral distress among critical care units nurses, this may be explained by the fact that these nurses have ethical conflicts when giving patients with unusually aggressive patient care, when patients are treated like objects to fulfil institutional requirements, or when patients or their families receive incorrect or inadequate information about the course of treatment, outcomes and prognosis.

The researcher believes that nurses who are required to deliver futile care faced with dilemma, they are aware that the care is ineffective but they are forced to do so by agency policies.

Table (4.5), this table shows that the nurses recorded moderate level related to organization conflict, this result agree with the findings of the research applied by (Epstein *et al.*, 2019) who shows that the moral distress results from challenges within organizations (such as poor teamwork, inadequately guiding policies or procedures, and unaddressed staff members shortages).

Table (4.6) this table shows that the critical care unit nurses who participant in the study recorded moral distress due to caring conflict which presented with health care team and patients caring domain. Moral distress perceived by these nurses are related to complex cases or issues relating to terminal illness, patient communication, patient pain, and the appropriateness of the medical care (Georges & Grypdonck, 2002), this feeling of powerlessness, due to negative outcomes of life prolonging treatment. Lack of

autonomy and authority, influencing their moral experience, feeling of insecurity, and helplessness has a significant impact on nurses' perceptions and attitudes when faced with moral distress, which effect their physical and psychological status and effecting working outcome. Furthermore, nurses who work in intensive care units may experience higher levels of moral distress due to situations such as those related to extending life, incompetent or inadequate treatment by a physician, working with coworkers and other healthcare professionals who lack the necessary skills, inadequate staffing and resources, exposure to the dying and death of the critically ill, lack of competency of nursing, lack of information regarding treatment alternatives and quality of life (McAndrew *et al.*, 2018).

Table (4.7), this table reveals that the critical care units nurses who work in different critical units recorded moderate distress level, these finding disagree with the study carried out in Iran by (Vaziri *et.al.*,2015) who finds that the nurses employed in the intensive care unit (ICU), neonatal intensive care unit (NICU), and emergency unit (EMS) had the highest degrees of moral distress, because the patients in these units had the most sever medical conditions, the necessary diagnostic and therapeutic treatments needed to be done quickly, and the high workload of tasks, In these units, nurses are more likely to experience moral distress

Table (4.8) shows no significant relationship presented between nurses' moral distress and working place (emergency unit, coronary care unit and intensive care unit) at p- value (0.284). This finding was agreed with study carried out by (Borhani, *et al.*,2015) who finds that the nurses in critical care units experience the most distress, clearly due to the extremely intense situations in these treatment environments that are linked to more difficult ethical challenges.

Table (4.9) demonstrates that there is no significant relationship between the moral distress level and their demographical characteristics related to (Sex, educational qualification, marital status, residency) in $P \leq 0.05$, while significant relationship founded between moral distress level and the participants age. These results go long with study carried by (Borhani *et al.*, 2014) whose find statistically significant relationship between moral distress and age, this finding indicate decreasing moral distress with increasing age, nurses gain more experience, thus they are more able to defend themselves against moral pressures and challenges when they arise.

Table (4.10) demonstrates that there is no significant correlation found between the moral distress level and the study sample employment characteristics related to (working place, years of employment in the field, working shift) in $P \leq 0.05$, while significant statistical relationship founded between the moral distress level and the years of experience in the specific place. These findings are supported by study applied by (Emmamally & Chiyangwa, 2020) shows that the significant associations between moral distress level and years of experience in CCU ($p=0.022$).

The researcher believes older nurses with more experience in nursing gain a wealth of information and expertise in treatment and care, and they develop their own opinions about how to treat the disease, which could have a direct impact on how they feel about the therapeutic plan and nursing interventions. They were distressed and would have more intense moral dilemma when faced with unjust or inadequate treatment and care plans.

As the finding which presented in tables and analyzed in chapter four and five which clearly answer the research questions about the level of moral distress and its relation with the nurses demographical and employment data.

which shows that the critical care nurses suffer from moral distress when you work with complicated cases because Critical care nurses work closely with patients spending an extensive amount of time at the bedside of the patient which allows them to observe patients and symptoms such as pain and suffering of patients who are on life-sustaining treatment for long periods. In addition, critical care nurses (CCNs) are faced with ethical challenges in their delivery of nursing care. where they feel compelled to make ethical decisions that are encountered to their professional and personal values in relation to various situations that arise in the clinical setting. Furthermore, there is no significant relationship between moral distress level and the demographical characteristics of the participants (Sex , educational qualification, marital status, residency). Whereas significant relationship founded between moral distress level and their age, this mean that critical care nurses more experienced and knowledgeable in solving problems and challenges they face in complex work environment, so they can face less moral distress than other. Moral distress level of critical care nurses related to organization conflict were moderate, this means that the lack staff, resources and the constricts imposed by the institution on nurses may be a reason for increasing the level of moral distress.

Chapter Six
Conclusion
&
Recommendation

Chapter Six

Conclusions and Recommendations

6.1. Conclusions

It can be concluded that:

The majority of the study sample was male, their age between (20-30) age group, bachelor degree holder, married and with urban residency.

Most of the study sample have experience (1-10) years of employment in nursing field, while most of them have ≤ 5 of experience in the critical care and emergency unit.

The majority of the study sample in the critical care units suffered from moderate moral distress level related to health care team conflict.

Regarding the moral distress in critical care nurses show high level related to caring conflict, while moral distress level related to organization conflict the statistical results recorded moderate level.

Overall of the critical care nurses were suffered from moderate moral distress level.

Regarding nurses' moral level in the working place the statistical result recorded moderate level of moral distress in "intensive care unit, coronary care unit, emergency unit".

There is no significant relationships found between the nurses' moral distress and working place.

There is no significant correlation found between the moral anguish level and their demographical characteristics related to (Sex, educational qualification, residency and marital status) except their age.

Significant statistical found between the moral distress level and the years of experience in the specific work place, while no relationship found between (their years of employment in the field, working place, working shift) and moral distress level.

6.2. Recommendations:

Depending on the results of the study it is beneficial to suggest the following recommendation:

- 1- Reducing moral distress between health team members by using many strategies such as: encourage collaboration and promote culture of open communication about moral distress and provide opportunities for debriefing and reflection after difficult cases, support for each other in coping with complex moral problems to shared decision making amongst members, provide family members with adequate information about patient condition.
- 2- Nurses should be given a clear role during the decision-making about life-extension therapy. It is possible to both enhance the decision's quality and less moral distress by systematically involving nurses, preferably before the treatment decision is made.
- 3- Planning and implementing educational programs such as offering ethical workshops and courses about ethics for critical care nurses to explain the concept and to identify the coping strategies which can be used to decrease moral distress.

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Appendices

Appendix A: Ethical Approval

University of Babylon
College of Nursing
Research Ethics Committee



جامعة بابل
كلية التمريض
لجنة أخلاقيات البحث العلمي

Issue No:2

Date: 26 / 1 /2023

Approval Letter

To, نور علي شهيد

The Research Ethics committee at the **University of Babylon, College of Nursing** has reviewed and discussed your application to conduct the research study entitled " **Determination the Level of Moral Distress Among Critical Care Unit Nurses**".

The Following documents have been reviewed and approved:

1. Research protocol
2. Research instrument/s
3. Participant informed consent

Committee Decision:

The committee approves the study to be conducted in the presented form. The Research Ethics committee expects to be informed about any changes occurring during the study, any revision in the protocol and participant informed consent.


Prof. Dr. Shatha Saadi Mohammed
Chair Committee
College of Nursing
Research Ethical Committee
26 / 1 /2023

Appendix C1: Official Approval

جمهورية العراق		
Ministry Of Health Babylon Health Directorate Email:- Babel_Healthmoh@yahoo.com Tel:282628 or 282621		وزارة الصحة والبيئة دائرة صحة محافظة بابل المدير العام مركز التدريب والتنمية البشرية لجنة البحوث

استمارة رقم :- ٢٠٢٢/٠٣

رقم القرار :- ٢٤

تاريخ القرار :- ٢٠٢٣/٢/١٥

قرار لجنة البحوث

تحية طيبة ...

درست لجنة البحوث في دائرة صحة بابل مشروع البحث ذي الرقم (٢٠٢٣/٠٢٠ / بابل) المعنون (تحديد مستوى الضائقة الاخلاقيه بين ممرضى وحدات العناية الحرجه)

والمقدم من الباحثة (نور علي شهيد) إلى وحدة إدارة البحوث والمعرفى مركز التدريب والتنمية البشرية في دائرة صحة بابل بتاريخ ٢٠٢٣/٢/١٢ وقررت :

قبول مشروع البحث أعلاه كونه مستوفيا للمعايير المعتمدة في وزارة الصحة والخاصة بتنفيذ البحوث ولا مانع من تنفيذه في مؤسسات الدائرة .

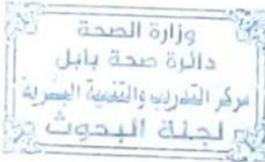
مع الاحترام

الدكتور

محمد عبد الله عجرش

رئيس لجنة البحوث

٢٠٢٣ / /



نسخة منه الى:

• مكتب المدير العام / مركز التدريب والتنمية البشرية / وحدة إدارة البحوث ... مع الأوليات.

دائرة صحة محافظة بابل / مركز التدريب والتنمية البشرية // ايميل المركز babiltraining@gmail.com

Appendix C3: Official Approval

جمهورية العراق		
<p>Ministry Of Health Babylon Health Directorate Email:- Babel_Healthmoh@yahoo.com</p> <p>لأجل عراق اخضر مستدام ..منعمل معا لترشيد استهلاك الطاقة الكهربائية والمحافظة على البيئة من التلوث</p>		<p>وزارة الصحة دائرة صحة محافظة بابل المدير العام مركز التدريب والتنمية البشرية وحدة ادارة البحوث</p> <p>العدد : ٢٧٠</p> <p>التاريخ: ٢٠٢٣/ ٢/ ٦</p>
<p>إلى / مستشفى الأمام الصادق (ع) مستشفى الحلة التعليمي مستشفى مرجان التعليمي</p> <p>م // تسهيل مهمة</p>		
<p>تحية طيبة ... أشارة إلى كتاب جامعة بابل/ كلية التمريض / الدراسات العليا ذي العدد ٨٨١؛ في ٢٠٢٣/٢/٥ نرفق لكم ربطا استمارات الموافقة المبدئية لمشروع البحث العائد للباحثة طالبة الدراسات العليا/ ماجستير (نور علي شهيد).</p> <p>للتفضل بالاطلاع وتسهيل مهمة الموما اليه من خلال توقيع وختم استمارات إجراء البحث المرفقة في مؤسساتكم وحسب الضوابط والإمكانات لاستحصال الموافقة المبدئية ليتسنى لنا إجراء اللازم على أن لا تتحمل مؤسساتكم أية تبعات مادية وقانونية مع الاحترام</p>		
<p>المرفقات : استمارة عدد ٢/</p>		
<p>الدكتور محمد عبد الله عجرش مدير مركز التدريب والتنمية البشرية ٢٠٢٣/ ١</p>		
<p>مستشفى مرجان للأمراض الباطنية والقلبية التخصصي (المرحلة) العدد : ١٥١٢</p>		
<p>نسخة منه إلى : • مركز التدريب والتنمية البشرية / وحدة إدارة البحوث مع الأوليات دائرة صحة محافظة بابل / مركز التدريب والتنمية البشرية // ايميل المركز // babiltraining@gmail.com</p>		

Appendix C4: Official Approval

<p>جمهورية العراق وزارة الصحة والبيئة الوزارة</p> <p>Ministry Of Health Babylon Health Directorate Email: Babel_Healthmoh@yahoo.com</p> <p>الخط عراق أخصب نظام سنعلم معا لترشيد استهلاك المياه بطرق سليمة والمحافظة على البيئة من التلوث</p>		<p>وزارة الصحة دائرة صحة محافظة بابل المدير العام مركز التدريب والتنمية البشرية وحدة إدارة البحوث</p> <p>العدد : ٢٧٠ التاريخ : ٢٠٢٣ / ١٦</p>
--	---	--

٢٢٨١
٢٤/١٨

الى / مستشفى الامام الصادق (ع)
مستشفى الحلة التعليمي
مستشفى مرجان التعليمي

م // تسهيل مهمة

تحية طيبة ...
أشارة إلى كتاب جامعة بابل/ كلية التمريض / الدراسات العليا ذي العدد ٤٨٠ في
٢٠٢٣/٢/٥
ترفق لكم ربطا استمارات الموافقة المبدئية لمشروع البحث العائد للباحثة طالبة الدراسات
العليا/ ماجستير (نور علي شهيد).

للتفضل بالاطلاع وتسهيل مهمة المومس إليه من خلال توقيع وختم استمارات إجراء البحث
المرفقة في مؤسساتكم وحسب الضوابط والإمكانات لاستحصال الموافقة المبدئية ليمسنى لنا
إجراء اللازم على أن لا تتحمل مؤسساتكم أية تبعات مادية وقانونية مع الاحترام

المرفقات :
استمارة عدد ٢ /

الدكتور
محمد عبد الله عجرش
مدير مركز التدريب والتنمية البشرية
٢٠٢٣ / ١

نسخة منه الى :
• مركز التدريب والتنمية البشرية / وحدة إدارة البحوث مع الأوليات ...
دائرة صحة محافظة بابل / مركز التدريب والتنمية البشرية // ايميل المركز / babiltraining@gmail.com

Appendix D: Permission to Use the Moral Distress Scale



Dear Dr. Corley, I am a master's candidate at the University of Babylon. I am writing to ask for your permission to use the Moral Distress Scale as part of my thesis research. I am also asking you to send me the original Moral Distress Scale that you made in 1995 in your research (Moral Distress of Critical Care Nurses).

Thank you.

Regards.



I am pleased to learn of your interest in the Moral Distress Scale. Since I am no longer doing research, Dr. Beth Epstein at the University of Virginia has taken over the research. The Scale has been revised. I have included her on this email so please contact her with your questions and your request.

Her email is: meg4u@virginia.edu.

I wish you well with your research.

Mary Corley, PhD

Appendices

From: نور علي شهيد <nona74732@gmail.com>
Sent: Friday, October 28, 2022 1:19 PM
To: Epstein, Beth (meg4u) <meg4u@virginia.edu>
Subject: Re: Moral distress scale

في الجمعة، ٢٨ أكتوبر ٢٠٢٢ ١٢:٠٧ ص نور علي شهيد
<nona74732@gmail.com> كتب:

Dear Dr. Beth Epstein

I am masters candidate at university Babylon. I am writing to ask your permission to use the moral distress scale as part of my thesis research.

I am also asking you to send me the original moral distress scale.

I sent a message to Dr. Merry asking him for the scale, and his response was (I am pleased to learn of your interest in the moral distress scale. Since I am no longer doing research, Dr. Beth Epstein at the University of Virginia over the research).

Thank you.

Regards.

⋮ ← ٢٨ أكتوبر Epstein, Beth (meg4u) إلى أنا ^ 

من
إلى
التاريخ
التشفير العادي (طبقة النقل الآمنة)
عرض تفاصيل تتعلق بالأمان

meg4u@virginia.edu - Epstein, Beth (meg4u)
nona74732@gmail.com - نور علي شهيد
٢٨ أكتوبر ٢٠٢٢ ٨:٢٦ م

Thank you. I'm sorry for the delay as I'm away at a conference.

We have recently revised and updated the moral distress survey. I'm attaching the paper describing the revision and the instrument itself for you to use.

Please let me know if you have questions.

Beth

Beth Epstein

Professor

Associate Dean for Academic Programs

*Professor, UVA Center for Health Humanities
and Ethics*

E meg4u@virginia.edu

P 434.924.0106

M 434.242.5927

University of Virginia

School of Nursing

CMNEB 3107

225 Jeanette Lancaster Way

Charlottesville, VA 22903



عرض النص المقتبس



Appendices



البريد الوارد

Moral distress scale



نور علي شهيد ٢٠٢٢/١٠/٢٨

إلى mccorley ^



من nona74732@gmail.com • نور علي شهيد

إلى mccorley@vcu.edu

التاريخ ٢٨ أكتوبر ٢٠٢٢ ٩:٣١ م

عرض تفاصيل تتعلق بالأمان

Dear Dr. Corley

I got the moral distress scale that you made in 2001. I just want your permission to use it in my research.

Thank you.

Regards.



١٦ فبراير Mary Corley

إلى أنا ^



من mccorley@vcu.edu • Mary Corley

إلى nona74732@gmail.com • نور علي شهيد

التاريخ ١٦ فبراير ٢٠٢٣ ٨:٠٤ م

التشفير العادي (طبقة النقل الآمنة)

عرض تفاصيل تتعلق بالأمان

I believe that I responded to your request by advising you to contact Dr. Epstein at the University of Virginia to obtain permission to use the Moral Distress Scale that has been updated. The one in the 2021 publication has been revised and you should use the one that is now considered valid. Dr. Epstein's email is; meg4u@virginia.edu.

I wish you well.

Mary Corley



البريد الوارد

Moral distress scale



نور علي شهيد ١٦ فبراير
إلى mccorley ^



من نور علي شهيد • nona74732@gmail.com
إلى mccorley@vcu.edu
التاريخ ١٦ فبراير ٢٠٢٣ ٩:٢١ م
[عرض تفاصيل تتعلق بالأمان](#)

I apologize to you, Dr. Corley.

Yes, you responded to my request in the past, and sent a letter to Dr. Epstein, after which he sent me the revised scale, but after I read the two scales, I saw that the scale that you used in your research(developmental and evaluation of a moral distress scale) that you did in 2001 is the best for my study, so I asked your permission to use it.

Thank you.



Mary Corley ١٩ فبراير
إلى أنا ^



من mccorley@vcu.edu • Mary Corley
إلى نور علي شهيد • nona74732@gmail.com
التاريخ ١٩ فبراير ٢٠٢٣ ٦:٤١ م
التشفير العادي (طبقة النقل الآمنة)
[عرض تفاصيل تتعلق بالأمان](#)

I understand your decision and wish you well.

Mary Corley

Appendix E: Informed Consent Form

السيد / السيدة

أنت مدعو للمشاركة بمشروع بحث علمي بعنوان:

(تحديد مستوى الضائقة الأخلاقية بين مرضي وحدات العناية الحرجة)

يرجى أن تأخذ الوقت المناسب لقراءة المعلومات الآتية بتأن قبل أن تقرر إذا ما كنت راغباً بالمشاركة أم لا. وبإمكانك طلب مزيداً من الإيضاحات أو المعلومات الإضافية عن أي أمر مذكور بالاستمارة أو عن الدراسة من الباحث أو أي مختص آخر.

أولاً: معلومات البحث	
اسم الباحث	نور علي شهيد
اسم المشرف	أ.د. سحر أدهم علي
أهداف البحث:	<ol style="list-style-type: none">1. To determine the level of moral distress among nurses in critical care units by using Corley moral distress scale.2. To identify the demographical and employment characteristics of study sample.3. To compare the level of moral distress among intensive care unit nurses related to their working area.4. To find out relationship between moral distress level and some variables related to demographical and employment characteristics (age, gender, years of experience, education qualification).
الفترة المتوقعة لمشاركة الشخص في البحث	20-25 minutes
الاجراءات المتبعة في جمع العينات	تملى الاستبانة ذاتيا من قبل المشاركين
المخاطر المتوقعة كنتيجة للمشاركة في البحث	لا يوجد

Appendices

ثانياً: معلومات للشخص المشارك بالبحث
1. ان المشاركة في هذا البحث طوعية
2. بإمكانك سحب مشاركتك من الدراسة متى شئت ولأي سبب
3. من حقك ان لا تجيب عن اي سوال لا ترغب بإجابته
4. ان مشاركتك بالبحث لن تحملك اي نفقات مالية
5. ان مشاركتك بالبحث لا يترتب عليها اي مسائلة قد تضر بك شخصياً أو بعملك.
6. ان اسمك سيكون سرىا وإن المعلومات الناتجة عن مشاركتك سوف تعامل بسرية تامة ولن يطّلع عليها أي شخص ما عدا الباحث والمشرّف ولجنه الاخلاقيات عند الضرورة.
7. وأن المعلومات التي ادليت بها والنتائج العلمية لهذا البحث هي للأغراض العلمية فقط ولن تكون هناك أية إشارة إلى لك أو لعائلتك في أي منشور عن هذه الدراسة.
8. ان من حقك بمعرفة النتائج العامة للبحث، او اي نتائج تتعلق بك بصورة خاصة.

ثالثاً: معلومات الاتصال
في حال وجود اي استفسار او شكوى من قبلك حول مشروع البحث بإمكانك الاتصال بالباحث أو لجنة اخلاقيات البحث في جامعة بابل – كلية التمريض
اسم الباحث نور علي شهيد
رقم الهاتف 07829305961
البريد الالكتروني noor.dohan.nurh67@student.uobabylon.edu.iq
لجنة أخلاقيات الأبحاث العلمية – جامعة بابل – كلية التمريض:
رقم الهاتف
البريد الإلكتروني

في حال كون عمر الشخص المشارك اقل من 18 سنة،
او كونه غير قادر على فهم أو قراءة الاستمارة يرجى
توقيع ولي أمره الشرعي.
اسم ولي أمر المشترك:

اسم المشترك بالبحث:
مصادقة السيد العميد:

ترفق الاستمارة او المقياس الذي سوف يستخدم لجمع العينة

Appendix F: The Questionnaire of the Study

Participant No ()

Hospital Name:

Part One:

Demographical Data:

1- Sex: Male Female

2- Age: years old

3- Education Qualification:

Secondary school nursing Diploma Bachelor
Post graduate

4- Marital status:

Married Single Divorced
Separated Widow

5- Residency:

Rural area Urban area

Part Two:

Employment characteristics:

1- Years of employment in the field: ≥ 1 year

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2- Working place:

Emergency unit

Coronary care unit

Intensive care unit

3- Years of experience in the specific work place:

Emergency unit years

Coronary care unit years

Intensive care unit years

4- Working shift:

Morning Evening

Part three:

Moral distress scale

First domain: Health care team conflict

	Items	Never	Rarely	Sometimes	Often	Always
		1	2	3	4	5
1	Assist the physician who in your opinion is providing incompetent care.					
2	Work with `unsafe' levels of nurse staffing.					

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3	Follow the family's request not to discuss death with a dying patient who asks about dying					
4	Follow the physician's request not to discuss death with a dying patient who asks about dying.					
5	Follow the physician's order not to tell the patient the truth when he/she asks for it.					
6	Follow the physician's request not to discuss Code status with the family when the patient becomes incompetent.					
7	Observe without intervening when health care personnel do not respect the patient's dignity					
8	Continue to participate in care for a hopelessly injured person who is being sustained on a respirator, when no one will make a decision, to 'pull the plug'.					
9	Follow the family's wishes to continue life support even though it is not in the best interest of the patient.					
10	Carry out a work assignment in which I do not feel professionally competent.					
11	Perform a procedure when the patient is not adequately informed about procedures which he/she is about to undergo.					
12	Follow the family's wishes for the patient care when I do not agree with them.					

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Second domain: Caring conflict

	Items	Never	Rarely	Sometimes	Often	Always
		1	2	3	4	5
1	Carry out the physician's orders for unnecessary tests and treatments for terminally ill patients.					
2	Initiate extensive life-saving actions when I think it only prolongs death.					
3	Carry out the physician's order for unnecessary tests and treatment.					
4	Prepare a terminally ill elderly patient on a respirator for surgery to have a mass removed if needed.					
5	Prepare an elderly man who is severely demented and a 'No Code' for surgery to have a gastrostomy tube put in if needed.					
6	Give medication intravenously to a patient who has refused to take the medication orally.					

Third domain: Organizational conflict

	Items	Never	Rarely	Sometimes	Often	Always
		1	2	3	4	5
1	Work in a situation where the number of staff is so low that care is inadequate.					

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2	Let medical students perform painful procedures on patients solely to increase their skill.					
3	Assist physicians who are practicing procedures on a patient after CPR has been unsuccessful.					
4	Provide better care for those who can afford to pay than those who cannot.					
5	Ignore situations of suspected patient abuse by care givers.					
6	Ignore situations in which I suspect that patients have not been given adequate information to insure informed consent.					
7	Discharge a patient when he has reached the maximum length of stay based on diagnostic related grouping (DRG) although he has many teaching needs.					
8	Carry out orders or institutional policies to discontinue treatment because the patient can no longer pay.					
9	Avoid taking any action when I learn that a nurse colleague has made a medication error and does not report it.					
10	Assist the physician who performs a test or treatment without informed consent.					

Appendices

11	Give only hemodynamic stabilizing medication intravenously during a Code with no compression or intubation.					
12	Follow the physician's request not to discuss Code status with patient.					

Appendices

رقم المشترك ()

اسم المستشفى:

الجزء الأول:

المعلومات الشخصية:

1- الجنس: ذكر

انثى

2- العمر: سنة

3- المؤهل التعليمي: اعدادية تمريض دبلوم

بكالوريوس دراسات عليا

4- الحالة الاجتماعية: متزوج اعزب مطلق

منفصل أرمل

5- السكن: مدينة ريف

الجزء الثاني:

معلومات العمل:

1- : سنوات الخدمة

اكتر من 1 سنة

2- مكان العمل الحالي:

وحدة الطوارئ

وحدة العناية المركزة

وحدة العناية القلبية

3- سنوات الخدمة في مكان العمل الحالي:

وحدة الطوارئ سنوات

وحدة العناية المركزة سنوات

وحدة العناية القلبية سنوات

4- نوبة العمل:

مساءً

صباحي

مقياس الضائقة الأخلاقية

المحور الأول: صراع الفريق الصحي

الفقرات	ابداً	نادراً	بعض الأحيان	غالباً	دائماً
	1	2	3	4	5
1					
أعمل مع طاقم طبي غير كفؤ باعترادي.					
2					
أعمل مع طاقم تمريضي غير كفوء.					
3					
استجابةً لرغبة أفراد أسرة المريض لا اتناقش عن حالة الموت مع مريض يحتضر ويسأل عن ذلك.					
4					
مراعاة لطلب الطبيب لا ادخل في نقاش عن الموت مع مريض يحتضر ويسأل عن ذلك.					
5					
امتنع عن مناقشة حالة المريض وتشخيصه الطبي مع المريض نفسه بطلب من الطبيب المعالج او اصرار أفراد أسرة المريض.					
6					
اتبع ما يطلبه الطبيب المعالج بعدم مناقشة التداخلات العلاجية الطارئة مع أفراد أسرة المريض عند سوء حالة المريض وفقدانه الأهلية.					
7					
أعضاء الفريق الصحي لا يحترمون كرامة المريض.					
8					
استمر في تقديم العناية والرعاية للمرضى المصابين بجروح عميقة والميؤوس من حالاتهم والخاضعين لجهاز التهوية الميكانيكي لعدم وجود من يتخذ قرار لإيقاف الجهاز عن العمل.					

Appendices

					9	استمر في الإجراءات الطبية لدعم حياة المريض بالرغم من عدم جدواها لإنقاذه وذلك تنفيذاً لرغبات افراد أسرته.
					10	اشعر باني غير مؤهل مهنياً للقيام بالأعمال المُعطاة الي.
					11	أقوم بأداء بعض الإجراءات بالرغم من عدم ابلاغ المريض بمعلومات كافية حولها.
					12	اتبع رغبات الاسرة في رعاية المريض حتى وأن كُنت لا اتفق معهم.

المحور الثاني: صراع الرعاية

	الفقرات					
	ابدأ	نادراً	بعض الأحيان	غالباً	دائماً	
	1	2	3	4	5	
1						أصرار الطبيب المعالج على إجراء الفحوصات وصرف العلاجات غير الضرورية للمرضى الميؤوس من شفائهم.
2						ابدأ بإجراءات شاملة لإنقاذ حياة المريض عند شعوري بانها ممكن ان تنقيه لفترة أطول على قيد الحياة.
3						أنفذ أوامر الطبيب المعالج لإجراء الفحوصات واعطاء بعض العلاجات غير الضرورية.
4						القيام بالتحضيرات المطلوبة لإجراء جراحة لمريض ميؤوس من شفائه خاضع لجهاز التهوية الميكانيكي ان لزم الامر.
5						أقوم بالتحضيرات اللازمة لإجراء عملية جراحية لرجل مُسن مصاب بالخرف الشديد ميؤوس من

Appendices

					حالته عن طريق وضع أنبوب فغر المعدة ان لزم الامر.
					6 إعطاء الدواء عن طريق الوريد للمريض الذي يرفض تناول الدواء عن طريق الفم.

المحور الثالث: صراع المؤسسة

الفقرات	ابداً	نادراً	بعض الاحيان	غالباً	دائماً
	1	2	3	4	5
1					
الرعاية التي تُقدم للمرضى غير كافية وذلك لقلة عدد مقدمي العناية.					
2					
اسمح لطلاب الطب بتأدية إجراءات مؤلمة على المرضى وذلك لزيادة مهاراتهم.					
3					
مساعدة الأطباء الذين يمارسون الإجراءات على المريض بعد فشل الإنعاش القلبي الرئوي.					
4					
توفير رعاية أفضل لأولئك الذين يستطيعون الدفع من أولئك الذين لا يستطيعون.					
5					
اتجاهل حالات الإساءة في معاملة المرضى من قبل مقدمي الرعاية.					
6					
أ تجاهل المواقف التي لا يتم تزويد المرضى بالمعلومات الكافية لضمان الموافقة المسبقة على الإجراءات العلاجية المقدمة لهم ضمن استمارة معينة.					
7					
الإسراع في تخريج المريض من المستشفى بالرغم من احتياجه الى الكثير من المهارات لتعلمها.					
8					
أنفذ التوجيهات أو اتبع إجراءات المؤسسة لوقف العلاج لأن المريض لم يعد قادراً على الدفع.					

Appendices

					9	اتجنب اتخاذ أي إجراء عندما اعلم أن زميلي في العمل قد ارتكب خطأ دوائياً ولم يُبلغ عنه.
					10	مساعدة الطبيب الذي يقوم بإجراء فحص أو علاج دون موافقة مسبقة من المريض.
					11	اكتفي بإعطاء دواء لتحسن الدورة الدموية عن طريق الوريد اثناء إنعاش القلب من دون اعطاء التنفس وتدليك القلب.
					12	اتبع طلب الطبيب بعدم مناقشة كيفية إنعاش القلب والرئتين مع المريض.

تحكيم

حضرة الأستاذة/الفاضل/ة

تحية طيبة

نظرا لما تمتلكه من خلفية ومكانة علمية وخبرة عملية في مجال اختصاصك يرجى التفضل بمراجعة ورقة الاستبانة المرفقة والخاصة برسالة الماجستير

وابداء ملاحظتك القيمة عليها للأخذ بها مع فائق الشكر والتقدير.

الاسم الكامل:

اللقب العلمي:

مكان العمل:

سنين الخبرة:

التوقيع:

الباحث

طالب الماجستير

نور علي شهيد

جامعة بابل / كلية التمريض

Appendix G: Panel of Experts

قائمة خبراء تحكيم استمارة الاستبيان

ت	اسم الخبير	اللقب العلمي	الاختصاص	مكان العمل	سنوات الخبرة
1	د. سجاى هاشم محمد	أستاذ	تمريض الصحة النفسية	أستاذ متمرس -كلية التمريض/ جامعة بابل	40 عام
2	د. امين عجيل ياسر	أستاذ	تمريض صحة المجتمع	كلية التمريض/ جامعة بابل	38 عام
3	د. قحطان هادي حسن	أستاذ	تمريض صحة المجتمع	كلية التمريض/ جامعة بابل	36 عام
4	د. حسين هادي عطية	أستاذ	تمريض صحة البالغين	كلية التمريض/ جامعة بغداد	36 عام
5	د. نهاد محمد قاسم	أستاذ	تمريض أطفال	كلية التمريض/ جامعة بابل	35 عام
6	د. ناجي ياسر سعدون	أستاذ	تمريض صحة مجتمع	كلية التمريض/ جامعة بابل	33 عام
7	د. شذى سعدي محمد	أستاذ	تمريض بالغين	كلية التمريض/ جامعة بابل	24 عام
8	د. حسام عباس داود	أستاذ مساعد	تمريض بالغين	كلية التمريض/ جامعة كربلاء	21 عام
9	د. حسن عبد الله عذبي	أستاذ مساعد	تمريض بالغين	كلية التمريض/ جامعة كربلاء	20 عام
10	د. صافي داخل نوام	أستاذ مساعد	تمريض الصحة النفسية	كلية التمريض/ جامعة كربلاء	20 عام
11	د. ماهر خضير هاشم	أستاذ	لغة عربية	كلية التمريض/ جامعة بابل	16 عام
12	د. صادق عبد الحسين حسن	أستاذ مساعد	تمريض بالغين	كلية التمريض/ جامعة بغداد	13 عام

Appendix H: Statistical Appendix

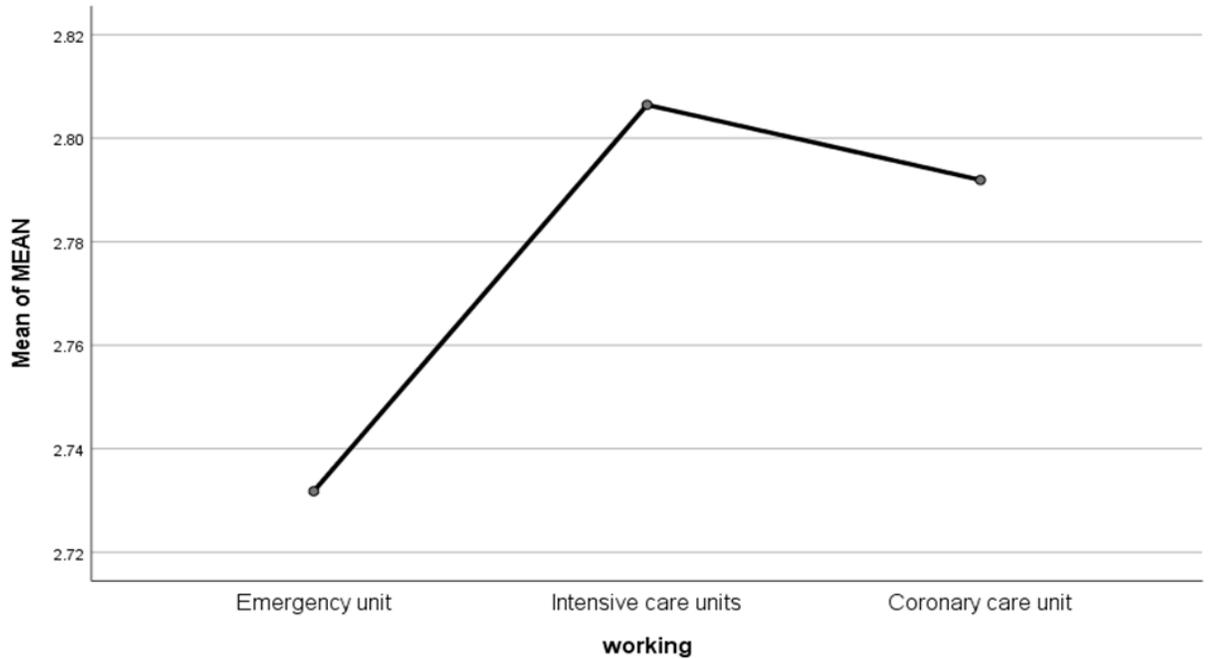


Figure (4. 2): Distribution of the moral distress levels of the nurses related to work place.

Figure (4.2): This figure presented that the critical care unit who work in different critical care units recorded moral distress level.

Table (4.11): Distribution of the moral distress levels of the nurses

Levels	Frequency	Percent
Low level	10	33.4%
Moderate level	15	50%
High level	5	16.6%

This table shows the distribution of the study sample (critical care unit nurses) related to their moral distress level.

Appendix I: Linguistic Report

Ministry of Higher Education and Scientific Research
 University of Babylon
 college of Basic Education

جمهورية العراق
 وزارة التعليم العالي والبحث العلمي
 جامعة بابل
 كلية التربية الاساسية

Ref. No.:
 Date: / /

عدد: ١٠٢٠
 تاريخ: ٢٠٢٣/٦/٢٢

كلية التربية الاساسية
 شعبة الموارد البشرية
 الصادرة

جامعة بابل / كلية التمريض
 السبورة
 العدد: ١٨٠٤
 التاريخ: ٢٠٢٣/٦/٢٢

م/ تقويم لغوي

تهديكم اطيب التحيات ...

كتابكم ذو العدد ٢٤٢٤ في ٢٢/٦/٢٠٢٣ نرافق لكم تقرير المقوم اللغوي الخاص برسالة
 طالبة الدراسات العليا / الماجستير (نور علي شهيد) الموسومة ب (تحديد مستوى الضائقة
 الأخلاقية بين ممرضي وحدات العناية الحرجة) بعد تقويمها لغوياً واسلوبياً من قبل (أ.م. نادية علي
 اكبر) وهي صالحة للمناقشة بعد الاخذ بالملاحظات المثبتة على متنها.

... مع الاحترام ...

المرفقات:
 - رسالة الماجستير
 - تقرير المقوم اللغوي

أ.د. فراس سليم جياوي
 معاون العميد للشؤون العلمية
 ٢٠٢٣/٧

المعلم المساعد
 Amman

نسخة منه الى:
 - مكتب العميد المحترم - للتوصل بالاطلاع مع الاحترام
 - أم نادية علي اكبر
 - الشؤون العلمية
 - الصادر

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 أمنية ٠٧٦٠١٢٨٨٥٦٦

مكتب العميد ١١٨٤
 معاون العلمي ١١٨٨
 معاون الإداري ١١٨٩

عراق - بابل - جامعة بابل
 بناية جامعة ٠٩٦٤٧٣٠٠٣٥٧٤٤

basic@uobabylon.edu.iq

المستخلص

الخلفية العلمية: يواجه ممرضي الرعاية الحرجة العديد من التحديات الأخلاقية بسبب المشاركة المتكررة في الرعاية التطيفية ورعاية نهاية الحياة، وأعباء العمل الثقيلة، والتواصل الوثيق بالمريض، وعدم اليقين في اتخاذ القرارات السريرية، والصراعات مع متخصصي الرعاية الصحية الآخرين. قد تؤدي الخلافات الأخلاقية التي لم يتم حلها إلى ضائقة أخلاقية. الضيق الأخلاقي هو شعور سيء وانزعاج نفسي يمكن أن ينتج عنه آثار ضارة على المرضى والممرضين والمنظمات.

الهدف: تهدف الدراسة الى تحديد مستوى الضائقة الاخلاقية بين ممرضي وحدات العناية الحرجة.

المنهجية: دراسة كمية وصفية - تم اختيار تصميم دراسة مقطعية لتحديد مستوى الضائقة الاخلاقية بين ممرضي وحدات العناية الحرجة في مستشفيات الحلة التعليمية. ولقد أجريت هذه الدراسة من الفترة ما بين 9 تشرين الثاني 2022 إلى 1 حزيران 2023. تم اختيار عينة غرضية غير احتمالية - لإجراء الدراسة والتي تكونت من (250) ممرض وممرضة يعملون في وحدات العناية الحرجة. من أجل جمع العينة تم اعداد نموذج استبيان خاصة مقسم إلى ثلاثة أجزاء؛ الجزء الأول يتكون من الخصائص الديموغرافية، والجزء الثاني يتضمن خصائص التوظيف، والجزء الثالث هو مقياس الضيق الأخلاقي الذي يتكون من (3) محاور. تم عرض الاستبيان على (12) من الخبراء لمعرفة مصداقيته، بينما تم حساب الموثوقية وكان معامل الارتباط (0.80) وهي مقبولة إحصائياً.

النتائج: أظهرت النتائج أن النسبة الاعلى 129 (51.6%) من افراد عينة الدراسة كانوا ممرضين ذكور، و225 (90%) كانوا تتراوح أعمارهم بين (20-30) سنة، ومعظم أفراد عينة الدراسة 126 (50.4%) كانوا من حملة درجة البكالوريوس، 131 (52%) كانوا متزوجين. أظهرت النتائج بأن مستوى الضائقة الأخلاقية كان معتدل بين ممرضي وحدة العناية الحرجة. لا توجد علاقة ذات دلالة إحصائية بين الضائقة الأخلاقية للممرضين ومكان العمل.

الاستنتاج: سجل معظم الممرضين المشاركين في الدراسة ضائقة أخلاقية معتدلة.

التوصيات: اوصت الدراسة بتخطيط وتنفيذ البرامج التعليمية مثل تقديم ورش عمل ودورات أخلاقية حول الأخلاقيات لممربي الرعاية الحرجة لشرح المفهوم وتحديد استراتيجيات المواجهة التي يمكن استخدامها لتقليل الضائقة الأخلاقية.



جمهورية العراق
وزارة التعليم العالي والبحث العلمي
جامعة بابل
كلية التمريض

تحديد مستوى الضائقة الأخلاقية بين ممرضي

وحدات العناية الحرجة

رسالة مقدمه إلى

مجلس كلية التمريض / جامعه بابل

جزء من متطلبات نيل درجة الماجستير علوم في التمريض

جامعة بابل

من قبل

نور علي شهيد

بأشراف

أ.د. سحر أدهم علي

تشرين الاول / 2023 ميلادية

ربيع الاول / 1445 هجرية