

Introduction

Nursing can be a stressful career choice given the complexity of the health care environment, acuity of child patients and explosion of new technology and an increasing demand for accountability in meeting pediatric patient safety and quality needs (**Parker et al., 2013**).

Pediatric nurses caring for pediatric patients with life limiting illness not only care for the physical needs of these pediatric patients and their families, but also, the psychosocial, emotional and spiritual needs. Care of critically ill pediatric patients requires the integration of highly technical skills with psychosocial and spiritual support (**Rogers, 2011, Hassan et al., 2013**).

Moral distress is a serious problem among pediatric nurses who work in a high stress environment and face daily challenges and many ethical situations in their practice and having no voice in the decision-making process. In addition critical care nurses continue to make moral decisions about their actions and regularly face moral situations and are distressed by them (**Nalley, 2013, Ibrahim et al., 2014**).

A concept of moral distress has been defined in somewhat varied ways over the years, it is generally refers to an experience when a person knows what is right to do but doesn't do it because

of external or internal impediments to the person's actions **(Carnevale, 2013)**.

Pediatric nurses might experience moral distress in practice but may not be familiar with the phenomenon which describes their experiences and resulting feelings, furthermore, it may not realize there are resources to deal with moral distress before it becomes a destructive force personally and affects their job satisfaction negatively **(Sauls, 2011)**.

Moral distress is the result of a dynamic interplay between a number of complex factors including personal values and morals, interpersonal relationships, power and empowerment, institutional and contextual constraints, professional ideals, organizational structure, economic constraints, and other social actors. In particular, moral distress may be an outcome of the complex dynamics of individual moral stance, nurses' role identification, particularly concerning moral decision making, conflict between moral claims, personal empowerment, and institutional constraints **(Beheshtifar, 2014)**.

In recognition of harmful effects of moral distress on pediatric nurses, pediatric patients, families and health care organizations, the provision of education and tools to address and manage moral distress in the work environment is imperative and will lead to essential improvements in pediatric patients care and

outcomes (American Association of Critical-Care Nurses (AACN), 2008).

Significance of the study

Nurses in pediatric intensive care units are at higher risk for moral distress due to the nature of children conditions and related ethical issues arising in these settings especially in light of the increasing complexity of the healthcare environment that may include performance expectations, finite resources, technology advancement and the competitive globalization of healthcare (**De Villers, 2010, Edmonson, 2010**).

Moral distress in health care has been identified as a growing concern and a focus of research in nursing and health care for almost three decades. Although moral distress is a well-documented phenomenon with its negative consequences, there are no studies conducted in Egypt to explore nurses' moral distress and its impact and related factors in the pediatric critical care units.

Aim of the Study

This study aimed to assess moral distress of nurses working in pediatric intensive care unit.

Research questions

1. What situations are associated with moral distress in pediatric ICU?
2. What are the intensity and frequency of moral distress of nurses in pediatric ICU?
3. Are there a relation between nurses' socio-demographic characteristics and their level of moral distress?

Review of Literature

Part I: Moral distress

Jameton, (1984) coined the term moral distress and identified three types of ethical conflict which nurses may experience in the clinical setting: moral uncertainty, moral dilemma and moral distress (**Falcó-Pegueroles et al., 2013**).

Jameton, (1993) later made a distinction between two forms of distress called initial and reactive distress. Initial distress is felt in the form of frustration, anger and anxiety when confronted with institutional obstacles, while reactive distress is the distress that felt when the people do not act upon their initial distress (**Silén, 2011**).

Definitions of moral distress

Moral distress is defined as the painful psychological disequilibrium that results from recognizing an ethically appropriate action that is difficult to take because of institutional obstacles such as a lack of time, supervisory reluctance, an inhibiting medical power structure, institutional policy, or legal considerations (**Corley et al., 2001**).

Moral distress is the pain or anguish affecting the mind, body or relationships in response to a situation in which the person is aware of a moral problem, acknowledges moral responsibility and makes a moral judgment about the correct action. It is traditional

negative stress symptoms that occur due to situations that involve ethical dimensions and where the healthcare provider feels not being able to preserve all interests and values at stake (**Nathaniel, 2002, Kälvemark et al., 2004**).

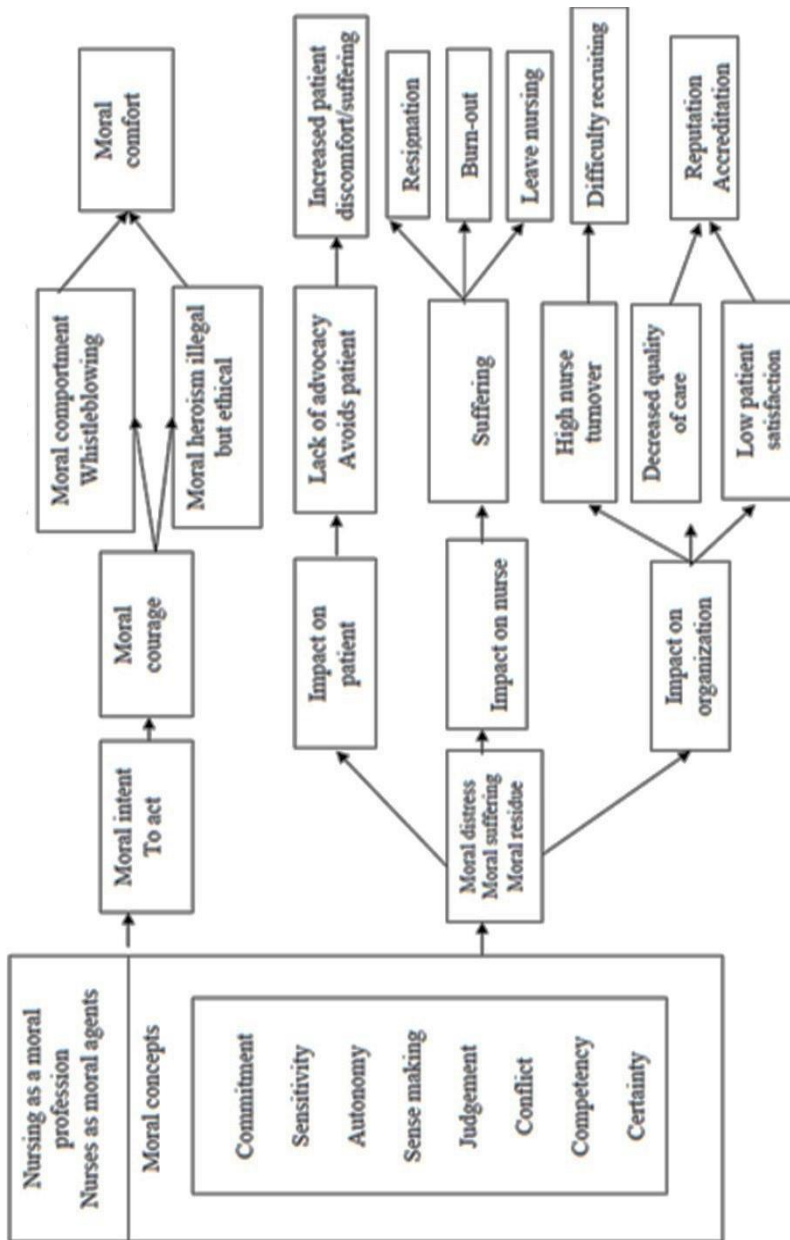
Moral distress is a form of distress that occurs when one knows the ethically correct thing to do, but is prevented from acting on that perceived obligation was known as moral distress. It is physical or emotional suffering that is experienced when constraints (internal or external) prevent one from following the course of action that one believes is right (**AACN, 2004, Pendry, 2007**).

As mentioned by **Schluter et al., (2008)** moral distress is an emotion that is expressed when the moral complexity of a situation is not leading to a resolution, thereby having the potential to cause harm to the individual nurse. Meanwhile, it is feelings of frustration, anger and anxiety when facing institutional obstacles and interpersonal conflicts about ones values (**Unruh, 2010**).

Theoretical Framework of moral distress

Corley, (2002) proposed a moral distress theory that is based on Jameton's moral distress concept and as seen in figure (1) (**Aft, 2011**).

Figure (1): Corley's Theory of Moral Distress.



Corley, M. (2002): Nurse moral distress: a proposed theory and research agenda. *Nursing Ethics*, 9, (6), Pp 636-650.

Corley's theory is based on two premises nursing is a moral profession and nurses are moral agents. When a nurse cannot enact moral agency becomes vulnerable to moral distress (**De Villers, 2010**).

The theory explained how moral distress impacts the nurse, the patient, and the organization. The result of moral distress on the patient is a nurse who avoids the patient and does not act as an advocate. The impact of moral distress on the nurse is suffering and that is lead to resignation from a position, burn-out or abandonment of nursing. The impact that moral distress has on the institution is high nurse turnover, low patient satisfaction, and decreased quality of care (**Aft, 2011**).

The theory lists the interrelated moral concepts that nurses embody as part of their development as moral agents and are important in explaining nurses' vulnerability to moral distress. These moral concepts are commitment, sensitivity, autonomy, sense making, judgment, conflict, competency, and certainty. If nurses in their workplaces are easily able to adhere to these basic moral concepts, they will maintain their moral integrity and experience moral comfort. If they cannot adhere to these moral concepts in their workplace, moral distress will result (**Sauls, 2011**).

These concepts defined by **Corley, (2002)** as the following

Moral commitment is defined as engagement with a moral issue in patient care, loyalty to the values involved and a willingness to take risks. Moral commitment is instrumental in the development of moral competency, enabling nurses to engage in moral practice and, as a result, experience less moral distress. Nurses are committed to their patients.

Moral sensitivity is the ability to recognize a moral conflict, show a contextual and intuitive understanding of the patient's vulnerable situation and have insight into the ethical consequences of decision on behalf of the person.

Moral autonomy is the freedom, right and responsibility to make choices.

Moral sense making is the structuring of moral meaning.

Moral judgment involves integrating numerous ethical considerations that count for or against a particular course of action in order to determine what ought to be done in a specific situation.

Moral conflict is a situation involving a clash of moral values concerning what is the morally right action to take.

Moral competency is the ability to make moral sense of situations, use good moral judgment and intention and engage in morally appropriate behavior.

Moral certainty is a feeling of absolute moral conviction that leads nurses to risk self, personally and professionally, to act on the 'rightness' of that conviction.

Types of moral Experience

There are many types of moral experience as, moral uncertainty, moral dilemmas, moral distress, moral residue, moral courage and emotional distress (Taylor, 2013).

Moral uncertainty

Moral uncertainty is a type of moral experience that occurs when pediatric nurses are uncertain if a moral problem exists, are unsure about its nature and are unclear which values conflict and which principles might facilitate clarification. For example moral uncertainty occurs when pediatric patient seems to be suffering unnecessarily and refusing pain medication and not being able to explain reasons for refusing efforts to help (Schwarz & Torzian, 2009).

Moral dilemma

Moral dilemma is a type of moral experience that occurs when two or more opposing actions can be equally justified and the pediatric nurse is unable to carry out both actions, thus faces a dilemma in choosing which ethical course to follow. It is impossible to choose an action without some form of loss by not taking the other course (Glidewell, 2012).

Moral residue

Moral residue is a type of moral experience that occurs in situations of moral distress when moral values have been violated due to constraints beyond control and the moral wound of acting against pediatric nurses' values remains. Moral residue is long-lasting and powerfully integrated into one's thoughts and views of the self. It is this aspect of moral distress the residue, that remains and that can be damaging to the self and one's career (**Epstein & Delgado, 2010**).

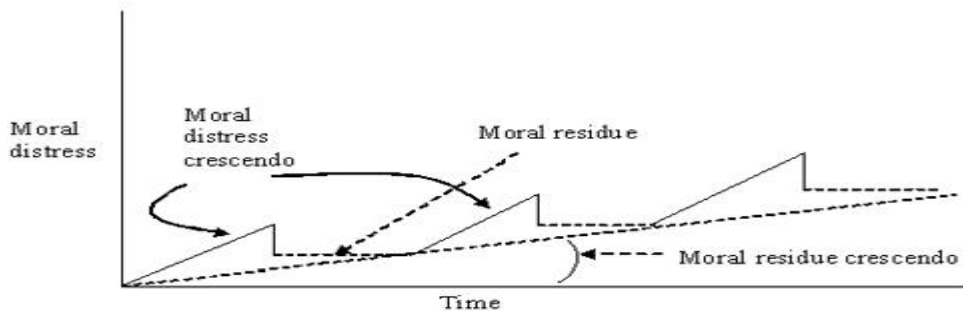
Crescendo effect

Epstein and Hamric, (2009) coined the term Crescendo Effect to refer to the cumulative building of moral distress over time that occurs with repeated exposure to morally distressing cases (**Weinzimmer et al., 2014**).

The crescendo effect model describes the interaction of two crescendos that are often experienced by nurses where an increase in moral distress causing an increase in moral residue as seen in Figure (2) (**Epstein & Hamric, 2009**).

Figure (2): Crescendo Effect.

(Solid lines indicate moral distress, dotted lines indicate moral residue)



Epstein, E., Hamric, A. (2009): Moral distress, moral residue, and the crescendo effect. *Journal of Clinical Ethics*, 20, (4), Pp 330–342.

Moral Courage

Moral courage is a type of moral experience and it is defined as doing the right thing even at the risk of inconvenience, ridicule, punishment, loss of job or security or social status, etc. It is vital to the willingness of individuals to take hold of and fully support ethical responsibilities essential to professional values. The ultimate goal of morally courageous behavior is to put ethical principles into action and protect ethical values perceived to be at risk. If nurses have a sufficient moral courage moral distress may didn't occur (**Gallagher, 2010, Murray, 2010, Dungate, 2011**).

Barriers to showing moral courage

All healthcare organizations and professionals have a responsibility to uphold high ethical standards and nursing leaders

are responsible for creating cultures that support acts of courage in nursing, so ethics experts have identified several barriers to morally courageous behavior: Organizational culture which sets the stage for how individuals respond to unethical behavior, lack of concern by colleagues who don't have the moral courage to take action, groupthink in which individuals collectively decide to look the other way when unethical behaviors occur with subsequent loss of independent thinking, and Preference for redefining unethical actions as acceptable (**Edmonson, 2010 , Lachman et al., 2012**).

Emotional distress

Emotional distress is a type of moral experience and it is defined as a highly unpleasant emotional reaction such as anguish, humiliation or fury which results from another's conduct. It is meaningful to distinguish moral distress from emotional distress and other kinds of distress which is more generic and may occur in a stressful work environment but may not have an ethical element (**Glidewell, 2012, De Veer et al., 2013**).

Pediatric nurse may be emotionally distressed, while restraining a pediatric patient, but is likely to become morally distressed only if the nurse believes that restraining the pediatric patient is morally wrong. Similarly a pediatric nurse may be

stressed because of long working hours but is likely to become morally distressed only when worrying that this impacts negatively on the quality of care. This requires moral reflection, reasoning and agency (**McCarthy & Deady, 2008**).

Causes of Moral Distress

A lot of researchers identify different causes of moral distress, but in any given situation not everyone will be morally distressed because the experience of moral distress is a personal, individual and in important ways a unique experience even when several people are distressed at the same set of events. In addition to values and obligations are perceived differently by various members of the pediatric healthcare team (**Epstein & Delgado, 2010, Kondrat, 2014**).

There are three categories of constraints that may lead to moral distress. These categories are: clinical situations care, internal constraints and external constraints. Root causes stemming from clinical situations describe commonly occurring situations that have been found to generate moral distress among healthcare providers, internal constraints refer to personal characteristics of providers and external constraints include factors inherent to a particular institution or common within the healthcare system as seen in table (1) (**Hamric et al., 2012**).

Table (1): Major Root causes of moral distress.

Clinical situations care
<ul style="list-style-type: none">• Providing unnecessary /futile treatment• Using resources inappropriately• Prolonging the dying process through aggressive treatment• Providing care that is not in the best interest of the patient• Inadequate informed consent• Providing inadequate pain relief• Working with caregivers who are not as competent as care requires• Providing false hope to patients and families• Hastening the dying process• Lack of truth-telling• Disregard for patient wishes• Lack of consensus re: treatment plan• Lack of continuity of care• Conflicting duties
Internal constraints
<ul style="list-style-type: none">• Perceived powerlessness• Lack of knowledge of alternative treatment plans• Inability to identify the ethical issues• Increased moral sensitivity• Lack of understanding the full situation• Lack of assertiveness• Self-doubt• Socialization to follow others
External constraints
<ul style="list-style-type: none">• Inadequate communication among team members perspectives• Tolerance of disruptive and abusive behavior• Differing inter- (nurse to doctor) or intra-professional (nurse to nurse)• Compromising care due to pressures to reduce costs• Inadequate staffing and increased turnover• Hierarchies within healthcare system• Lack of administrative support• Lack of collegial relationships• Policies and priorities that conflict with care needs• Nurses not involved in decision-making• Following family wishes of patient care for fear of litigation• Compromised care due to insurance pressure or fear of litigation

Hamric A., Borchers C., Epstein E. (2012): Development and testing of an instrument to measure moral distress in health care professionals. *AJOB Primary Research*, 3, (2), Pp 1-9.

Pediatric nurses highlighted their role as patient advocate. Pediatric patients' advocacy requires nurses to support and protect their children, when the pediatric nurses cannot achieve these professional goals to protect children from harm, to provide care that prevents complications and to maintain a healing psychological environment for children and families, they suffer from moral distress (**Lachman et al., 2012, Shorideh et al., 2012, Weinzimmer et al., 2014**).

Pediatric nurses spend more time with children than any other health care discipline and have a much deeper knowledge of these pediatric patients and they understanding their situation, they also have an intimate knowledge of the relative risks and benefits of a proposed course of treatment. Thus, they're intimately involved in the suffering caused by both the illness and the treatment, but they're not in any position to make decisions about any of it. Pediatric nurses have little power and even less authority opinions are often discounted because they're "just nurses"(**janfrn, 2011**).

In the process of implementing a decision into clinical practice, it has been shown that this can prove to be difficult due to contextual factors that limit pediatric nurses' ability to act in the desired way. These include hierarchical relationships, traditional structures of power, not being involved in decision making, poor

cooperation with physicians and feelings of not being respected as a professional. Besides these contextual factors, personal factors such as knowledge, experience, risk taking and boldness facilitate this process (**Goethals et al., 2010, Silén, 2011**).

Futility care is a situation that arises frequently in some nursing environments. An example of futile care would be performing cardiovascular resuscitation. And it is defined as providing clinical services (diagnostic, preventive, therapeutic, and rehabilitative) for a patient whose possibility of returning to life both physiologically and qualitatively is less than 5 per cent (**Houghtaling, 2012, Bahramnezhad et al., 2014**).

Involvement in the provision of care that pediatric nurses considered futile, or with no benefit to the patient, is a contributory factor to moral distress (**Gallagher, 2010**).

It is increasingly recognized that moral distress can be experienced in all health care professions and that some of the causes and solutions for addressing this concern are rooted in the inter-relations between these professions where in the healthcare workplace, there is always someone whom to report and someone from whom to take a report (**Jani, 2012**).

Nursing has been regarded a profession of self-sacrifice, duty, and service, that a pediatric nurse's primary responsibility is to follow the directives of the physician. Pediatric nurses have

personal values (moral agency) which may create role strain. Role strain is created by the sense of having two masters, the organization who pays their salaries and the physicians who direct their work (**Janfrn, 2011, Carnevale, 2013**).

Pediatric nurses experience moral and ethical situations revolving around distressing patient care dilemmas. Nurses have multiple ethical obligations including those to the children patient, the organization or institution in which they work, other healthcare professionals, and the nursing profession. Sometimes the pediatric nurse must decide to whom she or he owes a primary obligation. Therefore, moral distress is an ethical dilemma for nurses. The complexity and frequency of ethical dilemmas are the major determinants of the intensity of moral distress (**Unruh, 2010, Aft, 2011, Allari & Abu-Moghli, 2013**).

When confronted with an ethical problem pediatric nurses have to decide what actions to take in order to handle it, pediatric nurses often find themselves in ethically questionable situations that conflict with their personal and professional morals. Ethical conflicts are pervasive in today's healthcare settings, where organizations are trying to do more with less and medical advances and life-extending treatments often cause suffering (**Silén, 2011, Lachman et al., 2012, Wood, 2014**).

Pediatric nurses struggle to make clinical decisions involving conflicting ethical principles and these nurses often make ethical decisions whether knowingly or unknowingly during the course of their work because they are involved with human life's fundamental processes. Moral distress experienced when nurses felt powerless to implement changes or influence decision making (**Zuzelo, 2007, Shorideh et al., 2012, Huffman & Rittenmeyer, 2012**).

Individual nurses are not free to shape the ethical standards of their profession, nor are they free to act in any manner that they individually choose. These standards and actions are always socio-politically embedded (**Carnevale, 2013**).

When nurses unable to do what they consider the correct action and when face limitations in their capabilities for an autonomous practice, feeling forced to endanger their values and personal rules, they may experience moral distress (**Pauly et al., 2009, Regis & Porto 2011, Wood, 2014**).

Effects of moral distress

Moral distress has effects on the pediatric nurses, the pediatric patients and their families and the organizations (**Piers, 2010, O'Connell, 2015**).

Effects of moral distress on the nurses

Moral distress is a significant problem for pediatric nurses. It has physical, emotional and psychological sequels (**Kleinknecht-Dolf et al., 2014**).

Moral distress constitutes a significant cause of emotional suffering among pediatric nurses that may result in unfavorable outcomes for both nurses and pediatric patients. Moral distress can result in depression, anxiety, emotional withdrawal, frustration, anger and a variety of physical symptoms, such as headaches, insomnia, hypertension and gastrointestinal upset. Mentally, the nurse may feel “bogged down”, overloaded, anxious, and frazzled and the focus becomes doing the technical aspects of the job without the caring and critical thinking that is so critical to safe and high-quality nursing practice (**Dickerson, 2010, Allari & Abu-Moghli, 2013**).

Both mental and physical manifestations of stress can impact job performance leading to errors in patient care because pediatric nurses lose their capacity for caring, avoid pediatric patient contact and withdraw emotionally from these patients then fail even to give good physical care. There are relationships within moral distress, compassion fatigue, and perception of medication error (**Maiden et al., 2011, Leggett et al., 2013**).

Moral distress leads to loss of moral integrity, not only of healthcare providers but of healthcare systems as well. Moral integrity is a state of being, acting like and becoming a certain kind of person, this person is honest, trustworthy, consistently doing the right thing and standing up for what is right despite the consequences (**McClendon & Buckner, 2007, laabs, 2011**).

Moreover, Moral distress decreased job satisfaction and is a major cause of burnout and pediatric nurses' leaving the profession. Burnout is the frustration, loss of interest, decreased productivity, and fatigue caused by overwork and prolonged stress, it affects aspects of the well-being of healthcare workers and the quality of care provided (**Peterson et al., 2008, Cavaliere et al., 2010, Wisniewski, 2013**).

Although the problems of moral distress occurred at work, they adversely affected most pediatric nurses' personal and family lives with innocent spouses and pediatric nurses' children being the most affected (**Maluwa et al., 2012**).

Effects of moral distress on the pediatric patients

The picture is mixed regarding the impact of moral distress on the provision of care, with some findings suggesting that it does not impact negatively on care and others suggesting that it results in nurses withdrawing from pediatric patients. Moral

distress have a negative impact on the quality, quantity, and cost of pediatric patients care (**Schluter et al., 2008, Cavaliere et al., 2010**).

Moral distress may have an impact on the relationship between the pediatric nurses and the pediatric patients. Nurses who experience moral distress withdraw emotionally from pediatric patients. These nurses provide physical care by completing the required tasks but avoid forming a connection with the pediatric patients to avoid further distress (**Austin et al, 2009, Huffman & Rittenmeyer, 2012, Sirilla, 2013**).

An ineffective relationship between the pediatric patient and the nurse may impact pain management, increase medical errors and lead to an increased length of stay. So it is important to listening to pediatric patients, putting their needs first and upholding confidentiality because a significant point that is pediatric patients may not listen well to their health care providers unless they themselves feel listened to and this relation is vital to therapeutic outcomes (**Robinson, 2010, Nightingale, 2010, Helming, 2013**).

Effects of moral distress on the organizations

The experience of moral distress leads to absenteeism and poor productivity for the organization along with emotional

exhaustion for pediatric nurses and nurses leaders. This suffering may lead to burnout and may result in resignation if left unresolved (Coles, 2010, Allari & Abu-Moghli, 2013, Beheshtifar, 2014).

Nurse turnover is costly for health care organizations in terms of operational costs, profitability, productivity and efficiency. Nurse turnover ultimately affects quality of service and accreditation. High staff turnover not only costs institutions financially, it also costs facilities in terms of unit morale and patient safety (Sauls, 2011).

A clear relationship between inadequate nurse staffing and poor pediatric patient outcomes, including increases in mortality rates, hospital-acquired pneumonia, urinary tract infections, sepsis, hospital-acquired infections, pressure ulcers, upper gastrointestinal bleeding, shock and cardiac arrest, medication errors, falls, failure to rescue and longer than expected length of hospital stay. Adequate numbers of skilled and competent pediatric nurses are needed to ensure quality patient care. If moral distress is pervasive, the institution's accreditation and survival may be threatened (Berry & Curry, 2012, Nalley, 2013).

The economic and professional costs of such losses of pediatric nurses professional are significant and troubling. The

cost of hiring well-qualified healthcare professionals is far greater than the cost of retaining them, so it is important that moral distress issues are addressed to prevent further nurses from changing careers (**Buerhaus, 2008, Hamric et al., 2011, Allen et al., 2013**).

Nurses' response to moral distress

When nurses experience moral distress they may respond in at least one of three ways as mentioned by (**Hamric, 2010**):

- 1) The first response is a numbing of moral sensitivity and withdrawal from involvement in ethically challenging situations.
- 2) Nurses leave their position or leave the profession itself.
- 3) Nurses resort to conscientious objection to advocate for their patients.

Moral and ethical foundation of nursing profession

Nursing is a profession grounded in ethical standards and moral behavior where ethics and moral issues have been an important part of nursing practice throughout its evolution. Moreover moral distress in nursing seems rooted in a longstanding under-recognition of the moral complexity of nursing, so it is critical to examine nursing's strong ethical foundations to understand moral distress in nursing (**Sauls, 2011, Aft, 2011, Lamb & Storch, 2012**).

Moral agency of the nursing

Because nursing practice is increasingly recognized as a moral endeavor and the moral realm of nursing practice has been articulated with the concept of moral agency nurses are known as moral agents. Moral agency has been commonly construed as a person's capacity to engage in deliberate actions that are morally relevant i.e. touching on matters of right and wrong, good and bad, or just and unjust (**Carnevale, 2013**).

Nursing ethics

Nursing Ethics has had an important role to play in the dissemination of research on moral distress. It is the examination of all kinds of ethical and bioethical issues from the perspective of nursing theory and practice which in turn rest on the agreed core concepts of nursing, namely: person, culture, care, health, healing, environment and nursing itself (**Johnstone, 2011, McCarthy, 2013**).

Difference between ethics and morals

Morals are should and should not, ought and ought not of actions and behaviors and it is related closely to cultural and religious values and beliefs that govern our social interactions. Ethics are concerned with the basis of action rather than the action whether is right or wrong, good or bad (**Urden, et al., 2013**).

Code of Ethics for Nurses

Ethical guides for nurses are traditionally encoded in documents such as the American Nurses Association's Code of Ethics for Nurses (ANA) which embodying the public statement of nursing ethics is written by expert members of the ANA. Nursing codes of ethics have become common place ethical and legal instruments for explicitly stating nurses' obligations toward pediatric patients, their community, their nursing and inter professional colleagues, as well as the nursing profession (**Sauls, 2011, Carnevale , 2013**).

American Nurses Association Code of Ethics for Nurses, (2001) consists of nine provisions as mentioned by (**Slate, 2013**):

1. The nurse in all professional relationships practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
2. The nurse's primary commitment is to the patient, whether an individual, family, group, or community.
3. The nurse promotes, advocates for and strives to protect the health, safety and rights of the patient.
4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks

consistent with the nurse's obligation to provide optimum patient care.

5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence and to continue personal and professional growth.
6. The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality healthcare and consistent with the values of the profession through individual and collective action.
7. The nurse participates in the advancement of the profession through contributions to practice, education, administration and knowledge development.
8. The nurse collaborates with the other health professional and the public in promoting community, national and international efforts to meet health needs.
9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice and for shaping social policy.

Ethical Principles

To influence patient care from an ethical perspective a pediatric nurse also needs understanding of ethical principles and models. Knowledge of ethical principles arms the pediatric nurse

with power to be a major player in the decision-making process regarding patient care (**Parker, 2007**).

The ethical principles are useful in ethical discussions because even if people disagree about which action is right in a situation, they may be able to agree on the principles that apply and provide the foundation for ethical rules, which are specific prescriptions for actions (**Qadous, 2011**).

Inherent in ethical decision-making is the application of ethical principles in difficult and conflicting situations that nurses may face in specific circumstances during the practice of their profession , so nurses are at all times expected to observe and apply fundamental ethical principles in their interaction with healthcare users (**South African Nursing Council, 2013**).

The four ethical principles that are most commonly used are autonomy, beneficence, non-maleficence and justice (**Rich & Butts, 2014**).

Autonomy

It is agreement to respect another's right to self-determine a course of action, support of independent decision making. Autonomy involves one's ability to self- rule and to generate personal decisions independently. Honoring the principle of autonomy means that the nurse respects a client's right to make decisions even when those choices seem to the nurse not to be in

the client's best interest (**Qadous, 2011, Faculty school of nursing and allied health sciences, 2014**).

This concept applies to any adult person who is mentally competent. The right to autonomy has some limitations designed to protect the patient (especially if the patient is a child or a mentally incompetent adult). In the case of such a patient, a parent or legal guardian acts as the decision maker (**Centers for Disease Control and Prevention, 2012**).

Respect of patient's autonomy includes informed consent for treatment, facilitating patient choice regarding treatment options, accepting patient refusal of treatment, disclosing medical information, diagnoses and treatment options to patient and maintaining confidentiality (**Rich & Butts, 2014**).

Beneficence

Beneficence in nursing is the requirement that nurse take promote the well-being of the patient by preventing harm to the patient. Beneficence includes the obligation to help those in trouble, to protect patients' rights and provide treatment to people who need it (**Morrison, 2010, Keogh, 2013**).

Pediatric nurses must view beneficence from the perspective of the pediatric patient and families. Parents and the nurses may disagree on the benefits of treatment and potential outcomes.

Pediatric nurses need to support and respect parents' decisions even when disagreements sometimes arise (**Sundean, 2013**).

Nonmaleficence

It is the duty to “do no harm”. Although this would seem to be a simple principle to follow, in reality it is complex. The injunction to do no harm is often paired with beneficence, but a difference exist between two principles, beneficence requires taking actions to benefit others whereas nonmaleficence involves refraining from actions that might harm others (**Qadous, 2011, Rich & Butts , 2014**).

Sometimes harmful action is necessary, but it should never be automatic, the benefits provided through procedure should outweigh the suffering caused when the benefits of the procedure balanced against the harm and if there is greater benefit the act is viewed as an ethical one (**Morrison, 2010**).

Justice

Justice in health care is usually defined as a form of fairness. This implies the fair distribution of goods in society and requires looking at the role of entitlement (**McCormick, 2013**).

Nurses often face decisions in which a sense of justice should prevail, for example, a pediatric nurse making home visits finds pediatric patient tearful and depressed and knows she could help by staying for 30 more minutes to talk, however, that would take

time from her next pediatric patient who is a diabetic and needs a great deal of teaching and observation. So the nurse will need to weigh the facts carefully in order to divide her time justly among her pediatric patients (**Qadous, 2011**).

Interventions to address and reduce moral distress

Intervention to address moral distress achieves several goals. First, it gives a name to a phenomenon that has until recently been an unrecognized hazard in the healthcare arena, second, it reduces the threat to providers' moral integrity, third, it provides an avenue for those who are without power in certain circumstances to voice their opinion and to be heard, fourth, it allows moral distress to be recognized as a multi-disciplinary problem because moral distress is not a nursing problem but other health care providers are known to experience moral distress as well and finally, addressing moral distress reduces the crescendo of moral residue (**Epstein & Delgado, 2010**).

It is difficult to formulate convincing approaches for preventing or addressing moral distress, given that this concept is still quite poorly understood and strategies have been weakly evaluated to date, although there are numerous studies that identify the situations and the impact of moral distress but not many studies explore treatments and interventions for moral distress (**Wilson et al., 2013, Carnevale, 2013**).

Consultation in situations of moral distress is not a matter of analyzing single cases there are three levels of interventions that can help to ameliorate moral distress. The first is the pediatric patient level of intervention to bring pediatric nurses team members together for frank discussion, the second is a unit-level intervention to identify changes needed to prevent or minimize such situations in the future, and the third is an organizational level intervention to examine policies and modes of operation that compromise healthcare professionals' moral integrity (**Hamric, 2010**).

The **American Association of Critical-Care Nursing (AACN), (2004)** provided the “4A’s Model to Rise above Moral Distress” that offers a framework for critical care nurses to identify and deal with moral distress (**Chopivsky, 2015**).

The 4 A’s are: Ask, Affirm, Assess, and Act as mentioned by (**Molazem et al., 2013**):

Ask: pediatric nurse ask herself whether her feeling is a sign of moral distress or just a feeling of suffering. The aim of this stage is awareness of the existence of moral distress. Affirm: pediatric nurse makes sure about the existence of moral distress by sharing feelings with others and promises to reduce it. The aim of this stage is making a commitment to address moral distress. Assess: pediatric nurse identifies the source of moral distress, which might be personal or environmental, estimates the intensity of stress, and be ready for the act stage. The aim of this stage is to be ready to make an action plan. Act: pediatric nurse both personally and professionally attempts to reduce moral distress and uses strategies in order to reach this goal. The aim of this stage is preserving nurse’s integrity and authenticity.

Strategies for address and reducing moral distress have been recommended as seen in table (2) (**Epstein & Hamric, 2009**).

Table (2): Strategies used to address and reduce moral distress.

Strategy	Implementation
Speak up!	Identify the problem, gather the facts, and voice your opinion
Be deliberate	Know who you need to speak with and know what you need to speak about
Be accountable	Sometimes, our actions are not quite right. Be ready to accept the consequences, should things not turn out the way you had planned.
Build support networks	Find colleagues who support you or who support acting to address moral distress. Speak with one authoritative voice.
Focus on changes in the work environment	Focusing on the work environment will be more productive than focusing on an individual patient. Remember, similar problems tend to occur over and over. It's not usually the patient, but the system, that needs changing.
Participate in moral distress education	Attend forums and discussions about moral distress. Learn all you can about it.
Make it interdisciplinary	Many causes of moral distress are interdisciplinary. Nursing alone cannot change the work environment. Multiple views and collaboration are needed to improve a system, especially a complex one, such as a hospital unit.
Find root causes	What are the common causes of moral distress in your unit? Target those.
Develop policies	Develop policies to encourage open discussion, interdisciplinary collaboration, and the initiation of ethics consultations.
Design a workshop	Train nursing staff to recognize moral distress, identify barriers to change, and create a plan for action.

Epstein, E., & Hamric, A. (2009): Moral distress, moral residue, and the crescendo effect. *Journal of Clinical Ethics*, 20, (4), 330-342.

Recognition of pediatric nurses as moral agents and further exploration of interdisciplinary team education on ethics and moral distress, improved collaboration, communication and team support is warranted. In addition to creating work environments where pediatric nurses are invited to talk about moral problems and where they are involved in decision making are important strategies to diminish nurses' moral distress and to improve the quality of care (**Piers et al., 2012, Carnevale, 2013, Allen et al., 2013**).

Part II: Ethical climate

The ethical climate construct developed by Victor and Cullen 1987, 1988. Nearly a decade after the introduction of the term ethical climate in business ethics research, the term was introduced in the field of healthcare organizations. Business literature is rich with research on ethical climates within organizations, however, data specific to health care organizations is lacking (**Huerta, 2008, Shacklock et al., 2011, Lam, 2012**).

Definitions of the concept of ethical climate

Ethical climate is defined as the organizational conditions and practices that affect the way difficult patient care problems, with ethical complications, are discussed and decided. It is the collective ethical values, beliefs, and behaviors within the institution. These behaviors are often informal but exhibited, expected, and socialized (**Hart, 2005, Mallory et al., 2009**).

Ethical climate is defined as a composite of organizational members' perception of the ethical attitudes and how to deal with an issue (**Zehir et al., 2011**).

Ethical climate in healthcare settings is defined as organizational specific conditions that facilitate the discussion on the patients' health problems and their solutions, and provide a

framework for ethical decision-making in the clinical environment (Joolae et al., 2013).

Ethical Climate Theoretical Models used in Nursing Literature

The studies of ethical climate have used different theoretical model, such as Olson's work on ethical climate in hospitals and the ethical climate framework developed by Victor and Cullen (Silén, 2011).

Hospital Ethical Climate Survey (HECS) Model (Olson, 1998)

The HECS is strongly drawing on empirical business ethics and nursing ethics. HECS was developed and validated to measure nurses' perceptions of the hospital's ethical climate and was tested on sample of 360 nurses representing adult and pediatric nurses from various specialties, was drawn from two contrasting acute care hospitals in one large Midwestern city. One hospital was a religious-based, not-for-profit hospital and the second was a for-profit proprietary hospital (Porter, 2010).

The HECS detected differences in nurses' perspectives of the ethical climate. Nurses' perspectives fell into five inter correlated categories that described relationships between nurses

and peers, managers, patients, physicians and the hospital (**jooalee et al., 2013**).

Ethical Climate Questionnaire Model (Victor and Cullen, 1987, 1988)

The ethical climate questionnaire was developed in order to study the perception of ethical orientation in for-profit organizations, on a sample of 872 employees from 4 different business firms (a small printing company, a savings and loan, a manufacturing plant, and a local telephone company) (**Laratta, 2009, Shacklock et al., 2011**).

The ethical climate questionnaire is a two-dimensional matrix, which captures both the ethical criteria and locus of analysis involved in decision making, ethical climate criteria derived from moral philosophy and psychological theories, while loci of analysis derived from sociological theories (**Lam, 2012**).

Ethical criteria referred to a dominant or prescribed moral philosophy used in making ethical decisions in the organization or group interest, the three levels of this dimension were egoism, benevolence and principle. locus of analysis referred to whether the central concern of individuals within the group in ethical decision making are self-interest (individual), company interest (local), or societal interest (cosmopolitan).

By using all possible combinations of these two categorical dimensions, nine theoretical climate types were produced: Self-interest, Organizational Interest, Efficiency, Friendship, Team interest, Social Responsibility, Personal Morality, Organizational rules and procedures, and Law and codes as shown in Table 3 (Chouaib & Zaddem, 2013)

Table (3): The ethical climate typology for-profit Organizations

		Locus of analysis		
		Individual	Local	Cosmopolitan
Ethical Criteria	Egoism	Self-interest	Organizational Interest	Efficiency
	Benevolence	Friendship	Team interest	Social Responsibility
	Principle	Personal Morality	Organizational rules and procedures	Law and codes

Victor, B. and Cullen, J. (1988): The Organizational Bases of Ethical Work Climates. *Administrative Science Quarterly*, 33, (1), Pp 101-125. Coated in

Chouaib, A. and Zaddem, F. (2013): The Ethical Climate at Work Promoting Trust in Organizations. *Revue Interdisciplinaire Management & Humanisme*.1, (9), Pp 53-70.

Concepts related to ethical climate

Nursing research related to the ethical work climate of hospital organizations frequently uses several surrogate concepts, which results in considerable confusion. These overlapping terms

include work atmosphere, organizational climate and organizational culture (**Porter, 2010**).

Atmosphere

The social context of the work environment, termed “atmosphere,” was discussed as early as 1910 and was among one of the many topics investigated at the National Institute of Industrial Psychology during the 1930s in Britain (**Ostroff et al., 2013**).

Atmosphere is a group of features that differentiates an organization from other one. Organizational atmosphere relates to many factors such as: operation, efficiency, effectiveness, leading style, transfer decreasing, occupational satisfaction and organizational learning. Unsuitable organizational atmosphere can damage longer part of organizational capital and qualified pediatric nurses (**Jamrok & Neisari, 2013**).

Organizational climate and culture

Historically, the construct of climate preceded the construct of culture. The term “organizational climate” was coined in 1939 following a study of children schools and clubs by Kurt Lewin and his colleagues, then climate was formally introduced in the 1960s, however, organizational culture did not become a popular

issue for study in the management literature until the 1980s (**Kundu, 2007, Ostroff et al., 2013, Zahoor, 2013**).

At the beginning the concepts of organizational climate and culture were commonly undifferentiated in the literature and organizational climate often used interchangeably with organizational culture even though they are conceptually different (**Kuenzi & Schminke, 2009, Siourouni et al., 2012, Torres, 2013**).

A great deal of attention has been devoted to the question of whether the constructs of culture and climate are different, the same or interrelated (**Tricklebank, 2010, Ostroff et al., 2013**).

Organizational climate is briefly defined as the meanings people attach to interrelated bundles of experiences they have at work; Organizational culture is briefly defined as the basic assumptions about the world and the values that guide life in organizations (**Schneider et al., 2013**).

Climate involves employees' perceptions of what the organization is like in terms of practices, policies, procedures, routines and rewards While Climate focus on the "situation" and its link to perceptions, feelings and behavior of employees. Culture refers to ideologies, values and norms as reflected in stories and symbols and it is influenced by symbolic

interpretations of organizational events and artifacts (Tricklebank, 2010, Hatch, 2011, Ostroff et al., 2013).

Climate is more “immediate” than culture. Culture represents an evolved context embedded in systems, is more stable than climate, has strong roots in history, is collectively held, and is resistant to manipulation (Schein, 2010).

Association between ethical climate and organizational climate and culture

Organizational ethical climate is a sub-set of overall organizational climate and theoretically ethical climate has often been regarded as a certain type of organizational climate. Moreover organization’s ethical climate is one of the components in organizational culture (Ma’amor et al., 2012, Silén et al., 2012, Golparvar et al., 2014).

Nature of ethical climate

Ethical climate is the psychological life of organizations. This does not mean that ethical climate and psychological climate are the same, but they can be measured on the same level. Psychological climate is individual descriptions of organizational practices and procedures that relate to organizational influences on individual performance, satisfaction and motivation (Baltes, 2001, Schneider et al., 2011, Silén, 2011).

Each organization has its own ethics. Organizational ethics is a set of principles that promotes similar behaviors among the organization's staff and helps the organization and staff solve problems caused by conflicts within the system, such as personal tensions and disputes related to job responsibilities. Ethical work climate emerges to a large extent from organizational processes transmitting managerial expectations in terms of moral behaviors and process for resolving ethical problem (Mayer et al., 2010, Joolae et al., 2012).

The ethical climate of an organization would influence organizational members to manage conflicts and make ethical decisions. Ethical climate helps pediatric nurses identify the normative systems that guide their decision making, their actions and how they respond to ethical dilemmas that occur (Floyd, 2010).

When organizations have identifiable ethical climates, pediatric nurses are better able to recognize types of ethical dilemmas, to differentiate issues that are pertinent to the dilemmas and to identify a process that should be used to solve those dilemmas and when healthcare organizations enable their pediatric nurses to talk to others about difficult issues, such as those faced by nurses in the care of pediatric patients, and allow them to feel

that they can consult their colleagues, managers or clinicians, they create conditions which promote ethical thinking, ethical dialogue, hope and problem-solving (**Ahmad, 2011, Joolae et al., 2013**).

Positive work context also encourage ethical decision making and pediatric nurses feel comfortable in an environment where they have freedom to make ethical decisions. An organization's ethical climate contributes pediatric nurses at all level to makes ethical decisions. It becomes difficult for pediatric nurses to make ethical decisions in an unethical work environment (**Unal, 2012, Iqbal et al., 2013**).

Organizational climate symbolizes what an organization truly values and this is revealed through the shared perception of pediatric nurses, such as the kinds of behaviors that are encouraged, supported and rewarded within the organization. If an organization is committed to being ethical, this can have a direct impact on pediatric nurses' behaviors. Organizations with a positive ethical climate, pediatric nurses hold the view that "the right thing to do is the only thing to do" (**Vitell & Hidalgo, 2006, Verbos et al., 2007, Ghorbani et al., 2014**).

There is a relationship between hospital ethical climate and pediatric nurses' ethical attitudes. If there is inappropriate behaviors shown on top management which affect pediatric nurses

the ethical attitudes are negatively affect the work groups' ethical climate. The policies, procedures, norms and standards that define the ethical work climate result when both pediatric nurses and leadership engage in the process of ethics institutionalization (**Floyd, 2010, Zehir et al., 2011, Khanifar et al., 2012**).

Increasing unethical incidents in health care organizations make it important for researchers to study and develop a better understanding of the influence of ethics on organizational results. The first step of minimizing unethical behavior in work group is to consider the data of ethical climate at that time (**Zehir et al., 2003, Andrews et al., 2011**).

At personal level, most pediatric nurses have specific ethical beliefs, values, and principles that form their thinking, speech and behavior. The perceptions on ethical and unethical behaviors may be different depending on individual values and the situations that they faced. So it is also important to understand pediatric nurses' moral development (**Floyd & Yerby, 2014, Ma'amor et al., 2012, Golparvar & Azarmonabadi, 2014**).

Ethical values may change from pediatric nurse to another, so the ethical conduct envisages enacting code of conduct, ethics related policies and modus operandi, efficient monitoring mechanism and accountability for ethical lapses and unethical

behavior duly augmented by appropriate reward for ethical behavior (Unal, 2012).

Unethical clinical practice

Unethical clinical practice is converted to an important problem for all members of community and it defined as behavior observed by or reported to faculty that is actually or potentially detrimental to pediatric patients, pediatric patients' families and health care agency (Khanifar et al., 2012)

Unethical practice include but are not limited to: Negligence in patient care, Neglect of duty with actual cause or potential to cause patient harm, exhibiting aggressive or intimidating behavior (e.g., profanities, threats, loud talking, rudeness, verbal coercion), failure to adhere to principles of safe nursing practice (i.e. safe medication administration), dishonest communication with pediatric patients and their families (Rutgers school of nursing, 2013).

Effects of Ethical Climate

Ethical climate affect moral distress where, many research studies suggested that moral distress is associated with perception of ethical climate and positive ethical climate is necessary to support professional nursing practice and resolution of moral distress. In addition to higher levels of moral distress are

associated with poorer perceptions of the ethical climate of the unit (Hamric et al., 2011, Pauly et al., 2012, Allari & Abu-Moghli, 2013).

This is not surprising regarding the concept of moral distress as knowing the right thing to do but not being able to do it due to a multitude of constraints. A significant component of external constraints on moral action is the ethical climate of the work place. In order to understand the relationship between moral distress and the ethical climate, one must evaluate the concept of ethical climates (Porter, 2010, Aft, 2011).

Ethical climate affects not only the moral attitudes of the organization's pediatric nurses, but also directly affect job attitudes and outcomes (Cullen et al., 2003, DeConinck, 2010).

Ethical climate plays an important role in pediatric nurses performance, moreover positive ethical climate is essential to the pediatric nurses' ability to perform effectively and efficiently and to maximum potential. Enhancing workplace ethical climate could reduce medical errors and improve pediatric nurses' retention in hospitals (Jordan et al., 2009, Powell, 2012, Hwang & Park, 2014).

Ethical climate is directly, significantly and positively associated with job satisfaction and ethical climate creates

conducive environment that promotes ethical values, clarifies role ambiguity and provides clear direction for ethical decision making in ethical situations enabling pediatric nurses to enjoy the work **(Khan, 2012, Omar & Ahmad, 2014)**.

Job satisfaction can be defined as the extent to which the difference between the amount of rewards received by pediatric nurses and the amount they believed that they should receive. Moreover, pediatric nurses' job satisfaction is the fulfillment, gratification and enjoyment that comes from work and it is not just the money or the fringe benefits, but the feelings pediatric nurses receive from the work itself **(Molinari & Monserud, 2008, Asegid et al., 2014)**.

The effects of job satisfaction including benefits to both the pediatric nurses and the organization have been well-documented. A satisfied pediatric nurse who is focused on their professional tasks without being distracted by a negative environment, has a better performance. The benefits of job satisfaction for an organization are to reduce complaints and grievance regarding workers, better turnover and absenteeism and reducing the cost of training as a result of the termination of pediatric nurses. Lack of ethical consistency between the organization and its pediatric nurses can

cause stress and dissatisfaction (Unal, 2012, Hira & Waqas, 2012, Floyd & Yerby, 2014).

Dissatisfaction with work can cause poor job performance, lower productivity and staff turnover and is costly to organizations and outcome of health care. In addition it is easy to link a pediatric patient safety to pediatric nurses' satisfaction (Joolae et al., 2013, Asegid et al., 2014).

Ethical climate has a significant and positive impact on commitment. Level of pediatric nurses' commitment increase if there are positive ethical climates exist within the organization. In contrast, pediatric nurses' level of commitment reduces if their peers engage in unethical behaviors (Ma'amor et al., 2012, Unal, 2012).

Pediatric nurses' commitment is important to organization because committed pediatric nurses are likely to be more willing to make personal sacrifices for the sake of organization and workplace withdrawal behaviors including tardiness, absenteeism and intentions to leave. Organization commitment is defined as pediatric nurses' interest and connection to an organization (Tsai & Huang, 2008, Vitell & Singhapakdi, 2008, DeFoe, 2013).

Ethical climate have a significant positive relations with organizational identification. The concept of organizational

identification is defined as a psychological linkage between the individual and the organization whereby the individual feels a deep, self-defining affective and cognitive bond with the organization as a social entity (**Oncer & Yildiz, 2012**).

Organizational identification has a supportive and positive impact on the effectiveness of the organization and pediatric nurses' performance. Also organizational identification plays an important role in raising the job satisfaction, commitment, motivation and physical well-being of pediatric nurses (**DeConinck et al., 2013, Abuzaid, 2014**).

Ethical climate is a significant factor in pediatric nurses' decision to leave their work setting and ethical climate is important component of nursing retention. In addition, nurses whose responses on the Hospital Ethical Climate Survey indicated a perceived higher ethical climate were also more likely to report higher intentions to stay in their current work settings (**Han, 2014**).

Actions that promote a positive ethical climate

The two main areas that promote a positive ethical climate are meeting needs and sharing responsibility as seen in table (4) (**Silén et al., 2012**).

Table (4): Main areas, categories and subcategories regarding actions promoting a positive ethical climate

Main areas	Categories	Subcategories
Meeting needs	Giving considerate care	<ul style="list-style-type: none"> • Attending to the psychosocial needs of patients • Complying with the patients' wishes • Attending to the needs of next of kin
	Receiving and giving support	<ul style="list-style-type: none"> • Supporting each other in the work group • Receiving external psychosocial support • Head nurse attending to the staff's working situation • Using policies and routines as a help
	Satisfying the need for information	<ul style="list-style-type: none"> • Physicians giving reasons for decisions • Head nurse giving information on delicate matters
Sharing responsibility	Working as a team	<ul style="list-style-type: none"> • Collaborating interprofessionally • Reaching consensus for care interprofessionally
	Setting a standard for behavior	<ul style="list-style-type: none"> • Daring to speak out • Protecting the patients' privacy

Silén, M., Kjellström, S., Christensson, L., Sidenvall, B., Svantesson, M. (2012): What actions promote a positive ethical climate? A critical incident study of nurses' perceptions. *Nursing Ethics*, 19, (4), Pp 501-512.

Subjects and Methods

This study aimed to assess moral distress of nurses working in pediatric intensive care unit.

Technical Design

1) Research Design

A descriptive design was utilized in the present study.

2) Research Settings

This study was conducted in pediatric intensive care unit at Children Hospital affiliated to Ain Shams University and Tanta University.

3) Research Subjects

All available nurses work at the previously mentioned settings regardless their characteristics (No= 60).

4) Tools for data collection

Data were collected using the following Tools:

1-Pre-designed questionnaire sheet:

This sheet developed by researcher after reviewing the related literatures and was written in a simple Arabic language. It consisted of two parts:

Part 1:

Socio-demographic characteristics of the nurses as name, gender, age, marital status, educational level and years of experience.

Part 2:

- Knowledge of nurses about moral distress as definitions, causes, signs and symptoms and effects on nurses, patients and organizations.
- Knowledge of nurses about hospital ethical climate as definitions and relation between ethical climate and moral distress.

Scoring system:

The answers of studied nurses were checked with a key answer and the studied nurses' knowledge was categorized into three levels: poor (less than 50%), Average (50% > 75%) and good (75% & more).

2-Moral Distress Scale – Revised .

It was adopted from **Hamric et al., (2012)** to assess the level of moral distress of the studied nurses working at the previously mentioned settings. Moral Distress Scale - Revised is a 5 point likert scale. Each of the 21 items is scored by participants

in terms of the how often the situation arises (frequency) and how disturbing the situation is when it arises (level of disturbance).

Scoring System:

The scale for frequency ranges from 0 (never) to 4 (very frequently) and for level of disturbance from 0 (none) to 4 (great extent).

Score for overall moral distress is computed in a two part procedure. First, the frequency score and the level of disturbance score are multiplied for each of the 21 items (Frequency× level of disturbance) score, which ranges from 0 to 16, next, the composite score is obtained by summing each item's (Frequency× level of disturbance) score. The resulting score based on 21 items has a range of 0–336.

The total score are divided into three parts to represent low level of moral distress (0-111), moderate level (112-223), and high level (224-336).

The final section of the scale contains the following two questions not involved in the scoring system:

Q1: Have you ever left or considered quitting a clinical position because of your moral distress with the way patient care was handled at your institution?

- Yes, I left a position.
- Yes, I considered quitting but did not leave.
- No, I've never considered quitting or left a position.

Q2: Are you considering leaving your position now?

- Yes.
- No.

3- Hospital Ethical Climate Survey.

It was adopted from **Olson, (1998)** to assess the perception of hospital ethical climate of the nurses. Hospital Ethical climate Survey is a 5point- Likert scale consist of 26 variables in five factors organized according to the relationships with peers (items 1, 10, 18 and 23), patients (items 2, 6, 11 and 19), managers (items 3, 7, 12, 15, 20 and 24), hospital (items 4, 8, 13,16, 21 and 25), and physicians (items 5, 9, 14, 17, 22 and 26).

Scoring System:

Score for overall hospital ethical climate by giving Almost never true (score=1), rarely (score=2), sometimes (score=3), often (score=4) and almost always true (score=5).

The total score is obtained by summing the score of each item for 26 items, the resulting score based on 26 items has a range of 1–130, considering low (1-77), moderate (78-103) and high was (104-130).

Operational Design

Preparatory Phase

During this phase, a review of the study tool was prepared through reviewing the available local and international related

literature to be oriented with the various aspects of research problem.

Exploratory Phase

A Pilot study was carried out including on 10% of the nurses of the study sample to test the applicability and feasibility of the tools, then the tools was modified according to the results of pilot study.

Field Work

Approval was taken by e-mail from Dr. **Hamric** to use Moral Distress Scale- Revised and from Dr. **Olson** to use Hospital Ethical Climate Survey then, the actual field work was carried out over 6 months' period from January 2014 up to the end of June 2014. The researcher was available in the study setting 3 days/week (From Saturday to Monday) by rotation between the two places (Ain Shams and Tanta) and rotation in time include morning shift (9Am to 2 Pm) and after noon shift (2 Pm to 8 Pm) to be able to deal with different nurses. The purpose of the study and its expectations were explained by the researcher to studied nurses before starting interviewing and data gathering. Interviewing time rang from (15 to 30 minutes) for every nurse to clarify and prevent misunderstanding of tools items' meaning.

Ethical Consideration

All the gathered data was used for research purpose only. The studied nurses were informed about the purpose and expected outcomes of the study and they were assured that the study was harmless and their participation were voluntary and they were have the right to withdraw from the study at any time and without given any reason. They were assured also that anonymity and confidently will be guaranteed.

Administrative Design

Approval was obtained through an issued letter from Dean of faculty of nursing, Ain Shams University to hospitals directors of the both previously mentioned settings.

Statistical Design

The obtained data was organized, tabulated & analyzed using suitable statistical tests like number and percentage distribution. Chi-square test, mean and standard deviation were used to estimate the statistical significant difference between variables of the study; where

$P > 0.05$ there is no statistical significance.

$P \leq 0.05$ there is a statistical significance.

Results

The results of the present study are presented as the following:

- **Part I:**
 - Characteristics of the studied nurses.
- **Part II:**
 - Moral distress of pediatric intensive care unit nurses.
- **Part III:**
 - Hospital Ethical climate of pediatric intensive care unit nurses.
- **Part IV:**
 - Relations between variables of the study.

Part I: Characteristics of the Studied Nurses

Table (1): Number and Percentage Distribution of the Studied Nurses according to their Characteristics (No=60).

Items	No	%
Gender		
Male	3	5.0
Female	57	95.0
Age		
< 25 years	27	45.0
25 < 30 years	18	30.0
30-35 years	15	25.0
Mean±Standard deviation	27.3±.5.1	
Marital status		
Single	25	41.7
Married	33	55.0
Widow	2	3.3
Educational level		
Diplom	26	43.3
Bachelor	33	55.0
Diploma after Bachelor	1	1.7
Years of experience		
< 5 years	33	55.0
5 <10 years	13	21.7
10 <15 years	3	5.0
15-20 years	11	18.3
Mean±Standard deviation	7.1± 6.6	
Do you obtain courses about moral distress before		
No	60	100.0

Results

As regards characteristics of the studied nurses, table (1) showed that, the great majority (95%) of the studied nurses were females and 45% of them were in the age group less than 25years with a mean age 27.3 ± 5.1 . While more than half (55%) of studied nurses were married and had Bachelor and all of them (100%) had not obtained courses about moral distress before.

Part II: Moral Distress of Pediatric Intensive Care Unit Nurses

Table (2): Number and Percentage Distribution of the Studied Nurses according to their Knowledge about Moral Distress and Hospital Ethical Climate (No=60).

Items	No	%
Definition of moral distress		
Unknown	60	100.0
Causes of moral distress		
Unknown	60	100.0
Signs and Symptoms of moral distress		
Unknown	60	100.0
Effects of moral distress on: nurses, patients and organizations		
Unknown	60	100.0
Definition of hospital ethical climate		
Unknown	60	100.0
Relation between moral distress and hospital ethical climate		
Unknown	60	100.0

As regards knowledge of the studied nurses about moral distress and hospital ethical climate, table (2) clarified that, all of studied nurses (100%) were unknown definition, causes, signs & symptoms, effects of moral distress, definition of hospital ethical climate and relation between moral distress and hospital ethical climate.

Results

Table (3): Number and Percentage Distribution of the Studied Nurses according to their Total Knowledge about Moral Distress and Hospital Ethical Climate (No=60).

Level of total knowledge	No	%
Poor < 50%	60	100.0

Table (3) showed that, all of the studied nurses (100%) had poor level of total knowledge about moral distress and hospital ethical climate.

.

Results

Table (4): Percentage Distribution of the Studied Nurses

according to their Moral Distress Scale for Frequency
(No=60).

Item	Frequency				
	0	1	2	3	4
	%	%	%	%	%
1. Provide less than optimal care due to pressures from administrators or insurers to reduce costs.	25	3.3	26.7	26.7	18.3
2. Witness healthcare providers giving “false hope” to parents.	60	20	8.3	11.7	0
3. Follow the family’s wishes to continue life support even though I believe it is not in the best interest of the child.	35	11.7	16.6	15	21.7
4. Initiate extensive life-saving actions when I think they only prolong death.	1.7	1.7	6.6	23.3	66.7
5. Follow the family’s request not to discuss death with a dying child who asks about dying.	43.3	6.7	20	6.7	23.3
6. Carry out the physician’s orders for what I consider to be unnecessary tests and treatments.	8.3	3.4	10	30	48.3
7. Continue to participate in care for a hopelessly ill child who is being sustained on a ventilator, when no one will make a decision to withdraw support.	3.3	0	8.3	26.7	61.7
8. Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.	21.7	3.3	36.7	21.7	16.6
9. Assist a physician who in my opinion is providing incompetent care.	5	11.7	20	10	53.3
10. Be required to care for patients I don’t feel qualified to care for.	35	11.7	21.6	25	6.7

Results

Item	Frequency				
	0	1	2	3	4
	%	%	%	%	%
11. Witness medical students perform painful procedures on patients solely to increase their skill.	23.3	13.3	6.7	16.7	40
12. Provide care that does not relieve the child's suffering because the physician fears that increasing the dose of pain medication will cause death.	13.3	6.7	28.3	20	31.7
13. Follow the physician's request not to discuss the child's prognosis with parents.	16.7	1.6	15	16.7	50
14. Increase the dose of sedatives/opiates for an unconscious child that I believe could hasten the child's death.	86.7	8.3	0	3.3	1.7
15. 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.	41.7	23.3	10	10	15
16. Follow the family's wishes for the child's care when I do not agree with them, but do so because of fears of a lawsuit.	75	13.3	6.7	5	0
17. Work with nurses or other providers who are not as competent as the child's care requires.	10	3.3	15	31.7	40
18. Witness diminished patient care quality due to poor team communication.	13.3	6.7	16.7	21.6	41.7
19. Ignore situations in which parents have not been given adequate information to insure informed consent.	35	21.7	13.3	15	15
20. Watch patient care suffer because of a lack of provider continuity.	5	11.7	15	30	38.3
21. Work with levels of nurse or other care provider staffing that I consider unsafe.	28.3	21.7	18.3	11.7	20

Results

Table (4) revealed that, almost two thirds (66.7%) of studied nurses had most occurrence frequency of item 4(Initiate extensive life-saving actions when I think they only prolong death). While the majority (86.7%) of them reported no occurrence of item 14(Increase the dose of sedatives/opiates for an unconscious child that I believe could hasten the child's death).

Results

Table (5): Percentage Distribution of the Studied Nurses according to their Moral Distress Scale for Level of Disturbance (No=60).

Item	level of disturbance				
	0	1	2	3	4
	%	%	%	%	%
1. Provide less than optimal care due to pressures from administrators or insurers to reduce costs.	0	0	5	16.7	78.3
2. Witness healthcare providers giving “false hope” to parents.	20	6.7	26.7	18.3	28.3
3. Follow the family’s wishes to continue life support even though I believe it is not in the best interest of the child.	35	13.3	6.7	10	35
4. Initiate extensive life-saving actions when I think they only prolong death.	43.3	6.7	13.4	3.3	33.3
5. Follow the family’s request not to discuss death with a dying child who asks about dying.	60	1.7	8.3	8.3	21.7
6. Carry out the physician’s orders for what I consider to be unnecessary tests and treatments.	8.3	1.7	16.7	10	63.3
7. Continue to participate in care for a hopelessly ill child who is being sustained on a ventilator, when no one will make a decision to withdraw support.	38.3	8.3	10	11.7	31.7
8. Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.	6.6	0	5	16.7	71.7
9. Assist a physician who in my opinion is providing incompetent care.	11.7	3.3	11.7	13.3	60
10. Be required to care for patients I don’t feel qualified to care for.	6.7	10	6.7	16.6	60
11. Witness medical students perform painful procedures on patients solely to increase their skill.	3.3	0	8.3	6.7	81.7
12. Provide care that does not relieve the child’s suffering because the physician fears that increasing the dose of pain medication will cause death.	16.7	5	15	15	48.3

Results

Item	level of disturbance				
	0	1	2	3	4
	%	%	%	%	%
13. Follow the physician's request not to discuss the child's prognosis with parents.	36.7	8.3	15	13.3	26.7
14. Increase the dose of sedatives/opiates for an unconscious child that I believe could hasten the child's death.	33.3	5	5	11.7	45
15. 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.	6.7	0	5	11.6	76.7
16. Follow the family's wishes for the child's care when I do not agree with them, but do so because of fears of a lawsuit.	33.3	1.7	11.7	13.3	40
17. Work with nurses or other providers who are not as competent as the child's care requires.	1.7	0	0	10	88.3
18. Witness diminished patient care quality due to poor team communication.	0	0	5	13.3	81.7
19. Ignore situations in which parents have not been given adequate information to insure informed consent.	3.3	5	18.4	28.3	45
20. Watch patient care suffer because of a lack of provider continuity.	0	0	0	5	95
21. Work with levels of nurse or other care provider staffing that I consider unsafe.	5	1.7	1.7	11.6	80

Table (5) showed that, the great majority (95%) of studied nurses had most disturbed situation for level of disturbance of item 20 (Watch patient care suffer because of a lack of provider continuity). While more than half (60%) of them reported the least disturbed situation for level of disturbance of item 5 (Follow the family's request not to discuss death with a dying child who asks about dying).

Figure (1): Percentage Distribution of the Studied Nurses according to their Total Moral Distress Level.

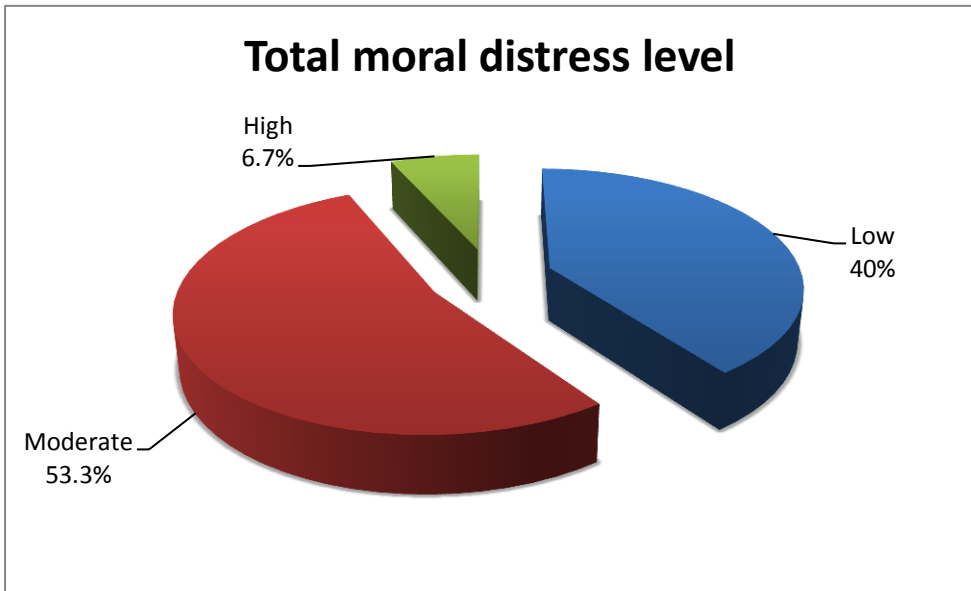


Figure (1), illustrated that, more than half (53.3%) of studied nurses had moderate level of moral distress.

Part III: Hospital Ethical Climate of Pediatric Intensive Care Unit Nurses.

Table (6): Number and Percentage Distribution of the Studied Nurses according to their Response on Questions of Moral Distress Scale (No=60).

Items	No	%
Nurses left or considered quitting a clinical position because of their moral distress		
Yes, left a position	7	11.7
Yes, considered quitting but did not leave	37	61.7
No, never considered quitting or left a position	16	26.6
Nurses considered leaving their position now		
Yes	21	35
No	39	65

Table (6) clarified that, more than half (61.7%) of studied nurses considered quitting a clinical position because of their moral distress but did not leave and 65 % of them considered not leaving their position now.

Results

Table (7): Percentage Distribution of the Studied Nurses according to their Response to Hospital Ethical Climate Survey (No=60).

Item	Almost Never True	Seldom True	Sometimes True	Often True	Almost Always True
1. My peers listen to my concerns about patient care.	0	3.3	13.3	46.7	36.7
2. Patients know what to expect from their care	0	8.3	18.4	45	28.3
3. When I'm unable to decide what's right or wrong in a patient care situation, my manager helps me.	3.3	5	25	43.4	23.3
4. Hospital policies help me with difficult patient care issues/ problems	41.7	26.7	26.6	3.3	1.7
5. Nurses and physicians trust one another	0	5	26.7	50	18.3
6. Nurses have access to the information necessary to solve a patient care issue/problem	1.7	1.7	3.3	41.6	51.7
7. My manager supports me in my decisions about patient care	8.3	16.7	23.3	38.3	13.4
8. A clear sense of the hospital's mission is shared with nurses	68.3	21.7	10	0	0
9. Physicians ask nurses for their opinions about treatment decisions	53.3	38.3	6.7	1.7	0
10. My peers help me with difficult patient care issues/problems	0	3.4	18.3	38.3	40
11. Nurses use the information necessary to solve a patient care issue/problem	8.3	15	43.3	28.4	5
12. My manager listens to me talk about patient care issues /problems	3.3	8.3	21.7	40	26.7
13. The feelings and values of all parties involved in a patient care issue/problem are taken into account when choosing a course of actions	20	41.7	35	3.3	0
14. I participate in treatment decisions for my patients	60	33.3	3.3	3.4	0
15. My manager is someone I can trust	13.3	3.4	23.3	43.3	16.7
16. Conflict is openly dealt with, not avoided	0	5	11.7	48.3	35

Results

Item	Almost Never True	Seldom True	Sometimes True	Often True	Almost Always True
17.Nurses and physicians here respect each other's' opinions, even when they disagree about what is best for patients	5	10	35	35	15
18.I work with competent colleagues	0	3.3	11.7	66.7	18.3
19.The patient's wishes are respected	0	3.3	6.7	40	50
20.When my peers are unable to decide what's right or wrong in a particular patient care situation, I have observed that my manager helps them	5	8.3	25	45	16.7
21.There is a sense of questioning, learning, and seeking creative responses to patient care problems	10	5	33.4	43.3	8.3
22. Nurses and physicians respect one another.	0	5	8.4	43.3	43.3
23.Safe patient care is given on my unit	0	3.4	18.3	50	28.3
24.My manager is someone I respect	0	1.7	1.7	23.3	73.3
25.I am able to practice nursing on my unit as I believe it should be practiced	0	5	18.3	51.7	25
26.Nurses are supported and respected in this hospital	18.2	31.7	31.7	16.7	1.7

Table (7) illustrated that, almost two thirds (68.3%) of studied nurses reported almost never true to the sentence of (A clear sense of the hospital's mission is shared with nurses), while 66.7% of them reported often true to the sentence of (I work with competent colleagues). Moreover more than two thirds (73.3%) of studied nurses answered almost always true to the sentence of (My manager is someone I respect).

Figure (2): Percentage Distribution of the Studied Nurses according to their Total Hospital Ethical Climate Level.

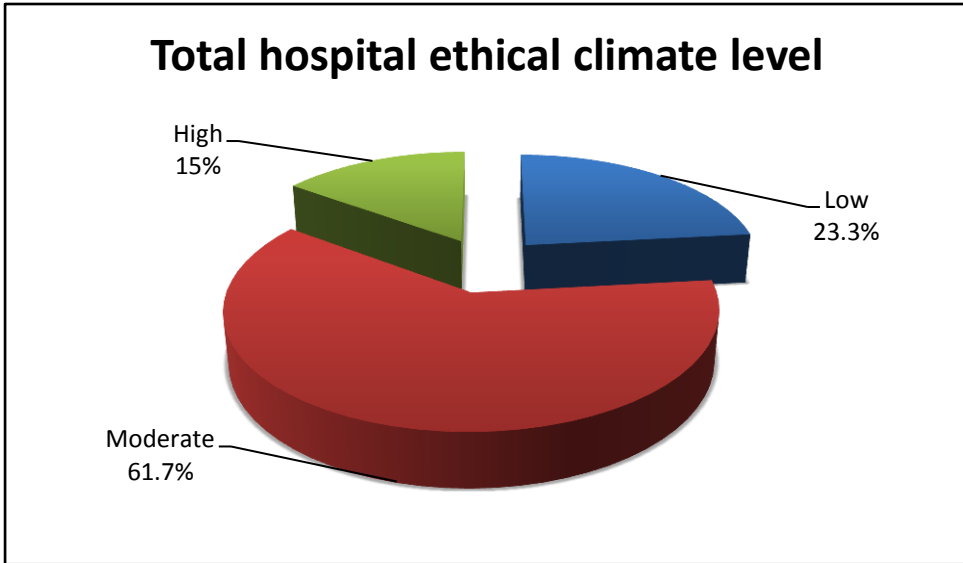


Figure (2) showed that, 61.7% of the studied nurses had moderate level of hospital ethical climate.

Part IV: Relations between Variables of the Study

Table (8): Relation between gender of Studied Nurses and their Total Moral Distress Level (No=60).

Gender	Moral distress level					
	Low (24)		Moderate (32)		High(4)	
	No	%	No	%	No	%
Female	24	42.1	29	50.9	4	7.0
Male	0	0.0	3	100.0	0	0.0
X²&P value	X ² =2.76			P > 0.05		

Table (8) showed that, there was no statistical significance difference between gender of studied nurses and their total moral distress level.

Figure (3): Relation between age of the Studied Nurses and their Total Moral Distress Level.

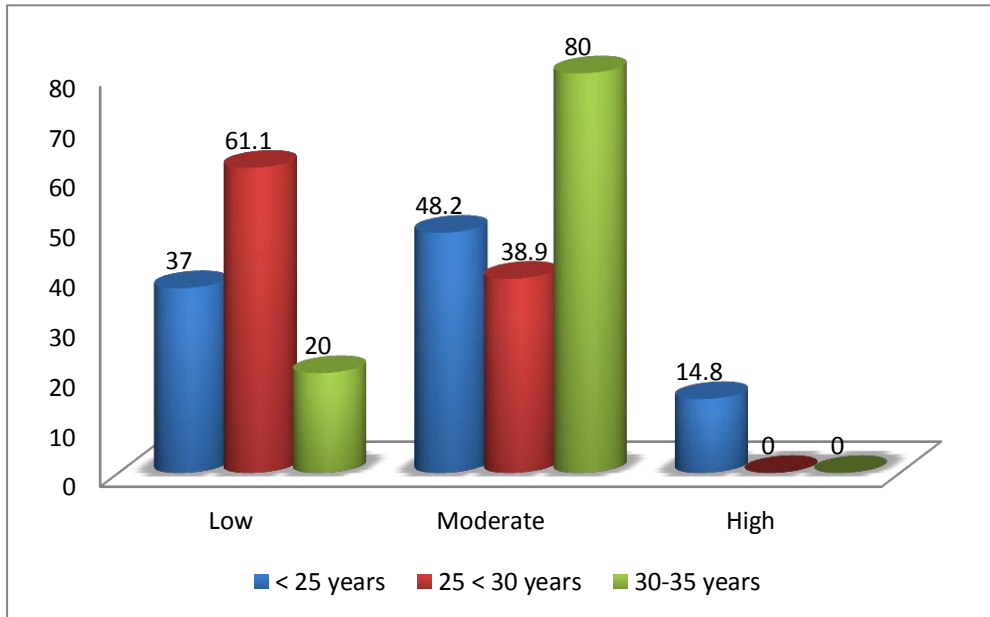


Figure (3) represented that, there was a statistical significance difference between age of the studied nurses and their total moral distress level. Where more than half (61.1%) of the studied nurses who aged 25 to less than 30 years had low moral distress level, while 80% of studied nurses who aged 30-35 years had moderate moral distress level.

Table (9): Relation between Marital Status of the Studied Nurses and their Total Moral Distress Level (No=60).

Marital status	Moral distress level					
	Low (24)		Moderate (32)		High(4)	
	No	%	No	%	No	%
Single	9	36.0	14	56.0	2	8.0
Married	14	42.4	17	51.5	2	6.1
Widow	1	50.0	1	50.0	0	0.0
X²&P value	X ² =.48			P > 0.05		

Table (9) illustrated that, there was no statistical significance difference between marital status of the studied nurses and their total moral distress level.

Figure (4): Relation between Educational Level of the Studied Nurses and their Total Moral Distress Level.

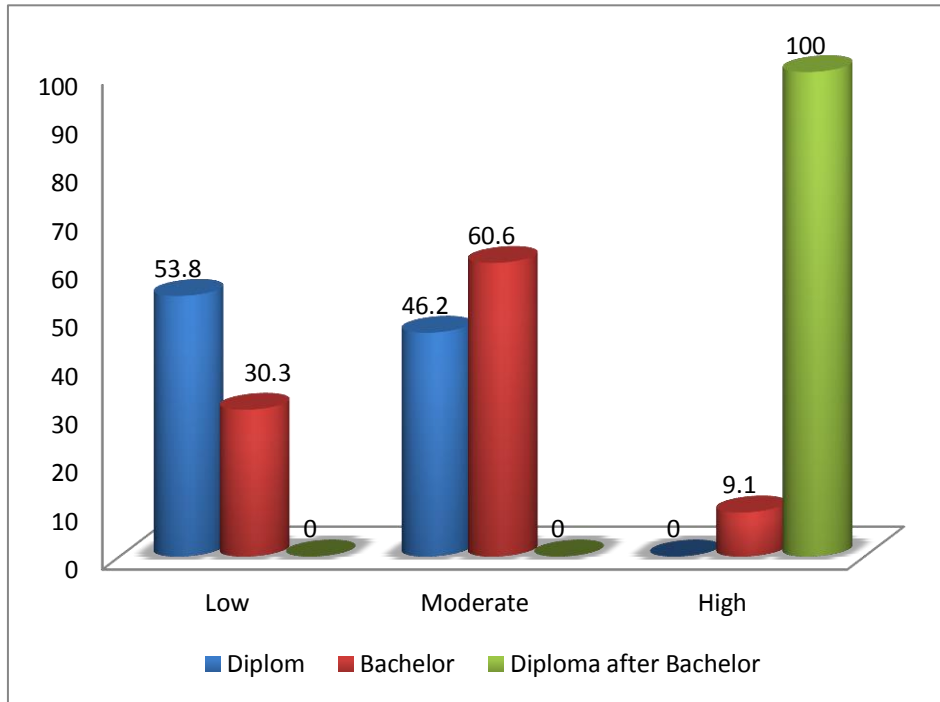


Figure (4) showed that, there was a statistical significance difference between educational level of the studied nurses and their total moral distress level. Where more than half (53.8%) of studied nurses who had Diplom were had low moral distress, while 60.6% of them who had Bachelor were had moderate level of moral distress.

Results

Figure (5): Relation between Years of Experience of the Studied Nurses and their Total Moral Distress Level.

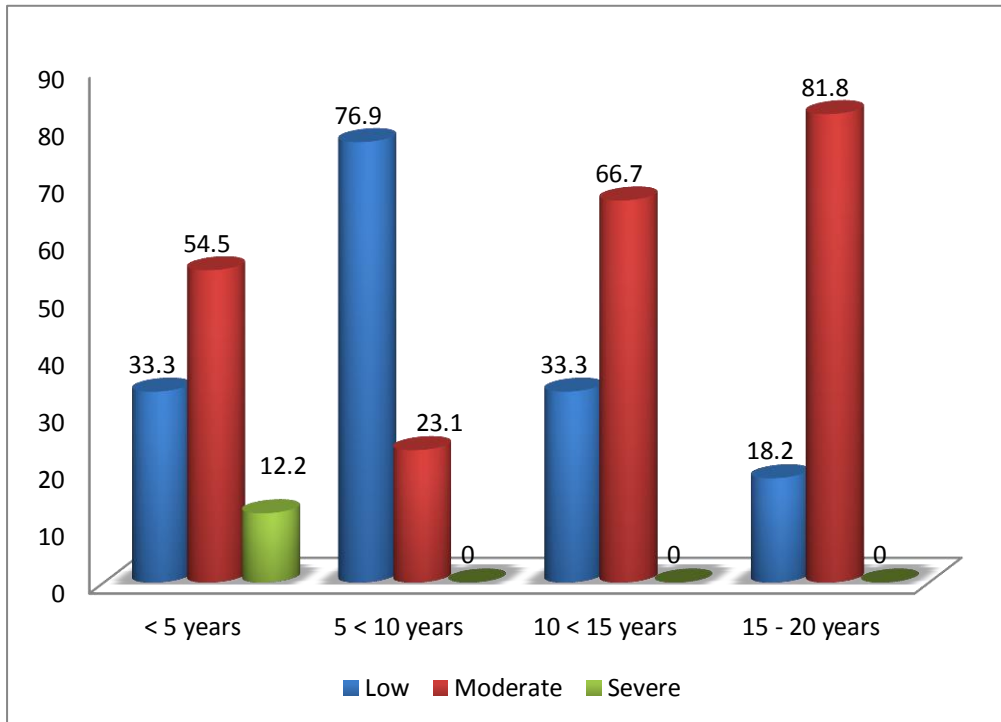


Figure (5) showed that, there was a statistical significance difference between years of experience of the studied nurses and their total moral distress level. Where more than three quarters (76.9%) of nurses who work from 5 years to less than 10 years had low moral distress level, while two thirds (66.7%) of nurses who work from 10 years to less than 15 years had moderate moral distress level.

Results

Table (10): Relation between gender of the Studied Nurses and their Total Hospital Ethical Climate Level (No=60).

Gender	Hospital Ethical climate level					
	Low (14)		Moderate (37)		High (9)	
	No	%	No	%	No	%
Female	13	22.8	35	61.4	9	15.8
Male	1	33.3	2	66.7	0	0.0
X²&P value	X ² =.62			P > 0.05		

Table (10) revealed that, there was no statistical significance difference between gender of the studied nurses and their total hospital ethical climate level.

Results

Figure (6): Relation between Age of the Studied Nurses and their Total Hospital Ethical Climate Level.

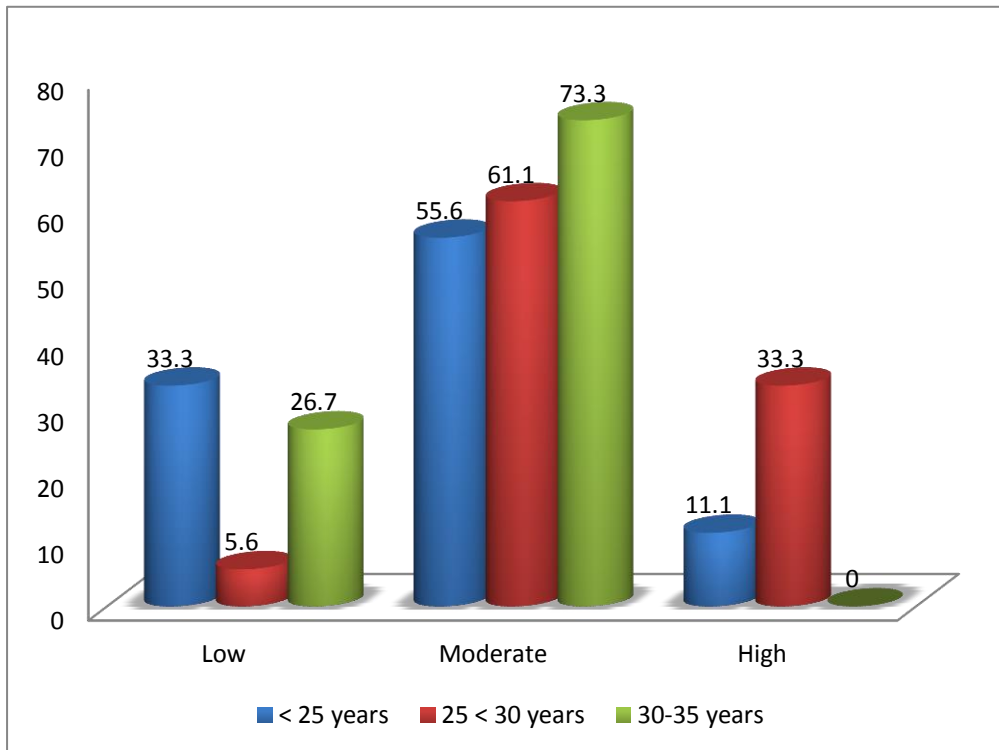


Figure (6) represented that, there was a statistical significance difference between age of the studied nurses and their total hospital ethical climate level. As 33.3% of nurses who aged less than 25 years had low hospital ethical climate level, while more than two thirds (73.3%) of them who aged 30-35 years had moderate hospital ethical climate level.

Table (11): Relation between Marital Status of the Studied Nurses and their Total Hospital Ethical Climate Level (No=60).

Marital status	Hospital Ethical climate level					
	Low (14)		Moderate (37)		High (9)	
	No	%	No	%	No	%
Single	5	20.0%	16	64.0%	4	16.0%
Married	9	27.3%	19	57.6%	5	15.2%
Widow	0	0.0%		100.0%	0	0.0%
X²&P value	X ² =1.71			P > 0.05		

Table (11) showed that, there was no statistical significance difference between marital status of the studied nurses and their total hospital ethical climate level.

Results

Table (12): Relation between Educational Level of the Studied Nurses and their Total Hospital Ethical Climate Level (No=60).

Educational Level	Hospital Ethical climate level					
	Low (14)		Moderate (37)		High (9)	
	No	%	No	%	No	%
Diplom	4	15.4	17	65.4	5	19.2
Bachelor	9	27.3	20	60.6	4	12.1
Diploma after Bachelor	1	100	0	0.0	0	0.0
X²&P value	X ² = 4.77			P > 0.05		

Table (12) illustrated that, there was no statistical significance difference between educational level of the studied nurses and their total ethical climate level.

Results

Figure (7): Relation between Years of Experience of the Studied Nurses and their Total Hospital Ethical Climate Level.

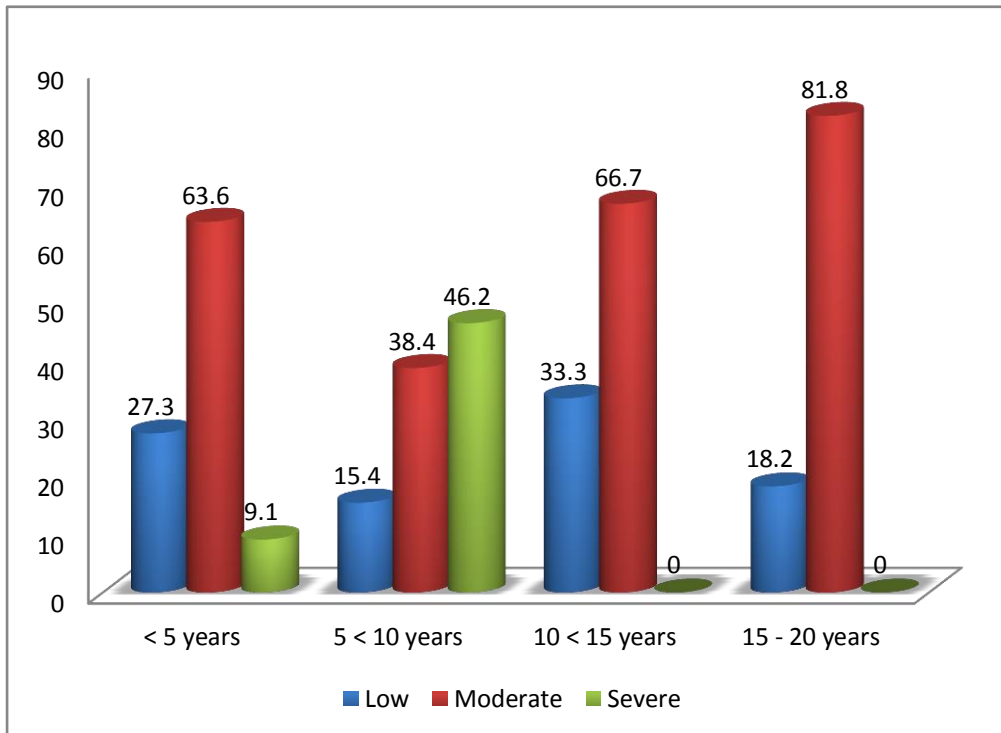


Figure (7) showed that, there was a statistical significance difference between years of experience of the studied nurses and their total hospital ethical climate level.

Results

Figure (8): Relation between Total Moral Distress Level of the Studied Nurses and their Total Hospital Ethical Climate Level.

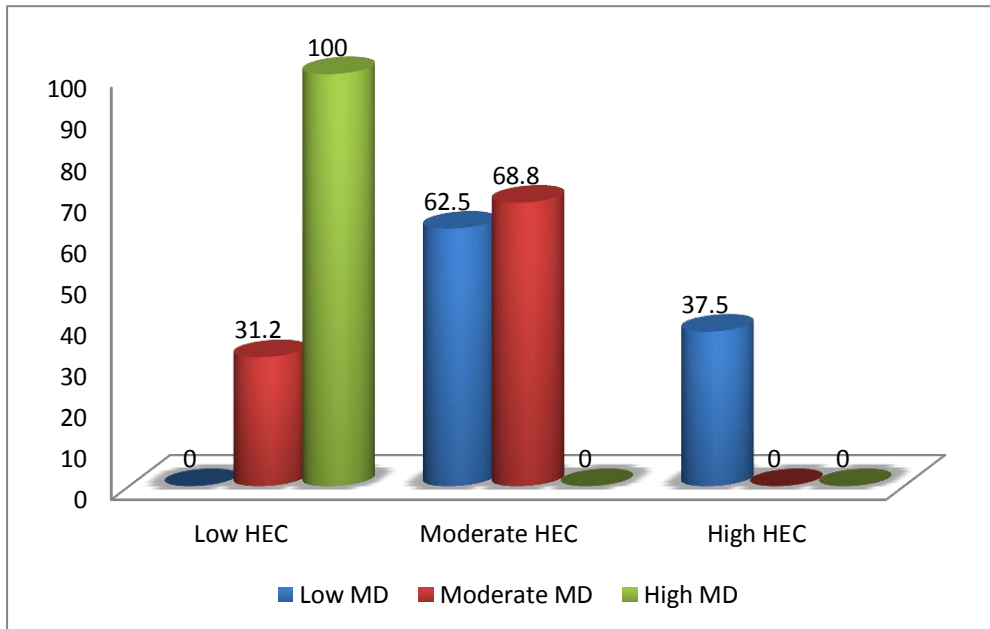


Figure (8) revealed that, there was a statistical significance difference between total moral distress level of the studied nurses and their total hospital ethical climate level.

Discussion

Nursing workers experience moral problems and conflicts in trivialized situations in the work environments, which are taken as inseparable parts in their professional life. Those professionals who are repeatedly exposed to situations and not being able carrying out what considered being the ethically appropriate actions, are potentially subject to moral distress (**Barlem, et al., 2013, Allen, et al., 2013**).

Moral distress has the potential to create suffering in those nurses who experience it, affecting the nurse's ability to practice in an ethical manner and possibly compromising the care the nurse provides and it involves a violation of personal values and disrupts moral identity, also moral distress can fracture nurses' self-images, feelings of worth, and integrity (**Radzvin, 2011, Weinzimmer et al., 2014**).

The present study aimed to assess level of moral distress of nurses working in pediatric intensive care unit. Regarding to characteristics of the studied nurses, the finding of the present study showed that, the majority of the studied nurses were females. This finding is in agreement with finding of **DeVeer et al., (2013)**, who studied Determinants of Moral Distress in Daily

Discussion

Nursing Practice: a Cross Sectional Correlational Questionnaire Survey and found that the majority of nursing staff members were females. The mean age of the studied nurses in the current study was 27.3 ± 5.1 years. This finding is accordance with finding of **Allari & Abu-Moghli, (2013)**, who studied Predictors of Moral Distress among Jordanian Critical Care Nurses and mentioned that, participants were comparable with a mean age of 27 years old.

The finding of the present study showed that, more than half of studied nurses were married. This finding is similar with finding of **Hassan et al., (2013)**, who studied Moral Distress Related Factors Affecting Critical Care Nurses and reported that, more than three quarters of the studied nurses were married.

The finding of the current study showed that, more than half of studied nurses had Bachelor. This finding is in agreement with finding of **De Villers, (2010)**, who studied Moral Distress and Avoidance Behavior in Nurses Working in Critical Care and Non-Critical Care Units and reported that, the majority of the nursing staff held a Bachelor degree in nursing.

The findings of the present study revealed that, all of the studied nurses did not obtain any programs about moral distress. This result is supported by result of **Hassan et al., (2013)**, who

found that none of the studied nurses had any previous in-service training programs about moral distress.

The current study illustrated that, all of the studied nurses hadn't any knowledge about moral distress. This finding is similar with finding of **Maluwa et al., (2012)**, who studied Moral Distress in Nursing Practice in Malawi and reported that, none of the participants was initially familiar with the meaning of moral distress. It could be due to the concept of moral distress still unknown to all pediatric nurses and they didn't hear this concept before in their daily practice or in their curriculums.

The finding of the present study showed that, the studied nurses had the most occurrence frequency of item 4 (Initiate extensive life-saving actions when I think they only prolong death) in table (4). This finding is accordance with finding of **Hamric et al., (2012)**, who studied Development and Testing of an Instrument to Measure Moral Distress in Health Care Professionals and listed the top 10 clinical situations for frequency, item 4 ranked a second in their study. On the other hand the studied nurses had no occurrence of item 14 (Increase the dose of sedatives/opiates for an unconscious child that I believe could hasten the child's death) in table (4). This finding is an accordance with finding of **Sauls, (2011)**, who studied Moral Distress Experienced by Registered Nurses in Georgia and its

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Impact on Nurse Turnover and reported that, the lowest frequency score was item 14.

The studied nurses of the current study had the most disturbed situation for level of disturbance of item 20 (Watch patient care suffer because of a lack of provider continuity) in table (5). This finding is in consistent with finding of **Sauls, (2011)**, who listed the top 10 clinical situations for level of disturbance, item 20 ranked as a seventh in her study.

The finding of the current study revealed that, total moral distress score for the great majority of studied nurses was in general low-to-moderate. This is the same result of **Sannino et al., (2014)**, who studied Moral Distress in the Neonatal Intensive Care Unit: an Italian Study and mentioned that, the studied nurses had a low-to-moderate experience of moral distress. In addition, more than half of studied nurses in the present study had moderate level of moral distress. This is consistent with finding of **Allari & Abu-Moghli, (2013)**, who reported that, the nurses in critical care units reported moderate level of moral distress. More over in the current study there was minimum percentage of studied nurses had high moral distress level. This finding is agree with finding of **Radzvin, (2011)**, who studied Moral Distress in Certified Registered Nurse Anesthetists: Implications for Nursing Practice

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and found that, staff nurses generally experienced moderate level of moral distress and a small number of them experienced high level of moral distress.

The finding of the present study showed that, more than half of the studied nurses considered quitting but did not leave their clinical position because of their moral distress. This finding is consistent with finding of **Hamric et al., (2011)**, who studied Moral Distress and Ethical Climate in Nurses and Physicians in Intensive Care Unit (ICU) Settings and mentioned that, the number of nurses considering leaving their current position due to moral distress was high.

The current study showed that, more than half of the studied nurses answered almost always true to the sentence 24 (My manager is someone I respect) in table (7). This finding is agree with finding of **Khalesi et al., (2014)** who studied Psychometric Properties of the Persian Version of the “Hospital Ethical Climate Survey” and reported that items 24 had the highest average. It could be due to our culture and religion enhances respecting our managers even there are differences in views.

More than half of the studied nurses had moderate level of hospital ethical climate. This result is consistent with result of

Sauerland et al., (2014), who studied Assessing and Addressing Moral Distress and Ethical Climate, Part 1 Dimensions of Critical Care Nursing and reported that nurses believed their work climate was moderately ethical.

The finding of the current study revealed that, there was no statistical significance difference between sex of the studied nurses and their total moral distress level. This finding is consistent with finding of **Dodek et al., (2012)**, who studied Moral Distress in ICU Professionals is Associated With Profession and Years of Experience and reported that males and females reported similar level of moral distress. Moreover this finding is not accordance with finding of **O'Connell, (2015)**, who studied Gender and the Experience of Moral Distress in Critical Care Nurses and revealed that, there was a statistical significance difference between sex and the mean moral distress scores of studied nurses, where females reported higher moral distress scores than did males.

The finding of the present study showed that, there was a statistical significance difference between age of the studied nurses and their total moral distress level. This finding is similar to the finding of **Borhani et al., (2014)**, who studied The Relationship between Moral Distress, Professional Stress and

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Intent to Stay in the Nursing Profession and found that, there was a significance relation between age and moral distress. This finding is not accordance with **Hassan et al., (2013)**, who revealed that, there was no significance difference between age of the nursing staff and their level of moral distress.

The finding of the present study revealed that, there was no statistical significance difference between marital status of studied nurses and their total moral distress level. This finding is consistent with finding of **Shoorideh et al., (2014)**, who studied Relationship between ICU Nurses' Moral Distress With Burnout and Anticipated Turnover and reported that there were no correlation between marital status and moral distress.

The result of the current study revealed that, there was a statistical significance difference between educational level of the studied nurses and their total moral distress. Where pediatric nurses with more education have higher levels of moral distress. It could be due to higher educated nurses may have more confidence in their decisions concerning pediatric patient care because these nurses have much scientific knowledge and much ethics knowledge than less educated nurses but in actual situations they haven't any authority to implement what considered to be right and forced to carry out doctors' orders to what considered

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unnecessary tests and treatments. This result was similar with result of **Schluter et al., (2008)**, who studied Nurses' Moral Sensitivity and Hospital Ethical Climate: a Literature Review and reported that, there was a significance relationship between educational level and moral distress and clarified that nurses with more education have higher levels of moral distress. In contrast of result of **Sirilla, (2013)**, who studied Moral Distress in Nurses Providing Direct Patient Care on Inpatient Oncology Units and found that, when the nurses' level of education increased the moral distress score decreased.

The current study revealed that there was a statistical significance difference between years of experience of studied nurses and their total moral distress level. This finding is consistent with finding of **Allen et al., (2013)**, who studied Moral Distress among Healthcare Professionals at a Health System and reported that, nurses with more years of experience in their profession did not demonstrate higher moral distress. At variance with finding of **Epstein & Hamric, (2009)**, who studied Moral Distress, Moral Residue and the Crescendo Effect and mentioned that those with more years of experience in their profession demonstrated higher moral distress.

Regarding relation between sex of the studied nurses and their total hospital ethical climate level the result of the current study showed that there was no statistical significance difference. This result is accordance with **AL-Omari, (2013)**, who studied The Perceived Organizational Ethical Climate in Hashemite University and mentioned that there was no statistical significance difference between male and female faculty members in the perceived ethical climate. At variance with **Proios et al., (2010)**, who studied Ethical Climate and Sports Person Ship and reported that, there was a significance relation between sex and ethical climate.

The result of the present study revealed that, there was a statistical significance difference between age of studied nurses and their total hospital ethical climate level. This result is consistent with result of **Forte, (2011)**, who studied How Does Organizational Climate Influence the Ethical Behavior of People in an Organization?, and found that, there was a statistical significance relationship between age and organizational ethical climate. This result is not consistent with **Mobasher et al., (2008)**, who studied Assessing the Ethical Climate of Kerman Teaching Hospitals and reported that, there was no statistical significance difference between age and total score of the ethical climate.

The finding of the current study showed that there was no statistical significance difference between educational level of the studied nurses and their hospital ethical climate level. This finding is the same with finding of **Erkmen et al., (2011)**, who studied A Study about the Relationship between Political Behavior and Ethical Climate in Banking Sector and clarified that, employees' education didn't have significance relationship with ethical climate. This finding is disagree with finding of **Parboteeah et al., (2008)**, who studied Ethics and Religion: an Empirical Test of a Multidimensional Model and reported that, education level has a significance effect on perceived ethical climate.

The result of the present study revealed that, there was a statistical significance difference between years of experience of studied nurses and their total hospital ethical climate level. This result is not consistent with result of **Ghorbani et al., (2014)**, who studied Public and Private Hospital Nurses' Perceptions of The Ethical Climate in their Work Settings, Sari City, 2011 and reported that, there was a significance relation between years of experience and ethical climate.

The current study revealed that there was a statistical significance difference between total moral distress level and total hospital ethical climate level of the studied nurses. This finding is

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accordance with finding of **Sauerland et al., (2014)** who found that, nurses' moral distress negatively correlated with ethical climate. This finding is not accordance with finding of **Joolaee et al., (2011)**, who studied The Relationship between Nurses' Perception of Moral Distress and Ethical Environment in Tehran University of Medical Sciences and mentioned that, there was no significance relationship between moral distress of the studied nurses and their ethical climate of their workplace.

Conclusion

The current study concluded that:

All studied nurses had a poor level of total knowledge about moral distress and hospital ethical climate, and more than half of them had moderate level of total moral distress. Studied nurses' level of moral distress mainly affected by their age, level of education and years of experience. Moreover, more than half of studied nurses had moderate level of total hospital ethical climate. Studied nurses' level of hospital ethical climate affected by their age and years of experience. In addition to, there was a statistical significance difference between studied nurses' level of moral distress and their level of hospital ethical climate.

Recommendations

In the light of the study findings, the following recommendations are suggested:

- Provide continuous training courses about moral distress for pediatric ICU nurses where nurses be aware of moral distress, causes and coping mechanisms.
- Emphasis on importance of presence of ethics committees in hospitals and staff education on how to utilize these hospital ethics committees.
- Offering staff support through individual and group counseling and debriefing session with other healthcare professionals where open interdisciplinary communications are facilitated and nurses' concerns are listened to.
- Healthcare organizations need to create policies that support nurses facing unethical situations without fair of the others authority.
- Further researches are needed to measure moral distress in Egypt and its effect on the patient care because almost all of our understandings about moral distress are from western international literature except one study in Egypt, one study in Jordan and few studies in Iran.
- Further researches are needed to measure ethical climate aspects and its relation with moral distress.

Summary

Moral distress is a common problem that can have adverse effects on pediatric nurses, children patients and the healthcare system as a whole. Moral distress occurs when an individual knows what the right course of action should be in a particular situation, but that person is hampered from acting on that knowledge by a variety of factors. Researchers indicated that there is a significant relationship between moral distress and hospital ethical climate as when a perception of the ethical climate decrease, pediatric nurses report increased levels of moral distress and are more likely to leave a position (Borhani et al., 2014, Carlson, 2014, Sauerland, 2014).

Aim of the study

This study aimed to assess moral distress of nurses working in pediatric intensive care unit.

Technical Design

1) Research Design

A descriptive design was utilized in the present study.

2) Research Settings

This study was conducted in pediatric intensive care unit at Children Hospital affiliated to Ain Shams University and Tanta University.

3) Research Subjects

All available nurses work at the previously mentioned settings regardless their characteristics (No= 60)

4) Tools for data collection

Data were collected using the following Tools:

1-Pre-designed questionnaire sheet:

This sheet developed by researcher after reviewing the related literatures and was written in a simple Arabic language. It consisted of two parts:

Part 1:

Socio-demographic characteristics of the nurses as name, gender, age, marital status, educational level and years of experience.

Part 2:

- Knowledge of nurses about moral distress as definitions, causes, signs and symptoms and effects on nurses, patients and organizations.
- Knowledge of nurses about hospital ethical climate such as definitions and relation between ethical climate and moral distress.

Scoring system:

The answers of studied nurses were checked with a key answer and the studied nurses' knowledge was categorized into

three levels: poor (less than 50%), Average (50% > 75%) and good (75% & more).

2-Moral Distress Scale - Revised.

It was adopted from **Hamric et al., (2012)** to assess the level of moral distress of the studied nurses working at the previously mentioned settings. Moral Distress Scale - Revised is a 5 point likert scale. Each of the 21 items is scored by participants in terms of the how often the situation arises (frequency) and how disturbing the situation is when it arises (level of disturbance).

Scoring System:

The scale for frequency ranges from 0 (never) to 4 (very frequently) and for level of disturbance from 0 (none) to 4 (great extent).

Score for overall moral distress is computed in a two part procedure. First, the frequency score and the level of disturbance score are multiplied for each of the 21 items (Frequency× level of disturbance) score, which ranges from 0 to 16, next, the composite score is obtained by summing each item's (Frequency× level of disturbance) score. The resulting score based on 21 items has a range of 0–336.

Summary

The total score are divided into three parts to represent low level of moral distress (0-111), moderate level (112-223), and high level (224-336).

The final section of the scale contains the following two questions not involved in the scoring system:

Q1: Have you ever left or considered quitting a clinical position because of your moral distress with the way patient care was handled at your institution?

- Yes, I left a position.
- Yes, I considered quitting but did not leave.
- No, I've never considered quitting or left a position.

Q2: Are you considering leaving your position now?

- Yes.
- No.

3- Hospital Ethical Climate Survey.

It was adopted from **Olson, (1998)** to assess the perception of hospital ethical climate of the nurses. Hospital Ethical climate Survey is a 5point- Likert scale consist of 26 variables in five factors organized according to the relationships with peers (items 1, 10, 18 and 23), patients (items 2, 6, 11 and 19), managers

Summary

(items 3, 7, 12, 15, 20 and 24), hospital (items 4, 8, 13,16, 21 and 25), and physicians (items 5, 9, 14, 17, 22 and 26).

Scoring System:

Score for overall hospital ethical climate by giving Almost never true (score=1), rarely (score=2), sometimes (score=3), often (score=4) and almost always true (score=5).

The total score is obtained by summing the score of each item for 26 items, the resulting score based on 26 items has a range of 1–130, considering low (1-77), moderate (78-103) and high was (104-130).

Operational Design

Preparatory Phase

During this phase, a review of the study tool was prepared through reviewing the available local and international related literature to be oriented with the various aspects of research problem.

Exploratory Phase

A Pilot study was carried out including on 10% of the nurses of the study sample to test the applicability and feasibility of the tools, then the tools was modified according to the results of pilot study.

Field Work

Approval was taken by e-mail from Dr **Hamric** to use Moral Distress Scale- Revised and from Dr **Olson** to use Hospital Ethical Climate Survey then, the actual field work was carried out over 6 months' period from January 2014 up to the end of June 2014. The researcher was available in the study setting 3 days/week (From Saturday to Monday) by rotation between the two places (Ain Shams and Tanta) and rotation in time include morning shift (9Am to 2 Pm) and after noon shift (2 Pm to 8 Pm) to be able to deal with different nurses. The purpose of the study and its expectations were explained by the researcher to studied nurses before starting interviewing and data gathering. Interviewing time rang from (15 to 30 minutes) for every nurse to clarify and prevent misunderstanding of tools items' meaning.

Ethical Consideration

All the gathered data was used for research purpose only. The studied nurses were informed about the purpose and expected outcomes of the study and they was assured that the study was harmless and their participation were voluntary and they were have the right to withdraw from the study at any time and without given any reason. They were assured also that anonymity and confidently will be guaranteed.

Administrative Design

Approval was obtained through an issued letter from Dean of faculty of nursing, Ain Shams University to hospitals directors of the both previously mentioned settings.

Statistical Design

The obtained data was organized, tabulated & analyzed using suitable statistical tests like number and percentage distribution. Chi-square test, mean and standard deviation were used to estimate the statistical significant difference between variables of the study; where

$P > 0.05$ there is no statistical significance.

$P \leq 0.05$ there is a statistical significance.

Results

Findings of the current study can be summarized as the following:

- The great majority (95%) of the studied nurses were females and 45% of them were in the age group less than 25years with a mean age 27.3 ± 5.1 .
- More than half (55%) of studied nurses were married and had Bachelor.
- All of the studied nurses (100%) had not obtained courses about moral distress before.

Summary

- All of the studied nurses (100%) had a poor level of total knowledge about moral distress and hospital ethical climate.
- More than half (53.3%) of studied nurses had moderate level of moral distress.
- More than half (61.7%) of studied nurses considered quitting a clinical position because of their moral distress with the way children patients care was handled at their institution but did not leave.
- More than half (61.7%) of the studied nurses had moderate level of hospital ethical climate.
- There was no statistical significance difference between gender of studied nurses and their total moral distress level.
- There was a statistical significance difference between age of the studied nurses and their total moral distress level. Where more than half (61.1%) of the studied nurses who aged 25 to less than 30 years had low moral distress level, while 80% of studied nurses who aged 30-35 years had moderate moral distress level.
- There was no statistical significance difference between marital status of the studied nurses and their total moral distress level.
- There was a statistical significance difference between educational level of the studied nurses and their total moral distress level. Where more than half (53.8%) of studied nurses

Summary

who had Diplom were had low moral distress, while 60.6% of them who had Bachelor were had moderate level of moral distress.

- There was a statistical significance difference between years of experience of the studied nurses and their total moral distress level Where more than three quarters (76.9%) of nurses who work from 5 years to less than 10 years had low moral distress level, while two thirds (66.7%) of nurses who work from 10 years to less than 15 years had moderate moral distress level.
- There was no statistical significance difference between gender of the studied nurses and their total hospital ethical climate level.
- There was a statistical significance difference between age of the studied nurses and their total hospital ethical climate level. As 33.3% of nurses who aged less than 25 years had low hospital ethical climate level, while more than two thirds (73.3%) of them who aged 30-35 years had moderate hospital ethical climate level.
- There was no statistical significance difference between marital status of the studied nurses and their total hospital ethical climate level.

Summary

- There was no statistical significance difference between educational level of the studied nurses and their total ethical climate level.
- There was a statistical significance difference between years of experience of the studied nurses and their total hospital ethical climate level.
- There was a statistical significance difference between total moral distress level of the studied nurses and their total hospital ethical climate level.

Conclusion

The current study concluded that:

All studied nurses had a poor level of total knowledge about moral distress and hospital ethical climate, and more than half of them had moderate level of total moral distress. Studied nurses' level of moral distress mainly affected by their age, level of education and years of experience. Moreover, more than half of studied nurses had moderate level of total hospital ethical climate. Studied nurses' level of hospital ethical climate affected by their age and years of experience. In addition to, there was a statistical significance difference between studied nurses' level of moral distress and their level of hospital ethical climate.

Recommendations

In the light of the study findings, the following recommendations are suggested:

- Provide continuous training courses about moral distress for pediatric ICU nurses where nurses be aware of moral distress, causes and coping mechanisms.
- Emphasis on importance of presence of ethics committees in hospitals and staff education on how to utilize these hospital ethics committees.
- Offering staff support through individual and group counseling and debriefing session with other healthcare professionals where open interdisciplinary communications are facilitated and nurses' concerns are listened to.
- Healthcare organizations need to create policies that support nurses facing unethical situations without fair of the others authority.
- Further researches are needed to measure moral distress in Egypt and its effect on the patient care because almost all of our understandings about moral distress are from western international literature except one study in Egypt, one study in Jordan and few studies in Iran.
- Further researches are needed to measure ethical climate aspects and its relation with moral distress.

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List of Abbreviations

Abbreviation	Meaning
MD	Moral Distress
HEC	Hospital Ethical Climate
MDS-R	Moral Distress Scale-Revised
HECS	Hospital Ethical Climate Survey
ICU	Intensive Care Unit
ANA	American Nurses Association
AACN	American Association of Critical-Care Nursing

الملخص العربي

تعد المحنة الأخلاقية مشكلة شائعة لما لها من آثار سلبية على الممرضات و الممرضين اللذين يعملوا في وحدة العناية المركزة للأطفال، والمرضى من الأطفال، ونظام الرعاية الصحية ككل. تحدث المحنة الأخلاقية عندما تكون الممرضة أو الممرض على دراية بالقرار الصحيح الذي يجب إتخاذه في احد المواقف الخاصة برعاية المرضى ولكنهم لا يتمكنوا من تنفيذ هذا القرار بسبب العديد من المعوقات. وقد أوضح الباحثون أن هناك علاقة بين المناخ الأخلاقي للمستشفى ومستويات المحنة الأخلاقية حيث انه كلما قل المناخ الأخلاقي للمستشفى كلما زادت معاناة الممرضات و الممرضين من المحنة الأخلاقية وزادت رغبتهم في ترك مناصبهم أو ترك مهنة التمريض .

الهدف من الدراسة:

تهدف هذه الدراسة إلى تقييم المحنة الأخلاقية للممرضات اللاتي يعملن في وحدة العناية المركزة للأطفال

تصميم البحث:

تم إستخدام تصميم وصفي لإجراء هذه الدراسة.

الأمكان:

تم إجراء الدراسة في وحدة العناية المركزة في مستشفى الأطفال التابع لجامعة عين شمس وجامعة طنطا.

العينة:

عينة تشمل كل الممرضات و الممرضين اللذين يعملوا في الأماكن سالفة الذكر دون النظر إلى خصائصهم.

أدوات جمع البيانات:

تم جمع البيانات باستخدام الأدوات التالية:

١. ورقة إستبيان مصممة مسبقا:

هذه الورقة أعدتها الباحثة بعد مراجعة الدراسات السابقة و مكتوبة باللغة العربية البسيطة لتناسب مستوى الممرضات و الممرضين وكانت تتكون من جزئين:

الجزء ١:

الخصائص الاجتماعية والديموغرافية للممرضات و تشمل الاسم، الجنس، العمر، الحالة الإجتماعية، المؤهل العلمي و سنوات الخبرة.

الجزء ٢:

- معلومات الممرضات و الممرضين عن المحنة الأخلاقية و تشمل التعريف، الأسباب، الأعراض، و الآثار على الممرضات و الممرضين، المرضى من الأطفال و المستشفيات.
- معلومات الممرضات و الممرضين عن المناخ الأخلاقي للمستشفى و تشمل التعريف و علاقته بالمحنة الأخلاقية.

نظام التقييم:

بناء على تقييم مستوى المعلومات لدى الممرضات و الممرضين عن المحنة الأخلاقية يعتبر أقل من ٥٠% ضعيف، أكثر من ٥٠% و أقل من ٧٥% متوسط ومن ٧٥% فأكثر جيد.

٢. مقياس شدة المحنة الأخلاقية:

لتقييم مستوى المحنة الأخلاقية لدى الممرضات و الممرضين الذين يعملوا في الأماكن سألنا الذكر. ويتكون مقياس شدة المحنة الأخلاقية من ٢١ بند، ويتم قياس جميع البنود على مقياس ليكرت مكون من ٥ نقط من ٠ إلى ٤ لقياس بعدين هما: عدد

مرات تكرار الموقف الذي يسبب محنة أخلاقية و مستوى الإزعاج الذي يسببه حدوث هذا الموقف.

نظام التقييم:

يتم حساب مستوى المحنة الأخلاقية بضرب عدد مرات تكرار الموقف في مستوى الإزعاج لكل بند ، ثم تجمع حاصل ضرب ٢١ بند لنحصل على التقييم الكلي لمستوى المحنة الأخلاقية (٣٣٦).

تعتبر نتائج التقييم الكلي من (٠-١١١) محنة أخلاقية بسيطة , من (١١٢-٢٢٣) محنة أخلاقية متوسطة , ومن (٢٢٤-٣٣٦) محنة أخلاقية شديدة.

الجزء الأخير من مقياس شدة المحنة الأخلاقية يحتوي على سؤاليين:

س^١: هل سبق لك أن تركت أو فكرت في الاستقالة بسبب المحنة الأخلاقية الناتجة عن طريقة التعامل مع رعاية المرضى في مؤسستك؟

- نعم، لقد تركت منصبتي
- نعم، فكرت في الإ استقالة ولكن لم أترك منصبتي
- لا أبدا ، لم أفكر في الإ استقالة أو ترك منصبتي

س^٢: هل تفكر في ترك منصبك الآن؟

- نعم
- لا

٣. مقياس إستبائي للمناخ الأخلاقي للمستشفى:

لتقييم ادراك الممرضات و الممرضين للمناخ الأخلاقي بالمستشفى. يتم قياس جميع البنود على مقياس ليكرت مكون من ٥ نقط من ١ إلى ٥، يتكون استبيان المناخ الأخلاقي للمستشفى من ٢٦ بند لقياس خمسة عوامل نظمت وفقا لعلاقة الممرضات و الممرضين بزملائهم (البنود ١ و ١٠ و ١٨ و ٢٣)، المرضى (البنود ٢ و ٦ و ١١ و

١٩)، المديرين (البنود ٣ و ٧ و ١٢ و ١٥ و ٢٠ و ٢٤)، المستشفى (البنود ٤، ٨، ١٦، ١٣، ٢١ و ٢٥)، والأطباء (البنود ٥ و ٩ و ١٤ و ١٧ و ٢٢ و ٢٦)

نظام التقييم:

يتم حساب مستوى المناخ الأخلاقي للمستشفى بجمع التقييم لكل بند من ٢٦ بند لنحصل على التقييم الكلي للمناخ الأخلاقي للمستشفى (١٣٠).

تعتبر نتائج التقييم الكلي (١-٧٧) مناخ اخلاقي منخفض، من (١٠٣-٧٨) مناخ اخلاقي متوسط، ومن (١٠٤-١٣٠) مناخ اخلاقي مرتفع.

الدراسة الإستطلاعية:

تم تنفيذ الدراسة التجريبية متضمنة ١٠٪ من الممرضات و الممرضين من عينة الدراسة لاختبار صدق وثبات الأدوات، وقد تم تعديل الأدوات وفقا لنتائج الدراسة التجريبية.

التصميمات الإحصائية:

قد تم تنظيم البيانات التي تم الحصول عليها وجدولتها وتحليلها باستخدام الاختبارات الإحصائية المناسبة .

ومن أهم نتائج البحث مايلي:

- معظم العينة من الممرضات و الممرضين (٩٥%) منهم إناث و ٤٥% منهم كانوا في المرحلة العمرية أقل من ٢٥ سنة بمتوسط $27,3 \pm ٥,١$.
- أكثر من نصف العينة (٥٥%) كانوا متزوجين و حاصلين على درجة بكالوريوس.
- كل الممرضات و الممرضين في عينة البحث (١٠٠%) لم يحصلوا على أي دورات تدريبية عن المحنة الأخلاقية من قبل.

- كل الممرضات و الممرضين في عينة البحث (١٠٠%) حصلوا على مستوى ضعيف في المعلومات عن المحنة الأخلاقية.
- أكثر من نصف الممرضات و الممرضين في عينة البحث (٥٣,٣%) يعانون من محنة أخلاقية من الدرجة المتوسطة.
- أكثر من نصف العينة (٦١,٧ %) من الممرضات و الممرضين في عينة البحث فكروا في الإستقالة ولكن لم يتركوا مناصبهم بسبب المحنة الأخلاقية الناتجة عن طريقة التعامل مع رعاية المرضى في مستشفياتهم.
- أكثر من نصف العينة (٦١,٧ %) الممرضات و الممرضين في عينة البحث لديهم مناخ اخلاقي متوسط للمستشفى.

توجد علاقة ذات دلالة احصائية بين كلا من:

- أعمار الممرضات و الممرضين في عينة البحث والمحنة الأخلاقية حيث أكثر من نصف الممرضات و الممرضين في عينة البحث (٦١,١%) واللذين تتراوح أعمارهم بين ٢٥-٣٠ عاما يعانون من محنة أخلاقية من الدرجة البسيطة ، بينما ٨٠% منهم واللذين تتراوح أعمارهم من ٣٠-٣٥ سنة يعانون من محنة أخلاقية من الدرجة المتوسطة.
- مستوى التعليم للممرضات في عينة البحث والمحنة الأخلاقية لديهم حيث أن أكثر من نصف الممرضات و الممرضين في عينة البحث (٥٣,٨%) الحاصلين على دبلوم يعانون من محنة أخلاقية من الدرجة البسيطة ، بينما ٦٠,٦% من الحاصلين على بكالوريوس يعانون من محنة أخلاقية من الدرجة المتوسطة.
- سنوات الخبرة للممرضات في عينة البحث والمحنة الأخلاقية لديهم حيث أن أكثر من ثلاث أرباع الممرضات و الممرضين في عينة البحث (٧٦,٩%)

الذين يعملوا من ٥ سنوات لأقل من ١٠ سنوات يعانون من محنة أخلاقية من الدرجة البسيطة ، بينما ثلثي الممرضات و الممرضين (٦٦,٧%) الذين يعملوا من ١٠ سنوات لأقل من ١٥ سنة يعانون من محنة أخلاقية من الدرجة المتوسطة.

لا توجد علاقة ذات دلالة احصائية بين كلا من:

- جنس الممرضات و الممرضين في عينة البحث و المحنة الأخلاقية لديهم.
- الحالة الإجتماعية للممرضات في عينة البحث و المحنة الأخلاقية لديهم.

أيضا توجد علاقة ذات دلالة احصائية بين كلا من:

- أعمار الممرضات و الممرضين في عينة البحث و المناخ الأخلاقي للمستشفى حيث أن ٣٣,٣% من الممرضات و الممرضين الذين يبلغوا من العمر أقل من ٢٥ عاما لديهم مناخ أخلاقي منخفض للمستشفى ، بينما غالبية الممرضات و الممرضين (٧٣,٣%) الذين تتراوح أعمارهم بين ٣٠ عاما لأقل من ٣٥ عاما لديهم مناخ أخلاقي متوسط للمستشفى.
- سنوات الخبرة للممرضات و الممرضين في عينة البحث و المناخ الأخلاقي للمستشفى.

لا توجد علاقة ذات دلالة احصائية بين كلا من:

- جنس الممرضات و الممرضين في عينة البحث و المناخ الأخلاقي للمستشفى.
- الحالة الإجتماعية للممرضات و الممرضين في عينة البحث و المناخ الأخلاقي للمستشفى.
- مستوى التعليم للممرضات و الممرضين في عينة البحث و المناخ الأخلاقي للمستشفى.

و أخيرا توجد علاقة ذات دلالة احصائية بين:

المحنة الأخلاقية للممرضات و الممرضين في عينة البحث و المناخ الأخلاقي للمستشفى لديهن.

التوصيات:

في ضوء نتائج الدراسة ، يمكن اقتراح التوصيات التالية:

- توفير دورات تدريبية مستمرة حول المحنة الأخلاقية للممرضات و الممرضين في وحدة العناية المركزة للأطفال حتى يكونوا على دراية كافية بالمحنة الأخلاقية وأسبابها وآليات التكيف معها.
- التأكيد على أهمية وجود لجان أخلاقيات داخل المستشفيات بالإضافة إلى تعليم الممرضات و الممرضين كيفية الاستفادة من هذه اللجان داخل المستشفيات.
- تقديم الدعم للممرضات و الممرضين من خلال جلسات الإرشاد الفردي والجماعي و جلسات الإستجواب مع باقي المتخصصين من الفريق الطبي حيث يكون التواصل و الإستماع إلى إهتمامات الممرضات و الممرضين.
- تحتاج المنظمات الطبية لتغيير السياسات لمساعدة الممرضات و الممرضين في مواجهة المواقف الغير أخلاقية في العمل بدون خوف من سلطة الآخرين.
- ضرورة وجود المزيد من الأبحاث لقياس المحنة الأخلاقية في مصر و تأثيرها على رعاية المرضى لأن معظم معرفتنا عن المحنة الأخلاقية من خلال الدراسات الغربية العالمية بإستثناء دراسة واجدة في مصر وأخرى في الأردن والقليل جدا في إيران.
- ضرورة وجود المزيد من الأبحاث لدراسة جوانب المناخ الأخلاقي للمستشفى و علاقته بالمحنة الأخلاقية .

المحنة الأخلاقية للممرضات اللاتي يعملن
في وحدة العناية المركزة للأطفال:
دراسة وصفية

توطئة للحصول على درجة الماجستير
في تمريض الأطفال

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المحنة الأخلاقية للممرضات اللاتي يعملن
في وحدة العناية المركزة للأطفال:
دراسة وصفية

توطئة للحصول على درجة الماجستير
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٢٠١٥

Moral Distress Of Nurses Working In Pediatric Intensive Care Unit: An Assessment Study

Thesis

Submitted for Partial Fulfillment of the Requirements for the Master
Degree in Pediatric Nursing

Supervised by

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**Faculty of Nursing
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2015**

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By

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2015**

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Walaa Abd Allah El-Tayar

Abstract

The **aim** of this study was to assess moral distress of nurses working in pediatric intensive care unit. **Design** a descriptive design was used. **Settings** this study was conducted in pediatric intensive care unit at children hospital affiliated to Ain Shams University and Tanta University. **Subject** all available nurses working at the previously mentioned settings regardless their characteristics (No=60). **Tools** of data collection involved 3 tools. 1)- Pre-designed questionnaire sheet which included two parts: part I included Socio-demographic characteristics of the nurses and part II included knowledge of nurses about moral distress and hospital ethical climate, 2)- Moral Distress Scale and 3)- Hospital Ethical Climate Survey. **Results** the main results of the current study showed that all of the studied nurses had a poor level of total knowledge about moral distress and hospital ethical climate and more than half of them had a moderate level of both moral distress and hospital ethical climate. More than half of studied nurses considered quitting a clinical position because of their moral distress. There was a statistical significance difference between studied nurses' level of moral distress and their level of hospital ethical climate. **Conclusion** from the findings of the current study it can be concluded that all studied nurses had a poor level of total knowledge about moral distress and hospital ethical climate, and more than half of them had moderate level of total moral distress. Studied nurses' level of moral distress mainly affected by their age, level of education and years of experience. Moreover, more than half of studied nurses had moderate level of total hospital ethical climate. Studied nurses' level of hospital ethical climate affected by their age and years of experience. In addition to, there was a statistical significance difference between studied nurses' level of moral distress and their level of hospital ethical climate. **Recommendations** this study recommended that: Provide continuous training courses about moral distress for pediatric ICU nurses where nurses be aware of moral distress, causes and coping mechanisms. Further researches are needed to measure moral distress in Egypt and its effect on the patient care because almost all of our understandings about moral distress are from western international literature except one study in Egypt, one study in Jordan and few studies in Iran.

Key words: moral distress, ethical climate, pediatric nurses, ICU, ethics, morals.

*Introduction
And
Aim of the study*

Review of Literature

Subjects and Methods

Results

Discusión

Conclusion and Recommendations

Summary

References

Appendix I

Appendix II

Appendix III

Arabic Summary

Appendix IV
