

Moral Distress among selected Sri Lankan Medical Officers

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Abstract:

Introduction

Moral distress was first defined as a phenomenon that occurs when nurses cannot carry out what they believe to be ethically appropriate actions because of various constraints. Now it has been discovered that other healthcare professionals also undergo moral distress.

Objective

The objective of the study was to assess the level of moral distress among medical officers in selected health care institutions in Sri Lanka.

Methods

A Multi centered descriptive cross-sectional study was carried out among 156 medical officers in 04 selected government healthcare institutions in Sri Lanka using a validated pretested self-administered questionnaire.

Results

“Carry out medical orders for what I consider to be unnecessary tests and treatments” was the most frequently encountered moral distress situation as declared by the majority (69.2%, n=108) of participants. Similarly, it was the situation which has caused highest intensity of moral distress as declared by 64.5% (n=100) of participants.

There was a significant association between average working hours per week and frequency of moral distress at 5% significance level with a p value of 0.001. Work setting (p=0.019), average working hours per week (p=0.001) and highest educational qualification (p=0.034) had a significant association with the intensity of moral distress.

Conclusion & Recommendations

The frequency of moral distress was significantly associated with average working hours per week. The intensity of moral distress was significantly associated with average working hours of per week, highest educational qualification and work setting.

Therefore, it is recommended that the Sri Lankan health authorities should train Medical Officers to cope up with moral distress situations.

Key words

Moral distress, frequency of moral distress, intensity of moral distress

Introduction

Moral distress was first defined as a phenomenon that occurs when nurses cannot carry out what they believe to be ethically appropriate actions because of various constraints.⁽¹⁾ These constraints include inadequate resources, excessive workloads, lack of time, high patient acuity, patient care concerns, conflicting patient-family needs and professional conflict.⁽²⁾ It is now known that other healthcare professionals are also affected by moral distress which leads to frustration, depression, absenteeism, job dissatisfaction that might negatively affect patient care.⁽³⁾⁽⁴⁾

This cross-sectional study was carried out to assess the level of moral distress among medical officers in selected health care institutions in Sri Lanka.

Methods

A descriptive cross-sectional study was carried out in 04 government healthcare institutions namely, The Police Hospital Narahenapita, Ashroff Memorial Hospital Kalmunai South, Base Hospital Pottuvil and De Soysa Hospital for Women Colombo which were selected on convenience of the researchers. The study was carried out for a period of 03 months from January 2020. The study population was the Grade Medical Officers of the above healthcare institutions. No specific sampling method was used and the total study population (N=239) was included in the study. The criterion for the inclusion was service experience more than 06 months and those who were on leave for more than 06 months were excluded from the study. A validated pretested self-administered questionnaire was used for data collection. It was developed based on a questionnaire used by Clark and the team using the 21 MDS- R (Moral Distress Scale-Revised)⁽⁵⁾. The questionnaire consisted of 2 main sections. Section A which consisted of questions related to socio demographic data of participants (question 01 to 08) and Section B which consisted of questions related to frequency of encounters of moral distress and intensity of distress (questions 09 to 29). In sections B “frequency of encounters” was measured using a 5-point Likert scale ranging from “Never” (0) to “Very Frequently” (4) and “intensity of moral distress” was measured using a 5-point Likert scale ranging from “None” (0) to “Great Extent” (4). The questionnaire was validated to suit Sri Lankan set up with expert opinion, pretesting and revision of questions based on feedback provided at pretesting.

Data Analysis

The data extracted from questionnaires were coded and first entered in an Excel spreadsheet. After rectifying errors data were transferred into Statistical Package for the Social Sciences (SPSS 21.0) for analysis. The data were summarized, and frequencies, percentages and means were calculated. To assess the association between the variables Chi square test was used and $p < 0.05$ was recognized as statistically significant.

Ethical Approval

Ethical approval for the study was obtained from Ethical Review Committee Faculty of Medicine University of Colombo (REFERENCE:EC-19-148). The administrative clearance was obtained from the respective heads of institutions where the study was carried out. Informed written consent was taken from all participants before data collection.

Results

The socio demographic characteristics are summarized in Table 1.

Table 1 Socio Demographic Characteristics of Participants

Socio Demographic characteristics		Mean (SD)	Frequency(n) (%)
Age		38.60(8.514) yrs.	
Experience		09.96(7.829) yrs.	
Gender	Male		93(59.4%)
	Female		63(40.4%)
Marital Status	Never Married		25(16.0%)
	Married		129(82.7%)
	Divorced		02(01.3%)
Work Setting	Medical Area		79(51.0%)
	Surgical /Operating Area		22(14.2%)
	Emergency Room		19(12.3%)
	Intensive Care Unit		18(11.6%)
	Paediatrics		05(03.3%)
	Day Clinics		12(07.7%)
Average Working Hours	31-40 hours		04(02.6%)
	41-50 hours		35(22.4%)
	51-60 hours		94(60.3%)
	>61 hours		23(14.7%)
Highest Educational Qualification	Master's Degree		12(07.7%)
	Post Graduate Diploma		39(25.0%)
	Bachelor's Degree		105(67.3%)
Considering to Leave job Due to Moral Distress	Yes		08(05.2%)
	No		146(93.6%)

Out of the total number of participants (239), only 156 participants returned the completed questionnaire which resulted in a response rate of 65.2%. Among the respondents majority (59.4%,n=93) were males, 82.7%(n=129) were married, 51%(n=79)working in the Medical speciality,60.3%(n=94) working for 51 to 60 hours per week, 67.3%(n=105) had Bachelor's Degree as the highest educational qualification with a mean age of 38.6(SD=8.5)years and mean experience of 9.9(SD=7.8) years. Majority (93.6%, n=146) were not considering leaving job due to moral distress. (Table 1)

In the questionnaire frequency of moral distress encounters were categorized in a 5 point Likert scale ranging from "Never" (0) to "Very Frequently" (4), during analysis those were categorized into 3 groups as "Never" which included "0" in the Likert scale, "Low" which included "1" and "2" and " High" which included "3" and "4". (Table 2)

Statement (14) "Carry out medical orders for what I consider to be unnecessary tests and treatments", statement (13) "Follow the family's request not to discuss death with a dying patient who asks about dying" and (12) " Initiate extensive life-saving actions when I think they only prolong death" with frequencies of 69.2%(n=108),61.5%(n=96) and 60.3%(n=94) respectively have been recorded as the mostly encountered moral distress situations.(Table 2)

Majority of respondents have agreed that they have never encountered situations such as statement (22) "Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient's death"72.9%(n=113), statement (10) "Witness healthcare providers giving "false hope" to a patient or family"70.3%(n=109) and (24) "Follow the family's wishes for the patient's care when I do not agree with them, but do so because of fears of a lawsuit" 63.2%(n=98).(Table 2)

Table 2 Frequencies of Moral Distress Encounters of Participants

Moral Distress Statement	Frequency of Moral Distress Encounters		
	Never	Low	High
9. Provide less than optimal care due to pressures from administrators or insurers to reduce costs.	(96)61.5%	(59)37.8%	(1)0.6%
10. Witness healthcare providers giving “false hope” to a patient or family.	(109)70.3%	(46)29.7%	(00)0%
11. Follow the family’s wishes to continue life support even though I believe it is not in the best interest of the patient.	(25)16%	(43)27.6%	(88)56.4%
12. Initiate extensive life-saving actions when I think they only prolong death.	(07)4.5%	(55)35.3%	(94)60.3%
13. Follow the family’s request not to discuss death with a dying patient who asks about dying.	(20)12.8%	(40)25.6%	(96)61.5%
14. Carry out medical orders for what I consider to be unnecessary tests and treatments.	(14)09%	(34)21.8%	(108)69.2%
15. Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support.	(21)13.5%	(68)43.6%	(67)42.9%
16. Avoid taking action when I learn that a colleague has made a medical error and does not report it.	(28)18.1%	(119)76.8%	(08)06.2%
17. Assist a healthcare provider who, in my opinion, is providing incompetent care.	(21)13.5%	(74)47.4%	(61)39.1%
18. Be required to care for patients I don’t feel qualified to care for	(89)57.4%	(54)34.8%	(12)7.7%
19. Witness students perform painful procedures on patients solely to increase their skill	(19)12.2%	(51)32.7%	(86)55.1%
20. Provide care that does not relieve the patient’s suffering because other healthcare providers fear that increasing the dose of pain medication will cause death	(72)46.5%	(72)46.5%	(11)7.1%
21. Follow the healthcare providers’ request not to discuss the patient’s prognosis with the patient or family	(56)36.1%	(80)51.3%	(19)12.3%
22. Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient’s death.	(113)72.9%	(38)24.5%	(04)2.6%
23. Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.	(81)52.3%	(72)46.5%	(02)1.3%
24. Follow the family’s wishes for the patient’s care when I do not agree with them, but do so because of fears of a lawsuit	(98)63.2%	(53)34.2%	(4)2.6%
25. Work with other healthcare providers who are not as competent as the patient care requires	(86)55.5%	(55)35.5%	(14)9%
26. Witness diminished patient care quality due to poor team communication	(45)29%	(66)42.6%	(44)28.4%
27. Ignore situations in which patients have not been given adequate information to insure informed consent	(44)28.4%	(76)49%	(35)22.9%
28. Watch patient care suffer because of a lack of provider continuity.	(34)21.9%	(111)71.6%	(10)6.5%
29. Work with levels of healthcare staffing that I consider unsafe	(60)38.7%	(86)55.5%	(9)5.8%

In the questionnaire intensity of moral distress encounters was categorized in a 5-point Likert scale ranging from “None” (0) to “Great Extent” (4). During analysis those were categorized into 3 groups as “None” which included “0” in the Likert scale, “Low Extent” which included “1” and “2” and “High Extent” which included “3” and “4” as in Table 3.

Majority of respondents(64.5%,n=100) have experienced “ High Extent” of moral distress in situations like “Carry out medical orders for what I consider to be unnecessary tests and treatments”(statement 14), (63.5%,n=99)participants (statement 19) “Witness students perform painful procedures on patients solely to increase their skill” and (62.6%,n=97)participants (statement 12) “Initiate extensive life-saving actions when I think they only prolong death”.(Table 3).

Majority of respondents(70.8%,n=109) claim that they have “no moral distress” in situations like “Witness healthcare providers giving “false hope” to a patient or family”, “Follow the family’s wishes for the patient’s care when I do not agree with them, but do so because of fears of a lawsuit” (63.6%,n=98) and “Provide less than optimal care due to pressures from administrators or insurers to reduce costs” with a percentage of 63.2%(n=98). (Table 3)

Table 3 Intensity of Moral Distress of Participants

Moral Distress Statement	Intensity of Moral Distress		
	None	Low Extent	High Extent
9. Provide less than optimal care due to pressures from administrators or insurers to reduce costs.	(98)63.2%	(50)32.3%	(07)4.5%
10. Witness healthcare providers giving “false hope” to a patient or family.	(109)70.8%	(40)26%	(05)3.2%
11. Follow the family’s wishes to continue life support even though I believe it is not in the best interest of the patient.	(23)14.8%	(44)28.4%	(88)56.8%
12. Initiate extensive life-saving actions when I think they only prolong death.	(08)5.2%	(50)32.3%	(97)62.6%
13. Follow the family’s request not to discuss death with a dying patient who asks about dying.	(24)15.5%	(118)76.1%	(13)8.4%
14. Carry out medical orders for what I consider to be unnecessary tests and treatments.	(13)8.4%	(42)27.1%	(100)64.5%
15. Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support.	(15)9.7%	(73)47.1%	(67)43.2%
16. Avoid taking action when I learn that a colleague has made a medical error and does not report it.	(26)16.9%	(116)74.8%	(13)8.4%
17. Assist a healthcare provider who, in my opinion, is providing incompetent care.	(25)16%	(65)41.7%	(66)42.3%
18. Be required to care for patients I don’t feel qualified to care for	(96)61.9%	(52)33.5%	(07)4.5%
19. Witness students perform painful procedures on patients solely to increase their skill	(15)9.6%	(42)26.9%	(99)63.5%
20. Provide care that does not relieve the patient’s suffering because other healthcare providers fear that increasing the dose of pain medication will cause death	(71)45.8%	(60)38.7%	(24)15.5%
21. Follow the healthcare providers’ request not to discuss the patient’s prognosis with the patient or family	(52)33.5%	(75)48.4%	(28)18.1%
22. Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient’s death.	(110)71%	(27)17.4%	(18)11.6%
23. Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.	(88)56.8%	(38)24.5%	(29)18.7%
24. Follow the family’s wishes for the patient’s care when I do not agree with them, but do so because of fears of a lawsuit	(98)63.6%	(40)26%	(16)10.4%
25. Work with other healthcare providers who are not as competent as the patient care requires	(85)54.8%	(28)18.1%	(42)27.1%
26. Witness diminished patient care quality due to poor team communication	(46)29.9%	(51)33.1%	(57)37%
27. Ignore situations in which patients have not been given adequate information to insure informed consent	(48)31%	(57)36.8%	(50)32.3%

28. Watch patient care suffer because of a lack of provider continuity.	(33)21.3%	(81)52.3%	(41)26.5%
29. Work with levels of healthcare staffing that I consider unsafe	(60)38.7%	(67)43.2%	(28)18.1%

The association between some of the selected socio demographic factors and frequency of moral distress was analyzed using Pearson Chi square test as in Table 4.

Table 4 Association between selected socio demographic characteristics and frequency of moral distress

Socio demographic characteristic	Chi square value	p value
Work setting	9.977	0.443
Average working hours per week	28.77	0.001

(Level of significance 5%)

According to Table 4 there was a significant association between average working hours and frequency of moral distress ($p=0.001$) at 5% significance level. But there was no evidence to prove a significant association between work setting and frequency of moral distress.

Table 5 shows the association between selected socio demographic characteristics and intensity of moral distress.

Table 5 Association between selected socio demographic characteristics and intensity of moral distress

Socio demographic characteristic	Chi square value	p value
Experience	0.333	0.847
Gender	0.521	0.771
Marital status	3.802	0.148
Work setting	21.286	0.019
Average working hours per week	34.855	0.001
Highest educational qualification	10.434	0.034
Considering to leave job due to moral distress	4.057	0.132

(Level of significance) 5%

According to Table 5 work setting ($p=0.019$), average working hours ($p=0.001$) and highest educational qualification ($p=0.034$) had a significant association with intensity of moral distress.

Discussion

In Sri Lanka, most of the doctors (60.3%, $n=94$) work for 51-60 hours as usually there are only 04 Grade Medical Officers in a unit and each doctor must do at least 02 on call duties per week in addition to their normal duty hours. The majority (67.3%, $n=105$) have earned only bachelor's degree as their highest educational qualification and this is due to the fact that unless doctors want to become medical specialists they remain as Grade Medical Officers which is sufficient to become successful General Practitioners while engaging in government service as well. It is interesting to note that majority (93.6%, $n=146$) haven't thought of leaving their

job due to moral distress. In Sri Lanka, despite a lot of sacrifices made to become a doctor, being a doctor is considered as a privilege. Even though it is a very stressful and distressing very rarely doctors think of quitting their job. On the other hand, when the job is a permanent job with entitlement for pension and other privileges, they rarely think about quitting the job. Moreover, if they quit the job, they cannot find a suitable alternative job instead. This is quite different from the results of a similar study done in Saudi Arabia among 342 nurses, physicians and consultants where 42.8%(n=137) were willing to leave their job due to moral distress.⁽⁶⁾

The most frequently encountered moral distress situation by majority of Sri Lankan doctors (69.2%, n=108) was “Carry out medical orders for what I consider to be unnecessary tests and treatments” (Table 2). In Sri Lanka healthcare is given free of charge at the point of delivery and even for a patient in ICU most of the medical tests and advanced treatment are provided free of charge. Therefore, there is a tendency for consultants to order extensive tests and treatment for patients. “Follow the family’s request not to discuss death with a dying patient who asks about dying” is the second most frequently encountered moral distress situation as claimed by 61.5%(n=96) participants. This is due to that in Sri Lankan culture it is believed that a dying person should be kept happy and if he is worried about impending death, his next birth will be in a bad place. Sri Lankan doctors respect family members’ will over the patient’s right to know the truth about his condition although this is against clinical ethics. Even though consultants know that initiation of extensive life saving measures to save the patient’s life is sometimes rarely useful they tend to do so due to cultural and religious beliefs being the majority of Sri Lankans are Buddhists (70.1%).⁽⁷⁾ Therefore, “Initiate extensive life-saving actions when I think they only prolong death” has come to the third place(60.3%, n=94). This practice goes hand in hand with “beneficence” in ethical principles. This is a bit similar to the results of a cross sectional study done in Bandung city among Emergency Department nurses where “Initiate extensive life-saving actions when I think they only prolong death” has come to the second most frequent moral distress situation with a rate of 2.14(SD=1.21).

In another study done in US on this subject the second and the third most common moral distress situations faced by medical doctors “Follow the family’s wishes to continue life support even though I believe it is not in the patient’s best interest” with a mean score of 4.54 (SD=4.41) and “Initiate extensive life-saving actions when I think they only prolong death” with a mean score of 4.15 (SD=3.89).⁽³⁾ Although the latter is similar to the Sri Lankan context the preceding situation may be common in US due to USA doctors’ fear of lawsuit.

The reason that “Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient’s death”72.9%(n=113) and “Witness healthcare providers giving “false hope” to a patient or family”70.3%(n=109) as the least common situations in the Sri Lankan study may be due to religious beliefs. “Follow the family’s wishes for the patient’s care when I do not agree with them, but do so because of fears of a lawsuit” 63.2% (n=24) is also not common in Sri Lanka as the health literacy of Sri Lankans is not much high and most of them believe that doctors will decide on the “best thing” for patients. This result is somewhat similar to a study done in New Zealand among 412 nurses where “Follow the family’s wishes to continue life support even though it is not in the best interest of the patient” was found as one of the least frequently encountered situation with a mean of 0.95 (SD=0.98).⁽⁸⁾

“Carry out medical orders for what I consider to be unnecessary tests and treatments”(64.5%, n=100) has become the situation which gives “high extent” of moral distress for majority of Sri Lankan doctors and “Initiate extensive life-saving actions when I think they only prolong death” (62.6%, n=97) has come to the third place.(Table 3). These are the most frequently encountered moral distress situations as well.(Table 2). Even though consultants order tests, treatments and lifesaving actions, as the Grade Medical Officers are the frontline healthcare workers who perform those when they face reality their extent of moral distress might become high. Likewise, they undergo “high extent” of moral distress when they happen to “Witness students perform painful procedures on patients solely to increase their skill” (63.5%, n=99) (Table 3). This may be due to their empathy towards patients. This result is similar to the results of the study done in Bandung city where “Viewing medical students doing painful procedures for patients who only aim to improve their skill with a mean score of 2.23(SD=1.342) and “Doing a doctor’s order to do what I consider to be unnecessary tests and/or treatments with a mean of 2.12 (SD=1.238).⁽⁹⁾

The majority of respondents (70.8%(n=109) claim that they have no moral distress in situations like” Witness healthcare providers giving “false hope” to a patient or family” with a percentage of, “Follow the family’s wishes for the patient’s care when I do not agree with them, but do so because of fears of a lawsuit”(63.6%,n=98) (Table 3). It is important to note that most of the doctors have never faced these two situations. (Table 2). As these two situations were rare it might be difficult for them to rate the intensity of moral distress if they happened to face with such situations. Therefore, majority might have claimed that they would not experience moral distress in such situations.

It is quite normal to see that when duration of work increases, frequencies of moral distress situations increase. As in Table 4 there is a significant association between average working hours and frequency of moral distress at 5% significance level (p= 0.000). But it should be noted that it does not explain whether this association is positive or negative. It is interesting to note that there is no significant association between work setting and frequency of moral distress. The reason may be that only 11.6%(n=18) of participants were from work settings as ICU where such situations frequently occur. (Table 1)

As in Table 5 it was found that gender, marital status and intention to leave job due to moral distress have no significant association with intensity of moral distress. The reason may be that moral distress depends on personality of doctors rather than other socio demographic factors. This is a bit different from the results of a study done in UK in 2015 among 171 ICU doctors and nurses where it was found that there is a significant association between the female gender and composite score of moral distress(p= 0.01).⁽¹⁰⁾ But

the above result of the local setting is a bit similar to the results of the study done among healthcare workers of Saudi Arabia in which it was revealed that there was no association between moral distress and the gender of the participants⁽⁶⁾

The work setting of Grade Medical Officers have a significant association with intensity of moral distress($p=0.019$). (Table 5). The reason may be that majority of the participants (62.6%) (Table 1) were from Medical area and Intensive Care Unit who experience more intense moral distress situations.

When duration of working hours increases it is quite natural to increase intensity of moral distress. This may be the reason for to be seen in Table 5 that there was a significant association between average working hours per week and intensity of moral distress($p=0.000$).

According to Table 5 highest educational qualification($p=0.034$) have a significant association with intensity of moral distress. This may be due to the reason that when doctors undergo training to increase their qualifications, they face more intensive moral distress situations. But from these results we cannot conclude whether there is a positive or negative association with educational qualifications and intensity of moral distress.

In the local study years of experience of doctors have no significant association with intensity of moral distress($p=0.847$) at 5% level of significance. (Table 5) Here the cut off value for years of experience was considered as the median (7.5 years) of the distribution as it was positively skewed.

This finding in the local study goes hand in hand with the study done in Tehran among physicians who practice in University hospitals where it was found that there was no relationship between work experience and intensity of moral distress.⁽¹¹⁾ This may be due to the fact that moral distress is a personal experience rather than a situational experience.

The association between age and intensity of moral distress was not analyzed here as age and years of experience have a positive relationship and it was predicted that the association between age and intensity of moral distress would be same as the association between intensity of moral distress and years of experience.

Limitations

There are several limitations of the study. The participants had to recall moral distress situations they have encountered which led to recall bias. Therefore, to receive more accurate data a prospective study should be done. The sensitive nature of moral distress situations might lead to underreporting of such incidents. This is another limitation of the study. The small sample size of the study might have given different results. Another limitation is that most of the research done on moral distress among healthcare workers are done among nurses. Therefore, it is very difficult to find sufficient literature on studies done on doctors.

In this study only the Grade Medical Officers were included. As a result, the findings could not be generalized for specialist medical officers and intern medical officers.

The study was conducted in 04 study settings representing different provinces in the country. Therefore, when compared to a study done in a single study setting the generalizability of the results were high. This was one strong point in this study.

Conclusion & Recommendations

Carrying out medical orders which seems to be unnecessary tests and treatments was the most frequently encountered as well as causing highest intensive moral distress situation for majority of Sri Lankan doctors. There was a significant association between average working hours and frequency of moral distress. But there was no evidence to prove a significant association between work setting and frequency of moral distress. Work setting, average working hours and highest educational qualification had a significant association with intensity of moral distress. The experience, gender, marital status and considering leaving job due to moral distress had no significant association with intensity of moral distress.

Therefore, it is recommended that Sri Lankan health authorities should take necessary actions to minimize moral distress situations by conducting training sessions on strategies to reduce moral distress like Yoga exercises, formation of self-help groups and clinical case conferences about moral distress situations. Strategies should be found to reduce average working hours per week as well. Periodic rotation of work setting will also help to minimize intensity of moral distress.

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