

The Relationship Between Nurses' Perception of Ethical Work Climate And Moral Distress at Kafr El-Dawar General Hospital

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Abstract

Background: The ethical work climate was defined as "a type of work climate that is best understood as a group of prescriptive climates reflecting the organizational procedures, policies, and practices with moral consequences.", while the moral distress was defined as "a broad concept that discusses a range of experiences of morally constrained individuals and can be understood as a response to the individual, institutional, or social constraints". **Aim:** To identify the relationship between staff nurses' perception of ethical work climate and moral distress at Kafr El-Dawar General Hospital. **Methods:** A descriptive, correlation research design. **Setting:** at Kafr Al-Dawar General Hospital, in all inpatient care units (N=12) and intensive care units (N=8). **Subject** all staff nurses (289 nurses). **Tools:** two tools were used, **Tool (I):** Hospital ethical climate survey and **Tool (II):** Moral distress scale. **Conclusion:** The present study revealed that there was statistically significant relationship between total ethical work climate and total moral distress. **Recommendations:** Nursing managers need to present continuous professional strategies and interventions for managing staff nurses' moral stress and ethical problems in order to foster and enhance supportive work environment, improve job satisfaction, and limit turnover.

Keywords: Ethical Work Climate, Staff Nurses, Moral Distress.

Introduction:

Nursing comprises the largest department of activity and personnel in healthcare organizations who have the longest and closest contact with patients (Haghighinezhad, Atashzadeh, Ashktorab, Mohtashami, & Barkhordari, 2019). Its main purpose is the provision of high quality of care for those patients and it is the profession that has always been intrinsically accompanied with common ethical concerns (Habiba, Eldin, & Ibrahim, 2018). In the realm of daily patient care activities, the nursing work climate can serve as the foundation for support mechanisms that nurses may utilize for coping with difficult situations and to moderate the effects of moral stress (Chen, Lee, Huang, Wang, & Huang, 2018).

Leading theoretical and empirical contribution in the field of Ethical Work Climate (EWC) goes to Victor & Cullen, 1988 who say EWC not only inferences that the organization members consider to be ethical, but it also helps members to understand, weigh and resolve such issues. Also EWC is viewed as a type of organizational work climate reflecting organizational practices, procedures, and policies with moral consequences (Koskenvuo, Numminen, & Suhonen, 2019).

Jones, 2019 defined EWC as the shared perception of knowing appropriate and correct behaviors and understanding, how ethical situations should be handled by an organization. In a health-care context, EWC is described by Grönlund, Söderberg, Dahlqvist, Andersson, & Isaksson, 2019 as shared values, perceptions, and decisions in the relations among health care

professionals, patients, managers, and organizations and mutual respect concerning ethical issues.

Olson, Suhonen, Stolt, Katajisto, & Charalambous, 2015 classified the Hospital Ethical Climate Survey (HECS) into five main dimensions which affect EWC as perceived by nurses working in the hospital, which include their relationships with peers, patients, managers, hospitals, and physicians relative to dealing with difficult patient care problems or issue. It has been argued that EWC influences nurses' wellbeing at work and the quality of patient care nurses provide, making it a significant factor in the nursing environment (**Mohammed, Elsayed, & Gaber, 2014**).

Morals and ethics in taking care of the patients are integral parts of nursing care in the nurse-patient relationship (**Gaber, Nassar, & Eldin, 2015**). Nurses often struggle with how to balance their personal beliefs with patient care decisions in various work environments with multiple responsibilities (**Saeedi, Jouybari, Sanagoo, & Vakili, 2019**). When a nurse is forced to act against their beliefs due to limitations such as lack of resources or lack of power some form of Moral Distress (MD) is to be expected (**Ghasemi, Negarandeh, & Janani, 2019**).

The term MD has been deployed to describe the psychological, emotional, and physiological suffering that nurses and other health professionals experience when they act in ways that are consistent with deeply held ethical values, principles, or commitments (**McCarthy, & Gastmans, 2015**). As the concept of MD was defined and examined in nursing literature in the past 20 years, the experiences described have resonated strongly with critical care. Nurses struggling to understand their emotional discomfort as it related to the ethical issues they encountered in practice (**McCarthy, & Gastmans, 2015**).

Jameton, 1993 is credited with publishing the first definition of MD, Who says that MD arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.

Crane, Bayl-Smith, & Cartmill, 2013 defined MD as the experience of psychological distress that results from engaging in, or failing to prevent, decisions or behaviors that transgress, or come to transgress, personally held moral or ethical beliefs. Also, **Asgari, Shafipour, Taraghi, & Yazdani-Charati, 2019** clarified MD as occurs when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision.

Corley, Elswick, Gorman, & Clor, 2001 classified Moral Distress Scale (MDS) into six main categories namely: physician practice, nursing practice, institutional factors, futile care, deception, and euthanasia. MD was found to cause negative feelings, burnout, and/or resignation. Not only external factors such as lack of staff but also internal ones affect MD (**Ahmed, El-Sayed, & Sleem, 2010**). Moral sensitivity, which is thought of as an advantage of nurses, could affect MD, as nurses being aware of existing ethical problems must feel little distress (**Ohnishi, Kitaoka, Nakahara, Välimäki, Kontio, Anttila, 2019**).

Significance of the study:

This study was conducted to provide baseline information about the relationship between nurses' perception of EWC and MD at Kafr El-Dawar General Hospital. While, nurses perceive a lot of problems in nursing practice such as: lack of support from managers and peers, ineffective communication between staff, shortage of staff with over workload which leads to internal conflict, lack of motivation, nurse dissatisfaction, physical illness, and a high turnover rate. **Fheem, 2013** conduct that about 46.34% of the studied nurses reported verbal abuse, followed by 41.46% of them claimed lack of respect and mistreatment. Significant relationship was found between work climate dimensions and nurses exposure to workplace incivility behaviors as verbal abuse and ignoring nurses' demands. These variables (EWC, MD) are significant enterprise to develop nurses' moral success, improve organizational standards and policies, promote vocational conversation, and support the work

environment; which enable nurses to provide a high quality of patient care. Moreover, the results of this study will guide a health care organization; chiefly hospitals to perceive factors related to high MD in nursing staff and assist them to take corrective measures to encourage nurses' success and integrity as well as to improve effectiveness, efficiency, and productivity of health care facilities.

The aim of the study:

Identify the relationship between staff nurses' perception of ethical work climate and moral distress at Kafr El-Dawar General Hospital.

Research question

What is the relationship between staff nurses' perception of ethical work climate and moral distress at Kafr El-Dawar General Hospital?

Subjects and Method

Research design:

A descriptive correlation research design was used in this study.

Setting:

This study was conducted at Kafr Al-Dawar General Hospital, inpatient care units (N=12) and intensive care units (N=8) namely: surgical units, medical units, pediatric and obstetric units, and critical care units.

Subjects:

The study was conducted at all staff nurses, who were available at the time of data collection, in the previously mentioned settings (N=289), with at least one year of experience.

Tools of the study

The study utilized two tools for data collection which was:

Tool I: Hospital Ethical Climate Survey (HECS):

This tool will be composed of two parts:

Part (1): Demographic characteristics of the study participants:

A demographic data of the study participants including questions about age, gender, educational qualifications, working unit, nursing experience, unit experience, and marital status.

Part (2): Hospital Ethical Climate Survey (HECS):

This survey was developed by **Olson, 1998** and validated by **Olson, Suhonen, Stolt, Katajisto, & Charalambous, 2015** to measure perception of ethical work climate and it contains 26 items divided into five dimensions: 1) peers (4 items), 2) patients (4 items), 3) managers (6 items), 4) hospitals (6 items), and 5) physicians (6 items). Responses were measured using a 5-point Likert scale ranging from (1) almost never true to (5) almost always true. 75% and more indicates presence of EWC.

Tool II: Moral Distress Scale (MDS):

This scale was developed by **Corley, 1995** and was used by **Heck, 2016** to measure staff nurses' moral distress. It includes 38 items which are classified into six main categories: 1) physician practice (12 items), 2) nursing practice (9 items), 3) institutional factors (4 items), 4) futile care (7 items), 5) deception (3 items), and 6) euthanasia (3 items). Responses were measured on a 5-point Likert rating scale ranging from (1) none to (5) great extent. 75% or more indicates high MD level.

Methods:

1. An official written permission was obtained from the Dean of Faculty of Nursing, Damanhour University, and the responsible authorities of the study settings after an explanation of the purpose of the study.

2. The two tools were translated into Arabic, and were tested for their content validity by five experts in the field of the study and accordingly, the necessary modifications were done.

3. The reliability of the two tools was tested statistically using Cronbach's Alpha Coefficient test to measure the internal consistency of the items composing each dimension of the tools. The result of Cronbach's Alpha Coefficient test proved to be strongly reliable for EWC (0.914), and (0.917) for MD.

4. A pilot study was carried out on 10% of the total sample size of staff nurses (n=28),

who were not included in the staff nurses in order to check and ensure the clarity and feasibility of the tools and to identify obstacles and problems that may be encountered during data collection and the necessary modifications were done.

5.Data was collected from the identified subjects, by the researcher through a hand-delivered questionnaire at their working setting after explaining the aim of the study. The data collection took about two months from 1/9/2019 to 30/10/2019.

6.Data obtained was analyzed using the appropriate statistical tests.

Ethical Considerations:

- The research approval was obtained from the ethical committee at the Faculty of Nursing-Damanhour University, prior to the start of the study.

- An informed written consent was obtained from the staff nurses after an explanation of the study aim.

- Privacy, confidentiality, and the right to refuse to participate or withdraw from the study were assured during the study.

- Anonymity regarding data collected was maintained

Statistical analysis:

1.The collected data was coded and entered in a special format to be suitable for computer feeding. Following data entry, checking and verification process were carried out in order to avoid any errors.

2.Data was analyzed using the statistical package for social science SPSS (version 20).

Results

Table (1): shows that 50.2% of the staff nurses' aged 50 years and more. In relation to nurses' gender: 96.5% were females. Regarding their educational qualifications, 40.1% of them had a technical institute of nursing diploma. With respect to the working department, 41.2% were working in medical departments. Moreover 42.9% of the staff nurses had more

than 5 years of experience in the current working units. Additionally, 86.9% of the nurses were married.

Table (2): portrays that regarding the majority of staff nurses viewed the physicians, hospitals, and managers domains as unethical work climate (91.3%, 83.7%, and 72.3% respectively), on the other hand, peers domain, 66.8% of the staff nurses viewed it EWC, while 49.5% of them viewed patients domain EWC, while 89.3% viewed the total work climate as unethical.

Table (3): shows that the vast majority of staff nurses had a high moral distress level regarding euthanasia, and deception domains had a high moral distress level (90.7%, and 78.9% respectively). Finally, almost all (81.7%) of the staff nurses had a total high moral distress.

Table (4): shows that 100% of staff nurses aged 50 years and more perceived work climate as unethical compared to 91.7% of those in the aged group from 20 to 30 years. Additionally, 89.6% of female staff nurses compared to 80.0% of male staff nurses perceived it as unethical climate. Moreover, the vast majority (91.4%) of technical nurses perceived an unethical work climate. Furthermore, 92.3% of staff nurses working in the pediatric and obstetric departments perceived an unethical work climate. Additionally, 100% of staff nurses in the aged group from 15 to 20 years of experience in their working unit perceived their work climate unethical. Finally, all 100% widowed and divorced staff nurses had an unethical work climate perception.

Table (5): reveals that 84.8% of staff nurses aged group 20 years had the highest moral distress level. The same was noticed as 90.0% of male staff nurses had the highest moral distress level. Moreover, 83.3% of the secondary school of nursing diploma nurses had the highest moral distress level. Furthermore, 85.7% of staff nurses working in medical units had the highest moral distress level. Additionally, 86.7% of staff nurses with experience since graduation 5 to less than 10 years had the highest moral distress level, while

88.9% of staff nurses aged group 20 years and more experience in working unit had the highest moral distress level. Finally, 100% of the widowed and divorced staff nurses had the highest moral distress level.

Table (6): illustrates that staff nurses with high moral distress, around 83.7% of them perceived the work climate as unethical, while staff nurses with low moral distress around 35.5% of them perceived the work climate as ethical, also 89.3% of total nurses with high moral distress perceived the work climate as unethical with statistically significant ($p=0.009^*$).

Table (7): reveals that statistically highly significant relations were found between peers and patients, managers, hospitals, and total EWC ($p=0.000^*$). Moreover, the peers had a significant relation to physicians ($p=0.016^*$). Also, patients had statistically highly significant relations with managers, hospitals, physicians, and total EWC ($p=0.000^*$). While managers had statistically highly significant relations with hospitals, physicians, and total EWC ($p=0.000^*$). Additionally, hospitals had statistically highly significant relations with physicians and total EWC ($p=0.000^*$). Finally, physicians had statistically highly significant relation with total EWC ($p=0.000^*$).

Table (8): illustrates that statistically highly significant relations were found between physician practice and nurses practice, institutional factors, futile care, deception, and total MD ($p=0.000^{**}$). Also, nurses practice had statistically highly significant relations with institutional factors, futile care, deception, and total MD ($p=0.000^{**}$). While institutional factors had statistically highly significant

relations with futile care, deception, and total MD ($p=0.000^{**}$). Additionally, futile care had statistically highly significant relations with deception, euthanasia, and total MD ($p=0.000^{**}$, $p=0.001^{**}$, and $p=0.000^{**}$, respectively). Also, deception had statistically highly significant relations with euthanasia and total MD ($p=0.000^{**}$). Finally, euthanasia had statistically highly significant relation with total MD ($p=0.000^{**}$).

Table (9): shows that statistically highly significant relation was found between peers and futile care ($p=0.001^{**}$). Moreover, peers had a significant relations with institutional factors and total MD ($p=0.031^*$, and $p=0.037^*$ respectively). Also, patients had statistically significant relations with institutional factors, futile care, deception, and euthanasia ($p=0.032^*$, $p=0.038^*$, $p=0.051^*$, and $p=0.053^*$ respectively). While managers had statistically significant relations with physician practice, nurses practice, institutional factors, futile care, deception, euthanasia, and total MD ($p=0.034^*$, $p=0.035^*$, $p=0.077^*$, $p=0.005^*$, $p=0.029^*$, $p=0.011^*$, and $p=0.012^*$ respectively). Additionally, hospitals had statistically significant relations with physician practice, futile care, deception, euthanasia, and total MD ($p=0.034^*$, $p=0.022^*$, $p=0.021^*$, $p=0.003^*$, and $p=0.050^*$ respectively). Physicians had statistically significant relations with nurses practice, institutional factors, futile care, deception, euthanasia, and total MD ($p=0.008^*$, $p=0.013^*$, $p=0.022^*$, $p=0.045^*$, $p=0.047^*$, and $p=0.014^*$ respectively). Finally total EWC had statistically significant relations with physician practice, nurses practice, institutional factors, futile care, deception, euthanasia, and total MD ($p=0.014^*$, $p=0.006^*$, $p=0.050^*$, $p=0.039^*$, $p=0.031^*$, $p=0.043^*$, and $p=0.008^*$ respectively).

Table (1): Demographic characteristics of the staff nurses working at the Kafr El-Dawar General Hospital:

Staff nurses' demographic characteristics	Staff nurses (N=289)	
	No	%
Age (years)		
• 20-	145	50.2
• 30-	107	37.0
• 40-	31	10.7
• 50+	6	2.1
Min – Max 20 – 52	Mean ± SD	30.99±7.180
Gender		
• Male	10	3.5
• Female	279	96.5
Educational qualifications		
• Secondary School of Nursing diploma	96	33.2
• Technical Institute of Nursing diploma	116	40.1
• Bachelor degree	77	26.6
Working department		
• Medical	119	41.2
• Surgical	38	13.1
• Pediatric/ Obstetric	91	31.5
• Intensive care units	41	14.2
Years of experience since graduation		
• < 5	53	18.3
• 5-	98	33.9
• 10-	55	19.0
• 15-	36	12.5
• 20+	47	16.3
Min – Max 1 – 35	Mean ± SD	10.73±7.417
Years of experience in the working unit		
• < 5	91	31.5
• 5-	124	42.9
• 10-	29	10.0
• 15-	18	6.2
• 20+	27	9.3
Min – Max 1 – 32	Mean ± SD	7.72±6.485
Marital status		
• Married	251	86.9
• Single	37	12.8
• Widowed / Divorced	1	0.3

Table (2): Distribution of staff nurses, according to their perception of EWC dimensions:

EWC dimensions	Levels	
	No.	%
Peers		
▪ Unethical	96	33.2
▪ Ethical	193	66.8
Patients		
▪ Unethical	146	50.5
▪ Ethical	143	49.5
Managers		
▪ Unethical	209	72.3
▪ Ethical	80	27.7
Hospitals		
▪ Unethical	242	83.7
▪ Ethical	47	16.3
Physicians		
▪ Unethical	264	91.3
▪ Ethical	25	8.7
Total EWC		
▪ Unethical	258	89.3
▪ Ethical	31	10.7

Cut off points for the present & absence = 75% of the maximum score

Table (3): Distribution of staff nurses, according to their levels of MD categories:

MD dimensions	Levels	
	No.	%
Physician practice		
▪ Low distress	79	27.3
▪ High distress	210	72.7
Nursing practice		
▪ Low distress	69	23.9
▪ High distress	220	76.1
institutional factors		
▪ Low distress	66	22.8
▪ High distress	223	77.2
Futile care		
▪ Low distress	64	22.1
▪ High distress	225	77.9
Deception		
▪ Low distress	61	21.1
▪ High distress	228	78.9
Euthanasia		
▪ Low distress	27	9.3
▪ High distress	262	90.7
Total MD		
▪ Low distress	53	18.3
▪ High distress	236	81.7

Cut off points for the present & absence = 75% of the maximum score

Table (4): The relationship between the studied staff nurses' perception of EWC and their demographic characteristics:

Staff nurses' demographic characteristics	EWC				Total		X ²	P
	Unethical (N=258)		Ethical (N=31)		N=289			
	No	%	No	%	No	%		
Age								
• 20-	133	91.7	12	8.3	145	50.2	X ² =	P=0.234
• 30	94	87.9	13	12.1	107	37.0	4.267	
• 40-	25	80.6	6	19.4	31	10.7		
• 50	6	100.0	0	0.0	6	2.1		
Gender								
• Male	8	80.0	2	20.0	10	3.5	X ² =	P=0.335
• Female	250	89.6	29	10.4	279	96.5	0.930	
Educational qualifications								
• Secondary School of Nursing diploma	85	88.5	11	11.5	96	33.2	X ² =	P=0.606
• Technical Institute of Nursing diploma	106	91.4	10	8.6	116	40.1	1.002	
• Bachelor degree	67	87.0	10	13.0	77	26.6		
Working department								
• Medical	103	86.6	16	13.4	119	41.2	X ² =	P=0.607
• Surgical	34	89.5	4	10.5	38	13.1	1.835	
• Pediatric/ Obstetric	84	92.3	7	7.7	91	41.2		
• Intensive care units	37	90.2	4	9.8	41	14.2		
Years of experience since graduation								
• < 5	48	90.6	5	9.4	53	18.3	X ² =	P=0.475
• 5-	89	90.8	9	9.2	98	33.9	3.516	
• 10-	48	87.3	7	12.7	55	19.0		
• 15-	34	94.4	2	5.6	36	12.5		
• 20+	39	83.0	8	17.0	47	16.3		
Years of experience in working unit								
• < 5	80	87.9	11	12.1	91	31.5	X ² =	P=0.588
• 5-	111	89.5	13	10.5	124	42.9	2.822	
• 10-	26	89.7	3	10.3	29	10.0		
• 15-	18	100.0	0	0.0	18	6.2		
• 20+	23	85.2	4	14.8	27	9.3		
Marital status								
• Married	221	88.0	30	12.0	251	86.9	X ² =	P=0.223
• Single	36	97.3	1	2.7	37	12.8	3.002	
• Widowed / Divorced	1	100.0	0	0.0	1	0.3		

X²: Chi Square Test

*statistically significant at P≤0.05

**highly significant at P≤0.001

Table (5): The relationship between the studied staff nurses' MD levels and their demographic characteristics:

Demographic characteristics	MD levels				Total N=289		X ²	P
	Low (N=2)		High (N=287)		No	%		
	No	%	No	%				
Age								
▪ 20-	22	15.2	123	84.8	145	50.2	X ² =2.066	P=0.559
▪ 30-	23	21.5	84	78.5	107	37.0		
▪ 40-	7	22.6	24	77.4	31	10.7		
▪ 50+	1	16.7	5	83.3	6	2.1		
Gender								
▪ Male	1	10.0	9	90.0	10	3.5	X ² = 0.481	P=0.488
▪ Female	52	18.6	227	81.4	279	96.5		
Educational qualifications								
▪ Secondary School of Nursing diploma	16	16.7	80	83.3	96	33.2	X ² = 0.490	P=0.783
▪ Technical Institute of Nursing diploma	21	18.1	95	81.9	116	40.1		
▪ Bachelor degree	16	20.8	61	79.2	77	26.6		
Working department								
▪ Medical	17	14.3	102	85.7	119	41.2	X ² = 4.100	P=0.251
▪ Surgical	10	26.3	28	73.7	38	13.1		
▪ Pediatric/ Obstetric	20	22.0	71	78.0	91	41.2		
▪ Intensive care units	6	14.6	35	85.4	41	14.2		
Years of experience since graduation								
▪ < 5	11	20.8	42	79.2	53	18.3	X ² = 3.838	P=0.428
▪ 5-	13	13.3	85	86.7	98	33.9		
▪ 10-	14	25.5	41	74.5	55	19.0		
▪ 15-	6	16.7	30	83.3	36	12.5		
▪ 20+	9	19.1	38	80.9	47	16.3		
Years of experience in working units								
▪ < 5	22	24.2	69	75.8	91	31.5	X ² = 5.316	P=0.256
▪ 5-	18	14.5	106	85.5	124	42.9		
▪ 10-	5	17.2	24	82.8	29	10.0		
▪ 15-	5	27.8	13	72.2	18	6.2		
▪ 20+	3	11.1	24	88.9	27	9.3		
Marital status								
▪ Married	47	18.7	204	81.2	251	86.9	X ² = 0.361	P=0.835
▪ Single	6	16.2	31	83.8	37	12.8		
▪ Widowed / Divorced	0	0.0	1	100.0	1	0.3		

X²: Chi Square Test

*statistically significant at P≤0.05

**highly significant at P≤0.001

Table (6): The relationship between staff nurses' work climate and MD levels:

Items	MD levels				Total N=289		Test of significance
	Low (N=53)		High (N=236)		No.	%	
	No.	%	No.	%			
Work climate							
▪ Unethical	42	16.3	216	83.7	258	89.3	X ² =6.816 P=0.009*
▪ Ethical	11	35.5	20	64.5	31	10.7	

X²: Chi Square Test

*statistically significant at P≤0.05

**highly significant at P≤0.001

Cut off points for the present & absence = 75% of the maximum score

Table (7): Correlation matrix among the studied staff nurses' EWC dimensions:

EWC dimensions	Correlation Coefficient	Peers	Patients	Managers	Hospitals	Physicians	Total EWC
Peers	r						
	p						
Patients	r	0.254					
	p	0.000**					
Managers	r	0.227	0.607				
	p	0.000**	0.000**				
Hospitals	r	0.308	0.483	0.614			
	p	0.000**	0.000**	0.000**			
Physicians	r	0.142	0.442	0.508	0.611		
	p	0.016*	0.000**	0.000**	0.000**		
Total EWC	r	0.433	0.752	0.856	0.837	0.754	
	p	0.000**	0.000**	0.000**	0.000**	0.000**	

r: Pearson Correlation Coefficient *statistically significant at $P \leq 0.05$ **highly significant at $P \leq 0.001$
 $r \geq 0.9$ very high correlation $r 0.7- < 0.9$ high correlation $r 0.5- < 0.7$ moderate correlation $r < 0.5$ low correlation

Table (8): Correlation matrix among the studied staff nurses' MD categories:

MD categories	Correlation coefficient	Physician Practice	Nurse Practice	institutional factors	Futile care	Deception	Euthanasia	Total MD
Physician Practice	r							
	p							
Nurse Practice	r	0.434						
	p	0.000**						
institutional factors	r	0.294	0.518					
	p	0.000**	0.000**					
Futile care	r	0.484	0.538	0.440				
	p	0.000**	0.000**	0.000**				
Deception	r	0.302	0.299	0.194	0.512			
	p	0.000**	0.000**	0.000**	0.000**			
Euthanasia	r	-0.002	0.100	0.048	0.203	0.225		
	p	0.957	0.089	0.419	0.001**	0.000**		
Total MD	r	0.764	0.785	0.614	0.815	0.563	0.261	
	p	0.000**	0.000**	0.000**	0.000**	0.000**	0.000**	

r: Pearson Correlation Coefficient *statistically significant at $P \leq 0.05$ **highly significant at $P \leq 0.001$
 $r \geq 0.9$ very high correlation $r 0.7- < 0.9$ high correlation $r 0.5- < 0.7$ moderate correlation $r < 0.5$ low correlation

Table (9): Correlation matrix between the studied staff nurses' EWC dimensions and MD

MD categories	Correlation coefficient	EWC dimensions					
		Peers	Patients	Managers	Hospitals	Physicians	Total EWC
Physician Practice	r	0.174	- 0.180	0.567 -	0.564	0.164 -	0.811
	p	0.080	0.079	0.034*	0.034*	0.082	0.014*
Nurse Practice	r	0.292	- 0.070	- 0.554	0.158 -	0.889 -	0.925 -
	p	0.062	0.107	0.035*	0.083	0.008*	0.006*
institutional factors	r	0.598	0.592	0.192 -	0.072	0.832 -	0.401
	p	0.031*	0.032*	0.077*	0.106	0.013*	0.050*
Futile care	r	0.992	0.122 -	0.938 -	0.711 -	0.707 -	0.512 -
	p	0.001**	0.038*	0.005*	0.022*	0.022*	0.039*
Deception	r	0.328	0.388 -	0.623 -	0.722 -	0.443 -	0.600 -
	p	0.058	0.051*	0.029*	0.021*	0.045*	0.031*
Euthanasia	r	0.027	0.371	0.853 -	0.955	0.428	0.466
	p	0.130	0.053*	0.011*	0.003*	0.047*	0.043*
Total MD	r	0.532	0.044 -	0.838 -	0.402 -	0.815 -	0.895 -
	p	0.037*	0.119	0.012*	0.050*	0.014*	0.008*

categories:
r: Pearson Correlation Coefficient *statistically significant at $P \leq 0.05$ **highly significant at $P \leq 0.001$

$r \geq 0.9$ very high correlation $r 0.7 < 0.9$ high correlation $r 0.5 < 0.7$ moderate correlation $r < 0.5$ low correlation

Discussion

Healthcare organizations and teams encounter vital challenges, including fast increases in demands in a workplace environment about patients' numbers, complex and challenging care, high expectations of quality, and expensive treatment application (Wahab, Bassiouni, & Zein Eldin, 2019). At the same time, there is a need to use the limited resources effectively and efficiently to face the constrained budgets, which are considered ethical stressors (Abuelela, Habiba, & , EIDin, 2014). Ethical climate can contribute to positive healthcare providers and patients' outcomes through; supporting nurses in patients' problem solving, coping with a different ethical dilemma, and minimizing the impacts of MD (EIDin, 2014). So; The current study sought to find the relationship between staff nurses' perception of EWC and MD at Kafr El-Dawar General Hospital.

Relationship between EWC and MD:

The study result indicated that there was a statistically significant relationship between total EWC and total MD. This result may be due to; working in the general hospital which had some properties as a heavy burden of physical and emotional demands on nursing staff, due to; excessive work, increase mortality rate, avoidance of conflicts resolutions, lack of cooperation between staff nurses and physicians, organizational and managers support, and resources.

This finding is consistent with a study was conducted by Gallagher, 2016, who concluded that organizations should develop EWC that embraced moral courage, wisdom, and integrity to prevent staff nurses' MD.

In addition, a study was done at Ain Shams University in Egypt, by El Tayar, 2015, who illustrated that there was a statistically significant difference between studied nurses' level of MD and their level of hospital EWC. Also, studies were done by Gallagher, 2016,

and Koskenvuori, Numminen, & Suhonen, 2019, who found that there was a significant relationship between EWC and MD. In contrast, a study was done by Atabay, Çangarli, & Penbek, 2015, who detailed that there was no correlation between EWC and MD.

Total EWC: The present study showed that the majority of staff nurses in the study sample perceived the total work climate as unethical. This result may be related to; increased staff nurses' workload and overtime, lack of communication between top management and staff nurses, absence of mutual respect and recognition between staff nurses and other healthcare providers, discontinuing patient' treatment to control the cost of care, negligence of patients' rights, conflict resolutions, hospital policy and procedure.

This finding is supported by Pauly, Varcoe, Storch, & Newton 2009, who mentioned that the perception of work climate is affected by the resources, the economy, and the political structures in healthcare organizations. Also, Koskenvuori, Numminen, & Suhonen, 2019, illustrated that factors such as collaboration, teamwork, quality improvement, and effective leadership can lead to EWC.

This finding in agreement with a study was done by Borhani, Hoseini , Abbaszadeh, Abbasi, & Fazljoo, 2014, who showed that the majority of study participants perceived bad EWC. However, this study is inconsistent with studies were done on staff nurses by Asgari, Shafipour, Taraghi, & Yazdani-Charati, 2019 and Lemmenes, Valentine, Gwizdalski, Vincent, & Liao, 2018, who assumed that the majority of staff nurses had a high perception level regarding their work climate.

Dimensions of EWC: Dimensions of EWC were ranked related to mean score as follows: peers, patients, managers, hospitals, and physicians. Regarding the peers' dimension, the result of the study showed that more than two-thirds of staff nurses viewed the peers'

dimension as ethical. This result may be attributed to; staff nurses' cooperation with each other especially in solving difficult patients' care problems, sharing their concerns about patient care, and providing safe patients' care by competent colleagues.

This finding is supported by **Ulrich & Grady, 2018**, mentioned that the nurses' relationship that rich with trust, respect between them, effective communication, and coordination improve EWC. Also, with these findings, a study was done by **Han, 2014**, who clarified that the peers' dimension represented as the highest level. Furthermore, there is a study was by **Olson, Suhonen, Stolt, Katajisto, & Charalambous, 2015**, who demonstrated that peers' dimension was found as the best assessments for HECS. Also, another study was done by **Constantina, Papastavrou, & Charalambous, 2019**, who proved that the peers' dimension represented as the highest rank.

Concerning the patients' dimension, the present study reported that about half of the staff nurses viewed the patients' dimension as an unethical work climate. This seems due to; the patients' preferences being respected by staff nurses who consider patients' rights. However, staff nurses hadn't access to the information necessary to solve a patients' care issues. The present study findings are in agreement with a study was done by **Asgari, Shafipour, Taraghi, & Yazdani-Charati, 2019**, who illustrated that patients' dimension was in the medial of mean rank in the five dimensions of EWC, as it had no effect in work climate.

Regarding the managers' dimension, the present study revealed that about three-quarters of the staff nurses viewed the managers' dimension as an unethical work climate. This result may be related to; a lack of mutual respect and trust between staff nurses and managers. Also, managers rarely listen to staff nurses' concerns or support them about decision-making related to patients' problem-solving.

This finding is compatible with a study was done by **Kyzar, 2016**, who demonstrated that nurses had a low level of EWC with managers' dimension. While these results are inconsistent with a study was conducted by **Asgari, Shafipour, Taraghi, & Yazdani-Charati, 2019**, who detailed that, the highest level obtained for EWC pertained to the dimension of managers.

Regarding hospitals' dimensions, the present study revealed that, the majority of staff nurses viewed the hospitals' dimension as an unethical work climate. This result may be attributed to; the absence of clarity of the hospital's mission and vision that should be shared with staff nurses. Hospitals' policies don't provide help for staff nurses with difficult patient care issues. Staff nurses are unable to practice nursing on their units as they believed it should be practiced. This finding is congruent with a study was done by **Constantina, Papastavrou, & Charalambous, 2019**, who proved that the lowest ranks were observed in the hospitals' dimension.

Regarding the physicians' dimension, the present study revealed that the majority of staff nurses viewed the physicians' dimension as an unethical work climate. This result may be due to; physicians didn't put staff nurses' opinions about patients' issues into their consideration, lack of mutual respect and trust between staff nurses and physicians. The present study finding was congruent with **Asgari, Shafipour, Taraghi, & Yazdani-Charati, 2019**, who found that the imbalance of power during the interaction among staff nurses and physicians affects their relationship with one another and may adversely affect the quality of nursing care.

In this respect with these findings, studies were done by **Han, 2014**, who revealed that the lowest rank of HECS was the physicians' dimension. Furthermore, a study was done by **Olson, Suhonen, Stolt, Katajisto, & Charalambous, 2015**, who found that the lowest level of EWC was physicians' dimension.

Total MD: This study results showed that the majority of staff nurses in the study

sample had a high level of MD. This result may be attributed to; staff nurses initiating extensive life-saving actions for the hopeless case while they thought this only prolongs patients' death. Moreover, staff nurses fall into the dilemma that is concerned with following physicians not discussing death with a patient. Also, they are forced to assist physicians to provide incompetent patients' care. In addition, they face difficulties in maintaining patients' privacy.

This finding is supported with a study was done by **Chen, Lee, Huang, Wang, & Huang, 2018**, who mentioned that the increased workload cause loss of nurses concentration and affect the quality of the patients' care, thus producing high MD. Also, with these findings a study was conducted at Alexandria University in Egypt, by **Abdalla, 2012**, who studied nurses' MD in the critical care units, and she indicated that nurses experienced high MD. Also, a study was done by **Shoorideh, Ashktorab, Yaghmaei, & Alavi-Majd, 2015**, who reported that MD was experienced by nurses was high.

Also, a study was conducted by **Silén, Svantesson, Kjellström, Sidenvall, & Christensson, 2011**, who showed that nurses feel a modest level of MD on the nursing unit. Also, a study was done by **Rabiee, Khatiban, & Cheraghi, 2012**, who found that MD experienced by nurses was moderate. Notwithstanding a study was conducted by **Karagozlu, Yildirim, Ozden, & Çınar, 2017**, who reported that nurses suffered the low level of MD.

Categories of MD: Categories of MD were ranked related to mean score as follows: euthanasia, institutional factors, deception, nursing practices, futile care, and physician practices. Regarding the euthanasia's category, this study indicated that the majority of staff nurses had the highest level of MD; this result may be attributed to; staff nurses being compelled to increase the dose of intravenous sedation for an unconscious patient in ICU as physicians' orders which may be hastened patients' death, also, staff nurses feel distressed when patients sometimes wish to die due to their poor prognosis.

This study is consistent with a study was done by **Hardy, & Vittone, 2012**, who mentioned that the end of life concerns, palliative sedation, euthanasia, and assisted suicide are complex areas, which need specific implications. While this result is inconsistent with a study was done in the USA, by **Corley, Minick, Elswick, & Jacobs, 2005**, who reported that, the MD item with the low rank was euthanasia's category.

Concerning institutional factors' category, this study clarified that more than three-quarters of the staff nurses had a high level of MD; this result may be attributed to; hospital's polices force staff nurses to discontinue patients' treatment when they had reached the maximum length of stay, in addition, they unable to offer healthcare services because the insurance company wouldn't cover all costs. This study result was in agreement with **Woods, Rodgers, Towers, & Grow, 2015**, who mentioned that increasing levels of nursing MD may be attributed to; a diversity of internal and most certainly external causes such as a lack of institutional support.

Regarding the deception category, this study clarified that the majority of staff nurses had high levels of MD, this result may be related to; staff nurses being compelled to give a medication intravenously during code blue "cardiac and respiratory resuscitation" with no compressions or intubation. Moreover, staff nurses incurred because the medications prescribed by doctors can't control the patients' pain. This finding is congruent with **Karagozlu, Yildirim, Ozden, & Çınar, 2017**, who stated that healthcare professionals become concerned when they are obligated to give aggressive treatments and inadequate pain medication. This conflicts with the caregivers' priority to maintain comfort for all patients if at all possible. While this result is inconsistent with a study conducted by **Corley, Elswick, Gorman, & Clor, 2001**, who reported that, the MD item with the low rating was deception's category.

Regarding nursing practices' category, this study found that more than three-quarters of the staff nurses had a high level of MD; this

result may be related to; staff nurses should sometimes carry out a patients' care however they didn't feel professionally competent, moreover, working with unsafe levels of healthcare providers, as those who work without a license. Also, some healthcare personnel doesn't respect patients' privacy.

This finding is compatible with a study was done by **Corley, Minick, Elswick, & Jacobs, 2005**, who concluded that the item with the highest rating was the nursing practices category. Similarly, a study was done by **Pauly, Varcoe, Storch, & Newton 2009**, who stated that the situation that produced the highest level of MD was working with staffing levels that were viewed as unsafe, and incompetent. Also, a study was done by **Woods, Rodgers, Towers, Grow, 2015**, who demonstrated that the item that elicited a high degree of MD was "work with nurses and other healthcare workers who they perceived to be unsafe or incompetent".

Regarding the futile care category, this study showed that more than three-quarters of the staff nurses had a high level of MD; this result may be due to; staff nurses sometimes being forced to follow the family's wishes for the patients' care although they don't convince. Also, they continued life support even though it wasn't in the best interest of the patient. Moreover, they should carry out the physician's orders for unnecessary tests and treatment for terminally ill patients. This result was supported with a study was done by **Papathanassoglou, Karanikola, Kalafati, Giannakopoulou, Lemonidou, & Albarran, 2012**, who reported that the items that caused high MD were the provisions of futile or aggressive care.

Concerning physician practices' category, this study concluded that more than two-thirds of the staff nurses had a high level of MD. This result may be due to; staff nurses being compelled to assist physicians who performed a test or treatment without informed consent. Sometimes they should ignore situations of suspected patient abuse by caregivers, patients hadn't been given adequate information to ensure informed consent, also, patients' suffering didn't be relieved as a consequence of physicians worry to increase the dose of pain

medication. Patients' status didn't discuss with them or their families as physicians requested. This finding is consistent with a study was done by **Constantina, Papastavrou, & Charalambous, 2019**, who suggested that there was a lack of support and cooperation between doctors and nurses regarding patient care and that threatened nurses' autonomy.

Relationship between EWC dimensions and MD categories: Regarding EWC dimensions, there was a significant correlation between managers' dimension with all MD categories. This result may be due to the influential role of the managers in supporting staff nurses' decision-making and problems solving, that are related to patients' care issues. This result is consistent with a study was conducted by **Hamric, 2012**, who detailed that, EWC factors, such as relationships with managers affected nurses' moral distress.

Concerning physicians' dimension, the present study clarified that there was a statistically significant relationship between physicians' dimension and all of MD categories except physician practices' category. This result may be due to; the important role of physicians in improving staff nurses' morale through asking them about their opinions related to patients' care issues. This study result is supported by a study was conducted by **Hamric, 2012**, who manifested that a correlation was found between the physicians' dimension and nurses MD at the rural hospital.

In addition, this study result indicated that there was a statistically significant relationship between hospitals' dimension and all of MD categories except nurses practice and institutional factors categories. This result may be attributed to; the prominence of shared hospital's policy, procedure, mission, and vision with staff nurses. Conflict resolution influences nursing performance to improve the quality of patients' care. This study result was in agreement with a study was conducted by **Corley, Minick, Elswick, & Jacobs, 2005**, who revealed that the correlation between hospitals' dimension and MD was significant.

Regarding patients' dimension, there was a statistically significant relationship between patients' dimension and all of MD categories except physician practice and nurse practice categories. This result may be related to; the worth of respecting patients' rights through; explaining the procedure, respecting patients' privacy and wishes, and the patient's informed consent. This result is supported by **Gutierrez, 2005**, who mentioned that the nurses' inability to communicate effectively with patients and other medical team members causes nurses' MD.

Concerning peers' dimension, there was a highly statistically significant relationship with futile care's category, and there was a statistically significant relationship with institutional factors' category. This result may be due to; the importance of peers co-operation in solving difficult patients' care problems, sharing concerns about patients' issues, and providing safe patients' care. This result is supported with a study was performed **Pauly, Varcoe, Storch, & Newton, 2009**, who revealed that EWC factors such as relationships with peers' dimension had an effect on MD among nurses.

Relationship between EWC and its dimensions: The finding of this study indicated that there was a highly statistically significant relationship between total EWC and all dimensions. This finding may be attributed to; when staff nurses feel that there is a collaboration between them for dealing with patients' issues, developing the problem-solving ability, respecting patients' wishes and privacy, promoting staff nurses and physicians' cooperation related to patients' treatment decisions, and enhancing managerial support for staff nurses through listening to considerations about patients' issues, it will lead to enhance EWC. This finding is consistent with a study was conducted by **Olson, Suhonen, Stolt, Katajisto, & Charalambous, 2015**, who mentioned that the significant correlations between the dimensions and the total EWC are evidence for the strong associations between the scales and the total EWC.

Relationship between MD and its categories: This study indicated that there was a highly statistically significant relationship between total MD and all its categories. These findings related to that staff nurses experience MD when they expose to stressful situations as abusing patients' rights by a caregiver through not having informed consent, staff ignorance to medical errors, unsafe patients' care that was given by health care providers, applying hospital discharge policy which allows discontinuing patients' treatment to save budget, extensive lifesaving action which seems to delayed death, and painless analgesic which was prescribed to patients.

This finding is compatible with a study was done by **Whitehead, Herbertson, Hamric, Epstein, & Fisher, 2015**, who mentioned that poor team communication and lack of provider continuity are the main causes for nurses MD. This study result was in agreement with a study was conducted by **Corley, Elswick, Gorman, & Clor, 2001, 2001**, who revealed that the correlations of all MD variables were calculated. The correlation between MD variables was significant.

Relationship between demographic characteristics and EWC: The study results indicated that there was no statistically significant relationship between all demographic characteristics of the staff nurses EWC including age, gender, educational qualification, department, years of experience, and marital status. This study result is supported by a study was done by **Owczarzak, 2019**, who found that there was no significant difference between the participants' gender and education level with EWC. While this result is inconsistent with a study was conducted by **Asgari, Shafipour, Taraghi, & Yazdani-Charati, 2019**, who mentioned that there are several factors, such as age and type of work affect the nurses' perceptions of EWC.

Relation between demographic characteristics and MD: The result of this study indicated that there were no statistically significant relations between all demographic characteristics and MD including age, gender, educational qualification, department, years of experiences, and marital status. This study result is compatible with a study performed by **Soleimani, Sharif, Yaghoobzadeh, Sheikhi,**

Panarello, & Win, 2019, who mentioned that, no significance of MD with nurses working in different hospital departments. While this result is inconsistent with a study was done by Lützen, Blom, Ewalds-Kvist, & Winch, 2010, who concluded that there is a statistical difference between sex and specialization with MD.

Conclusion

Conclusions of the study include:

What is the relationship between staff nurses' perception of ethical work climate and moral distress at Kafr El-Dawar General Hospital?

The result of the present study revealed that, there was a statistically significant relationship between the staff nurses' perception of Ethical Work Climate (EWC) and Moral Distress (MD) at Kafr El-Dawar General Hospital. The staff nurses in the study setting perceive generally unethical work climate with high moral distress.

Recommendation

In the light of the results of the current study, the following recommendations can be suggested:

Health care organizations and nurse managers should:

1. Provide the staff nurses with continuous feedback about their performance and promote the acceptance of individual differences.
2. Offer continuous job training to improve staff nurses' skills practice, participative decision making, problem-solving, and performance.
3. Share the hospital mission and vision, and clarify the hospital goals with staff nurses, that help them to understand their roles and responsibilities in the hospital.
4. Establish reinforcement strategies and a reward system for nurses who behave as ethical role models to enhance their effectiveness, efficiency, and loyalty.
5. Encourage sharing system among staff nurses in medical knowledge, information, and clinical experience.

6. Improve their communication skills with the top level managers using social and emotional intelligence technique.

7. Follow the directions of other health professionals, who make the primary decisions about patients, also involve in the decision-making process.

8. Future/ Further studies should be conducted as:

- Determine the relationships between ethical climate, health policies, and healthcare structures.
- Develop strategies to enhance positive ethical climates.
- Determine the relationship between moral distress and turnover.

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