



ORIGINAL RESEARCH ARTICLE

ETHICAL CHALLENGES IN HOSPITAL DUTY: NEPALESE NURSES' LIVED EXPERIENCE

Muna Sharma^{1,*}, Kalpana Sharma²

¹Department of Adult Health Nursing, Maharajgunj Nursing Campus, Institute of Medicine, Kathmandu, Nepal

²Department of Adult Health Nursing, School of Nursing, Chitwan Medical College, Bharatpur-10, Nepal

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***Correspondence to:** Muna Sharma, Department of Adult Health Nursing, Maharajgunj Nursing Campus, Institute of Medicine, Kathmandu, Nepal.
Email: muna.sharma@mnc.tu.edu.np

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ABSTRACT

Background: Nursing is ethically grounded profession. Nurses work in proximity with patients where they may encounter ethical problems too. However, little is known about the ethical challenge of nurses working in Nepal. Therefore, this study was undertaken to explore lived experience with ethical challenges among nurses working in government hospitals of Kathmandu, Nepal.

Methods: Qualitative phenomenological design was carried out among nurses working in the five government hospitals of Kathmandu, Nepal. Twelve nurses who had greater than 5 years of work experience in patient care were selected purposively for the study. Data was collected through face to face interview method using in-depth interview guideline. All interviews were recorded in a digital voice recorder. The collected verbatim was transcribed and analyzed thematically.

Results: All nurses experienced ethical challenges and perceived stress from those challenging situations. Three main themes derived from the participants' experiences of ethical challenges were: errors in patient management; justice to the patient; burn out from duty. Nurses found inappropriate service to the patients, limited access of treatment and care to the patients, errors in procedure, autonomy and confidentiality issues, compromised respect and dignity of patients. When nurses found stressful working situation and conflicting legal and moral obligations, they felt burnout that leads to compromised quality of patients care.

Conclusions: Nurses experience different ethically challenging situations in their duties. Experiences of these challenging situations are stressful and it affects nurses' ability to deliver quality service. Hence, attention should be given to address ethical challenges of nurses.

INTRODUCTION

Despite having good knowledge and skill regarding ethics, health professionals have chances of encountering with ethical problems.¹ Nurses frequently face ethical challenges² however the intensity of their experience may be different.^{3,4} Ethical challenges in nurses' working situation cause diminished workplace satisfaction that lead to physical and emotional illness, burnout, and staff turnover,⁵ hence ineffective health service. Nurses try to compensate quality care⁶ by prioritizing routine work than patient centered care, and do not respond to patients in time.^{3,7} In some situations, there may be violation of law.^{8,9} This might contribute to decreased quality of nursing care. In Nepal, medicine and technology are advancing in parallel with rising public expectations to have high-quality nursing care. At the same time, unethical behavior of health workers including nurses have frequently been reported in Nepal's National daily newspapers. Therefore, researchers intended to explore Nepalese nurses' lived experience of ethical challenges in their hospital duty.

METHODS

Qualitative phenomenological approach was carried out in

hospitals of Nepal Government namely; Bir Hospital, Kanti Children Hospital, Patan Mental Hospital, Teku Hospital and Bhaktapur Hospital. These hospitals were the major government hospitals located in Kathmandu Valley of Nepal. Twelve nurses with more than five years of work experience, involved directly in-patient care, and expressed interest to take part were purposively selected as study sample. Data was collected through face to face interview method using in-depth interview guideline. It consisted of 11 open-ended questions and probing was done as needed. E.g. "I want to know from you why the situation you considered a problem, how you perceived them, can you give me an example?" Digital voice recorder was used to record the interview.

Prior to data collection, ethical clearance and administrative approval were obtained. Nurses meeting the inclusion criteria were identified with the help of hospital administration. Afterwards, nurses were approached individually to ensure their voluntary participation. Then consent was taken and contact details were obtained to set date, time, and place for the interview mutually. Interview was conducted in Nepali language as it was their mother language and was initiated with broad open-ended questions so that nurses could speak freely. To maximize comfort of physical environment and privacy, inter-

views were arranged in a quiet room of their hospital and home setting where they felt comfortable. In order to maintain confidentiality, the recorded information had access only to the researcher. Rights of the participants were maintained by respecting the participants' decision to stop interview even in the middle. All the interviews were audio-taped on a digital voice recorder. For subsequent interview, date, time, and place were fixed with the participants. On the day of interview, a reminder call was given to them. When data sufficiency was achieved the interview was ended. Interviews were lasted for 45 to 75 minutes and the recordings were downloaded to a password-protected personal computer. The data was collected on 2015.

Data collection and analysis was done side by side. All the recorded information was labeled by giving code number, date, and time. The verbatim was transcribed. Following transcription, each tape recorder was listened at least twice by the researcher to verify accuracy of the transcription and then on at least one other occasion in the context of subsequent interviews with the participants. Initially, the information provided was confirmed with the participants then the data was analyzed thematically. After repeated reading of the transcripts, data was coded and major themes were emerged. During thematic analysis, individual data meaning was stored and restored as codes, and then patterns began to emerge. Patterns were combined and consolidated into common themes.

Ethics approval for this study was granted by the Institutional Review Committee, Institute of Medicine (Ref: 277(6-11-e5/070/071). Administrations approval was obtained from the hospital administrations for the permission of data collection. A rigorous informed consent process was followed: all participants were given verbal and detailed written information about the nature and purpose of the research before their participation; participants were made aware of their right to decline to answer questions and were assured that measures were in place to maintain confidentiality of the information.

RESULTS

The participants were working in medical, surgical, ICU, psychiatric and maternity care units (Table 1).

Table 1: Demographic characteristics of the participants

S. No.	Age in years	Years of experience	Working unit	Completed degree
1	45	25	Medical	Masters in nursing
2	43	22	ICU	Masters in nursing
3	42	22	Emergency	PBN
4	42	22	Maternity	PBN
5	41	21	Medical	Masters in nursing
6	40	19	ICU	Masters in nursing
7	39	20	Medical	PBN
6	39	19	Infectious unit	Masters in nursing
9	39	19	Surgical	PBN
10	34	15	Surgical	PBN
11	30	10	Psychiatric	PBN
12	26	6	Oncology	PBN

The findings regarding nurses' lived experience with ethical challenges are presented under the heading of total 4 themes and 16 subthemes (Table 2).

Table 2: Themes and subtheme emerged from participants' narration

Sub theme	Theme
Service to patients	Errors in patient management
Errors in procedures	
Autonomy and confidentiality issues	Justice to the patient
Access of treatment and care	
Respect and dignity of patients	
Stressful working situation	Burn- out from duty
Conflicting legal and moral obligations	

Errors in Patient Management

All nurses experienced errors in patient care management. In some instances, they experienced malpractices. Following sub-themes describes how the nurses experienced errors in patient management.

Service to Patients: Participants witnessed patients' suffering due to ignoring care needs of the patients. Sometimes health professionals shouted on patients and their relatives who visited hospital instead of listening to their problems.

Padma sharedsaid to a visitor "go to your bed, there is no problem, you are seeking unnecessary attention". the patient had high fever i.e.104 degree Fahrenheit.

Nurses described their working condition as physically and mentally demanding and seriously ill patients were in need of considerable care. But it was impossible to provide care due to insufficient staff.

Shanta reported: couple of days ago, I was alone in duty. A patient developed febrile convulsion, but I could not take care of the patient immediately, because I was looking after another critical patient. By the time I approached him, he was already unconsciousvery distressing event.

Participants felt that patients admitted in academic hos-

pitals were used as a tool for learning. According to them, some procedures were performed in patients solely to increase skill and knowledge of health personnel.

Gyani narrated *A mother was in labour pain and was waiting for normal delivery. Oneyear PG student rushed in labour room and tried forceps delivery but he was placing the forceps incorrectly. Although the mother had longer waited with labour pain, but there was no indication for the need of instrumental delivery, but it happens with medical students.*

Nalina also shared similar experience *Patient had no indication for lumbar puncture, but ...student ...performed the procedure. I think it is a waste of money for the patient to buy*

The working situation became stressful when nurses could not contact duty doctor, or the doctors could not respond to their calls in time for various reasons while patient's condition became critical. In such situations, sometimes nurses tried to alleviate patients' suffering and save their patients' lives by acting upon procedures beyond their duty and authority.

Chanda described: *If you are only a nurse on duty and start to search doctors in critical patients, you are delaying response to patients. Sometimes only three seconds delay in action can make the patients' condition even worse. Therefore, even nurses are not authorized I generally give injection hydrocortisone and lasix for cancer patients with pulmonary oedema and dyspnea.*

Inappropriate facility and health service contributed to patients suffering within health facility and these conditions challenge goal attainment of public health.

Errors in Procedures: Participants shared that health service is teamwork and it is not possible to be good alone in duty. Health professionals had to face consequences of inappropriate actions of their colleague.

Ashi said: *It was almost 8:30PM in my night duty, a visitor of a cabin came and yelled at me, "why did not you give this medicine to my patient that I brought here at 5PM?".....it had to be given at 6PM.....*

According to participants, sometimes flow rate of blood and intravenous fluid transfused to the patients were not maintained. That might sometimes cause patients to be over infused or under infused. This type of error affects patients' health.

Omni narrated: *Some of our staffs do not take care of the infused blood and I/V drip of patient. You know, sometimes they transfuse one-pint blood within two hours and sometimes in eight hours. As a rule, one-pint blood is transfused between three to four hours in normal condition.*

Nurses were aware about constraints, which sometimes cause it difficult to adhere to the protocols. Nevertheless, not following protocol intentionally was unfair to patients.

Bin shared: *Standard techniques are not applied while catheterizing patients. Health personnel do not put mask and gown during lumbar puncture and bone marrow aspiration. We do not wash our hands before touching patients because we do not have time for it.*

Position of bed bound patients as required is not done, and pressure area care intravenous line was also missing. These all resulted to increased risk of developing pressure sore, phlebitis and infection.

Tim said: *Some of our friends do not change intravenous line. They do not listen to the patient's cry of pain during medication and inject from the swollen line. Some patients develop phlebitis.*

Similar situation shared by San: *You cannot give chemo drugs from peripheral line of patients, because it damages the cells. However, in practice, our patients do not have central line and we are giving it through peripheral IV line.*

Sometimes medication error also happened that included prescribing and giving wrong drugs to patients using wrong routes, wrong time, and wrong dose.

Yof reported: *.....nurse was about to injectinjection through intramuscular route, you know, it was well known medicine given through the intravenous line.I stopped her but it was ordered like that in the patient's treatment chart*

However, nurses took strategies to prevent adverse reactions of medications when they were aware of a mistake.

Dik stated: *.....I injected injection diclofenac instead of injection ranitidine through the intravenous line of the patient. Suddenly I became conscious about my mistake and called the consultant doctor.....for the necessary action.*

Justice to the Patients

How the participants perceived justice in health facility to their patients is described under following sub-themes.

Autonomy and Confidentiality Issues: Participants experienced occasions where patients' rights to know their own disease condition and treatment plan, right to choose treatment options and rights to refuse treatment were neglected by health care providers. Protocol of informed consent was not followed.

Padma said: *We do not have the practice of giving all information about disease and treatment plan to our patients. However, we do not forcefully do procedures to patient who refuses.....*

Nalina also shared: *I saw many health professionals threatened the patients; "if you refuse....., something wrong will happen and you will have a big problem." I agree sometimes patients need counseling for their benefit, but threatening like this is not justifiable.*

It was also shared that informed consent was only a formality of taking signature from patients.

Chanda narrated: *In our unit, we have special consent form which we call 'high risk consent'..... however details of treatment plan are not given to patients.*

Participants perceived that parents of unwell children were informed about their children but it is insufficient, superficial and inappropriate to their level of understanding.

Dick shared: *.... parents came to nurse and asked "what did the doctor say to us?" it happened immediately after the explanation of doctor to them about operation plan of.....*

Participants shared that forced procedure and care were acceptable if patients were mentally incompetent.

Bin: *We must administer medicine forcefully to our patients.patients admitted in this hospital do not have insight we do not respect their decision.....*

Participants shared that patient's confidentiality was tried to respect but not possible to maintain privacy in special wards/units. But in general ward, where patients share common room, it was not possible to maintain confidentiality and privacy of patients.

San reported: *We do not write name and diagnosis in information board of ward with patients having serology positive.*

Gyan shared: *Parents request us not to disclose their children's diagnosis to others. Unfortunately, I feel that in this general ward, confidentiality cannot be maintained, because many people will be around*

Perception of confidentiality was different for the nurses working in infectious disease hospital. They faced ethical challenges especially when patient diagnosed with HIV/AIDS requested them not to inform his diagnosis to his wife.

Tim: *.....patient requested to keep his diagnosis from his wife.....I was confusedwhat is the wife's right?*

Access to Treatment and Care: Participants perceived that treatment and care to the patients is not timely accessible even if they arrived in hospital. It is due to inadequate nurse-patient ratio.

Omni reported: *I feel very bad parents stay in queue by holding their sick baby on lap. even in the emergency situationsaw many children died in a queue.....*

Yof said: *You know I'm alone on duty to look after of these 34 patients.instead of giving medication at 6:00 AM, I start at 5AM and it may continue till 8AM.... How can I listen voice of the patients?.*

Respect and Dignity of Patients: Participants agreed that some-

time they do not respect patients' dignity it happens due to work overload, argument in some issues with patients and visitors etc.

Padma reported: *..... talk politely to patients admitted in paying ward and rudely to patients admitted in general ward.admitted in paying wards and they need special care*

Different opinion was given by Bin: *There is no discrimination of care on the basis of socio-economic condition, position, and power of patients. However, more attention is given to the VIPs and relatives of health professionals. I think it is natural.*

Verbal abuse is also observed in the clinical setting. Few short tempered health personnel verbally abused innocent patients whereas some health workers could not control their anger and misbehaved with their patient's family.

Ashi said: *.....patient took pain medicine by herself to control pain...health person entered the patient's cabin and yelled at her.....*

Tim also shared: *.....questioned about the prognosis of his patient in the morning round of Suddenly, he pulled patients visitors. Out of the ward by holding the collar of his shirt*

Burn out From Duty

This theme described how participants faced difficulties during their duty.

Work Overload: Participants shared that they had high workload that increased pressure in caring situation. So despite consistent efforts, most of the time patients lacked basic care. In addition, they reported that they had given other tasks such as keeping records, and managing equipment/supplies, need to engage more in written work than caring to their patients.

Padma stated: *Three days ago, I was in a night duty, 12 patients from oncology unit became critical, some of them had high fever and rigor, some were bleeding, and two patients developed seizure. You know from 8PM to 4AM in the morning I was running around the ward to manage those patients. I had no time to finish the routine work. Do you think there could be quality care?.*

Dik reported: *Today we have 32 patients and only 2 nurses in this morning shift. In this hour we are rushed for new admissions, discharges, attend doctors' rounds, send investigations, collect reports, send and receive patient to and from operation theatre, investigations, make consultation with other units and many more.how can only two nurses manage them all, hence, there is no care for our patients.*

Similarly Shanta shared similar feeling: *All our work goes in preparing drugs and injecting it to our patients. You know a patient might have up to ten drugs and a nurse has to administer medication for around 30 patients who are admitted in this ward.*

Stressful Working Situation: Participants felt insecure in their

duties as they had to work by risking their own health. Such as acquiring disease from hospital and risk of legal action.

Yof shared: *Couple of days ago, I was alone in duty. A mentally patient entered my room and slapped on my face. I shouted to the visitors for my rescue.our duty room is insecure; we do not have police force and guard to control violent patients. I always finish my duty with fear.*

Nurses became stressful when they had to handle ward emergencies without authority to act in such situation.

Gyani said: *In some emergencies of patients, you cannot wait until the arrival of doctors, sometimes patient's condition becomes more critical..... I inject drugs to control patient's pain, alleviate dyspnea, though doctors do not prescribe it. It is very difficult for nurses; we are in the middle of doctors and patients.*

When nurses had to work with high level of stress, their behavior could not be professional with the patients, hence decreased quality of care.

San shared: *In my night duty at 7 PM I took handover, a patient was gasping. I made a call to on-duty doctor multiple times, but there was no response. I did my best effort to save the patient's life, but at 8pm, the patient passed away. You know by then the patient's family became angry with me and blamed me that I could not bring the duty doctor..... What can I do?*

Conflicting Legal and Moral Obligations: Nurses were duty bound in their respective working wards/units as a front line care provider. When their moral obligations clashed with their authority, the situations became stressful and disappointing to them. However, in some instances nurses forgot their authority and took risk to themselves from their unauthorized job only for benefit of patients.

Nalina said: *In my duty, a newly admitted patient started bleeding. His condition was poor; platelets count was very low. I searched for the doctor (call doctor) from 2PM to 4 PM, but unfortunately, I could not find the doctor. By 5 PM patient started to bleed heavily, there were petichae (bluish discoloration) in the patient's body. I could not wait for the duty doctor to call me back. Therefore, I called my boss. He instructed me in phone to transfuse one unit FFP and three units of platelet. You know the order was not written, I was confusedbut I did it to save my patient's life.*

Sometimes situations forced health personnel to act against their ethics. Despite great stress and risk, they took some actions to save the life of patients.

Tim stated: *It was three years ago in ahospital of a remote area.A mother with obstructed labor. Health facility with caesarian delivery was very far to refer patient and we had not facility. We health personnel took bold decision to and did operation in labor bed. I gave spinal anesthesia although I was not authorized.....*

Participant felt that nursing care was not being respected which decreased their self-esteem and burn out in duty. Feeling less powerful, being not respected, having no authority to influence health care system were sources of frustration and burn out from duty.

Chanda reported: *I felt people do not respect nursing care....therefore, I do not like to provide basic nursing care to patients.....*

DISCUSSION

All nurses were female with age ranged from 26 to 43 years, working in medical, surgical, ICU, emergency, maternity, psychiatric, infectious disease, and oncology units. Their average year of experience was 18 years.

The findings of this study were in congruence to those of previous research where ethical challenges were prevalent in nurses' working situations that affected the delivery of quality care.^{8,10-12} There was low quality of health services and procedural errors that resulted increased patients' suffering within the health care facility. Supportive findings were reported in studies of Turkey¹³, Norway¹⁴, Canada¹⁵, Sweden¹⁶, Iran¹⁷, Brazil¹⁸, Malaysia⁴ and Nepal.¹¹

Quality of care was compromised by not listening to patients' problems, not maintaining personal hygiene, and not recording temperature of patient. Adequate attention to the needs of patients was not given⁸ and it was difficult to maintain quality of nursing care.^{12,19} It was shared that patients had to wait in a long queue; restrooms and water supply to patients were inadequate. Supporting this, Chinese nurses showed their concern regarding prolonged treatment waiting time and discharge process of patient in their hospitals.²⁰ Sometimes flow rate of transfused blood/intravenous fluid, need of bladder and bowel movement, positions of bed patients were not considered. Reported in literature, "a patient comes to hospital with a single problem and leaves with dozens of bed sores and infection".¹⁷

Sometimes patients were used only as a learning tool especially in academic hospital and some procedures were performed only to enhance knowledge and skill of health professionals. Supporting this, literature showed that patients were treated as a tool of experiments.^{18,21,22} Patients' right to know their disease condition and treatment plan, right to choose treatment options, right to refuse treatment was neglected and the consent became only a formality. Literature showed that autonomy and confidentiality of the patient's information was not respected.^{3,8,21,23}

Finding showed patients' dignity was not respected; they were behaved rudely, shouted upon and verbally abused. Supportive study suggested that institutionalized client were abused physically and psychologically, were humiliated by shouting, swearing, verbal offending, and slapping. Women were more frequently abused than male²⁴ and

in some instances, abuse on minor were not reported.²⁵ In this study, nurses felt sandwich between patient and doctors when patients' condition turned serious and duty doctor could not answer to the nurses' call in time and they had to handle situation without authority. Similarly, a nurse of Iran expressed that '*she attempted five times to have resident see the patient, but he didn't come*'¹⁷ and nurses were forced to act contrary to their own opinion, superior knowledge, and prudent medical reasoning in many situations.²⁰

With limited very basic supplies such as bed sheet, blanket, patient's gown, intravenous needle, syringe, nursing care would be challenging. Because of this, some health professionals would not touch patient due to perceived risk to acquiring infection to themselves. Various studies supported that scarce human and material resources in health care setting made difficult to ensure quality nursing care.^{12,16,17,19,26} Since only two nurses usually had to look after for 30 to 40 patients, nurses in this study believed that actual nursing care was missing. In such situation they were worried and concerned that it becomes habit of some nurses to avoid nursing procedures even if they had free time to care their patients. Another study showed that a nurse had too many patients and had no time to care for²⁰ so they could not maintain proper attitude towards patients and exhibited incorrect behavior.^{25,27}

In this study, nurses were not assigned to duty according to education, expertise and area of interest. They were not promoted timely, felt disrespected, neglected. That caused decreased self-esteem, demoralized, less motivation to work, feeling burn out thus increased errors in caring situation. Supported literatures showed nurses had mandatory overtime, rigid division of daily work, and work scheduling regardless of the nurses' experiences and preferences²⁸ and felt underappreciated and

respected as professionals^{16,28} that increased frustration.²⁹

Nurses found gap between nursing education and practice, they could not implement what was learnt in their class. Similar to this finding, nursing students in their clinical posting found gap between theory learnt at college and the moral course of action in practice.³⁰ Nurses found their job description unclear and not specific to practical situation. They perceived high responsibility on duty without authority that created role confusion. Ambiguous nursing job description caused nurses to face ambiguous nursing role and confusion in their duty.¹⁷

CONCLUSION

It can be concluded that nurses perceive ethically challenged when they could not accomplish their professional obligations in their work with what they believed they must do and when they have to witness these situations. All nurses experience ethical challenges in their duty and experience of such situation is painful. Work overload and stressful working situations hinders delivery of quality care. Ethical challenges in nurses' duty need to be recognized and has to be supported through continuous professional development program.

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