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The Status Quo and Influencing Factors of the Moral Distress in Nurses in Tertiary Grade A Hospitals in Wuhan

Jingjing Zhao, Jing Xu*, Yiqing He

Wuhan Institute of Design and Sciences, Wuhan, China
Email: 1506592726@qq.com, *2956133841@qq.com

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Abstract

Background: As medical technology has advanced, it has also made it possible to maintain end-stage life support for longer periods of time, but it has also been accompanied by a debate about ineffective care, nursing is considered to be an ethically important profession, and nurses aim to achieve ethical goals such as providing the best possible care to patients, achieving high quality outcomes, but it is common when there are insufficient numbers of staff, inadequately trained staff, and organizational policies and procedures that make it difficult, or even impossible, for nurses to meet the needs of patients and their families. This conflict results in moral distress for nurses, yet limited attention has been paid to this phenomenon. **Objective:** To explore the current phenomenon of moral distress and its triggering factors in nurses in tertiary grade A hospitals in Wuhan, by targeting root causes and understanding the interplay between nurses and settings where moral distress occurs, interventions can be tailored to minimize moral distress with the ultimate goal of enhancing patient care. **Method:** Totally 384 nurses from clinical departments in 2 tertiary Grade A hospitals in Wuhan were investigated with the Chinese version Moral Distress Scale-Revised (MDS-R). **Result:** The total score of moral distress was 47.41 ± 27.14, and the mean scores of moral distress frequency and intensity were 1.01 ± 0.53 and 1.19 ± 0.61, which were at a lower level. The main source of moral distress for nurses is related to end-of-life care and medical decision communication; Nurses' moral distress scores were statistically significant ($P < 0.05$) when comparing scores by ages, title, salary, department, and years of service. **Conclusion:** Hospital facility leaders and nursing managers need to train nurses to develop competency development such as reflection, empathy, communication, positive thinking, and emotional intelligence to practice ethical dilemma response, and facilitate collaborative communication among healthcare members, so as to alleviate moral distress in nurses.

Keywords

Nurses, Moral Distress, Futile Care, Root Cause Analysis

1. Introduction

Jameton [1] defined moral distress in the nursing context as painful feelings or the psychological disequilibrium that occurs when nurses are conscious of the morally appropriate action, a situation requires, but cannot carry out that action because of institutionalized obstacles: lack of time, lack of supervisory support, exercise of medical power, institutional policy, or legal limits [2] [3]. In 1993, Jameton distinguished between initial and reactive moral distress. In initial distress, the person feels frustration, anger and anxiety when faced with institutional obstacles and interpersonal conflict about values [4], he defines reactive distress as "the distress that people feel when they do not act upon their initial distress". As a number of nursing theorists have pointed out, however, the very profession of nursing is an ethically grounded enterprise. Moral standards infuse its practice, and all nursing acts are fundamentally ethical [5].

In a moral dilemma, there is more than one right thing to do, but to act on one necessarily precludes acting on the others and advances in medical technology have made it possible to maintain end-stage life support for longer periods of time [6] [7] [8], but they are also accompanied by debates about ineffective care, and when nurses are forced to endure moral dilemmas, they may reduce patient health promotion efforts to avoid running out of time and energy [9] [10] and moral dilemmas that lead to instability in the nursing workforce, decreased quality of care delivery, and decreased patient satisfaction also have the potential to may hinder the healthy development of health care [11] [12]. Therefore, by conducting a study on nurses' moral dilemmas and their influencing factors in domestic tertiary hospitals, we aimed to provide a reference basis for nursing managers to carry out targeted interventions.

2. Materials and Methods

2.1. Participants

From May to August 2021, nurses working in internal medicine, surgery, emergency medicine, obstetrics and gynecology, pediatrics department, and intensive care units in 2 tertiary care general hospitals in Wuhan were conveniently selected as the study subjects. The inclusion criteria for the study subjects were: 1) obtaining a nurse practice certificate and formal registration; 2) working continuously in their current department for more than 1 year; 3) voluntarily participating in this study.

2.2. Instruments

The general socio-demographic information questionnaire of the study subjects

was designed by the researcher and included the gender, age, marital status, working hours, nature of employment, education, title, position, and section of the study subjects.

The Moral Distress Scale (MDS) was revised by Hamric [13] based on the Moral Distress Scale of Corley *et al.* [14], which was introduced and translated by Sun Xia *et al.* [15] and revised to form the Chinese version of the Nurse Moral Distress Scale according to China's national conditions. The Chinese version of the Nurse Ethical Dilemma Scale consists of 22 items and one open-ended question, each of which measures the frequency of occurrence and the degree of distress caused by a nurse's ethical dilemma. "Occasionally," "Fairly," "Frequently," "Very frequently"; Distress level "none," "mild," "average," "severe," "serious". The product of the frequency and intensity of moral distress is the score of each entry, and the final score of the scale is the sum of the scores of each entry. The scale scores range from 0 to 352, with higher scores indicating higher levels of ethical dilemma among nurses. The Cronbach's alpha coefficient for the total scale is 0.879, and the Cronbach's alpha coefficients for each dimension are 0.846, 0.724, 0.738, and 0.566, respectively.

2.3. Data Collections

Using a convenience sampling method, potential participants' names and units were obtained from personnel departments at the two hospitals. Individual departments at each hospital, including nursing and other departments, were contacted to schedule dates for administering the survey. The questionnaires were then distributed to participants with a cover page explaining the purposes and procedures of this study. All questionnaires were then collected by the researcher or were returned with the consent form in the addressed envelope provided or in mailboxes at the hospitals.

A total of 400 questionnaires were distributed in this study, 390 were collected, 384 were valid, and the effective recovery rate was 93%.

2.4. Data Analysis

An Excel database was established and SPSS 22.0 software was used for statistical analysis, with double entry and checking of the data to ensure the correctness of the data. General socio-demographic data, the moral distress and scores of each dimension of clinical nurses were statistically described using, composition ratios; two independent samples t-test or ANOVA was applied for one-way analysis of moral distress with the level of statistical significance set at P = 0·05.

3. Results

3.1. Participant Demographics

Among the 384 subjects included in the study, 10 (2.6%) were male and 374 (97.4%) were female; age ranged from 20 to 52 years, with an average age of (31.07 ± 6.37) years; initial education: 308 (80.2%) were specialists, 76 (19.8%)

were bachelor and above; highest education: 189 (49.2%) were specialists, 195 (50.8%) were bachelor and above (50.8%); marital status: 128 unmarried (33.4%), 256 married (66.6%); job establishment: 110 formally on staff (28.6%), 274 personnel agency or contract system (71.4%), the rest of the general information is shown in Table 1.

Table 1. Participant demographics (N = 384).

Variables	n	%	Moral distress of the nurse's ($\bar{X}$ ± s)	t/F	P
Gender				1.278	0.259
Male	10	2.6	54.36 ± 20.61		
Female	374	96.5	47.23 ± 27.28		
Ages				3.131	0.044
20 - 30	222	57.9	45.37 ± 26.81		
30 - 40	123	32.1	50.65 ± 27.91		
40 - 60	39	10	48.84 ± 25.74		
Departments				4.809	<0.001
Emergency Medicine	61	15.8	47.23 ± 27.28		
Internal Medicine	98	25.4	43.90 ± 26.34		
Surgery	102	26.6	46.83 ± 26.79		
Obstetrics and Gynecology, Pediatrics	83	21.5	44.18 ± 27.83		
ICU	41	10.7	56.58 ± 24.34		
Title				3.112	0.026
Nurse	117	30.5	42.76 ± 25.59		
Nurse practitioner	191	49.8	48.97 ± 28.02		
Supervisor nurse practitioner	58	18	49.02 ± 26.57		
eputy chief nursing officer and above	18	4.6	52.51 ± 26.35		
Position				0.010	0.922
staff	352	91.8	47.44 ± 27.30		
manager	32	8.2	47.09 ± 25.52		
salary				4.998	0.002
1000 - 3000	23	6.0	47.97 ± 26.37		
3000 - 5000	131	34.0	52.37 ± 27.27		
5000 - 7000	91	23.7	46.03 ± 25.33		
>7000	139	36.2	43.57 ± 27.71		
Years of nursing experience				2.937	0.033
1 - 2	34	8.9	40.01 ± 23.16		
3 - 5	92	24.0	45.46 ± 26.78		
6 - 10	127	33.1	48.02 ± 28.10		
>10	131	34	50.13 ± 27.09		

3.2. Current Status of Nurses' Moral Distress

The total score of nurses' moral distress was 47.41 ± 27.14, and the scores of each dimension were: value conflict dimension (16.19 ± 10.34), individual responsibility dimension (14.75 ± 10.98), failure to maintain the best interests of patients (11.57 ± 7.72), and damage to patients' interests (5.09 ± 4.61) (**Table 2**). Nurses' moral distress scores were statistically significant ($P < 0.05$) when comparing scores by ages, title, salary, department, and years of service (**Table 1**).

4. Discussion

The results of this study showed that the total score of nurses' moral distress was (47.41 ± 27.14), which was similar to the findings of domestic scholar Wenwen Zhang [16] on nurses in a tertiary hospital in Jinan. The scores for each dimension were (16.19 ± 10.34) for the value conflict dimension, (14.75 ± 10.98) for the individual responsibility dimension, (11.57 ± 7.72) for failure to uphold the best interests of patients, and (5.09 ± 4.61) for harming the interests of patients.

As can be seen from **Table 2**, the two highest scoring dimensions in each dimension were, value conflict, with a mean entry score of (2.70 ± 1.72), and failure to maintain maximum patient benefit, with a mean entry score of (2.31 ± 1.54). In clinical nursing, nursing staff are most often in contact with doctors and patients, and the communication between nursing, doctors, and patients is the most common relationship dilemma faced in nursing practice. In addition to dealing with the doctor-patient relationship, nurses also face the relationship dilemma with patients' families, and the value conflict dilemma in the nursing-doctor relationship is manifested in clinical activities, where doctors' medical decisions conflict with nursing decisions, and nursing staff are in a distress because they should follow medical advice due to professional ethical requirements, but make decisions that are contrary to them according to the requirements of nursing ethics [17]. The nurse-patient relationship dilemma is manifested by the fact that nursing staff are responsible for providing optimal care to patients, while patients have the right to give informed consent and participate in their own care and rehabilitation process, and both nurses and patients can be caught in a relationship dilemma if they do not adapt to the role change in time

Table 2. Total score of moral distress and scores of each dimension.

Dimension	Number of items	scores	median value
Total Moral Distress Score	22	47.41 ± 27.14	2.16 ± 1.23
Individual responsibility	8	14.75 ± 10.98	1.84 ± 1.37
Failure to uphold the best interests of the patient	5	11.57 ± 7.72	2.31 ± 1.54
Conflicting values	6	16.19 ± 10.34	2.70 ± 1.72
Harming the patient's interests	3	5.09 ± 4.61	1.70 ± 1.54

[18]. With the gradual establishment of the modern medical model, the role of nursing staff has changed from that of caring caregivers in the past to that of independent decision makers for nursing care programs. As the education level of nursing staff continues to improve, they have more and more opportunities for independent judgment and nursing care decisions, and are becoming more and more competent in specialty care, while doctors, influenced by the traditional concept of hierarchy of medical and nursing power, believe that nurses can only care for patients on the basis of carrying out doctors' orders and cannot think and make independent decisions about patients' treatment programs, which is the root cause of the dilemma in the ethical relationship between the two. Therefore, nurses should communicate more with physicians about medical decisions during treatment, make the best decisions in the interests of patients on the basis of respecting patients' values, and reduce the value conflicts between physicians and nurses caused by different starting points. In terms of failing to maintain the best interests of the patient, nurses, because they have the ethical goal of providing the best care for the patient, will ethically evaluate the medical decisions made by doctors, patients or family members, *i.e.*, they want the medical decisions to be consistent with the best interests of the patient, and in a study by Rushton [19]. it was stated that nurses believe that conscious adult patients have the right to know about their illnesses, and when Ethical dilemmas can also result when family members are reluctant to inform patients of the truth about their illness, when nurses feel frustrated, helpless and compassionate towards patients, and when the choices made by the subject of medical decision making are not aligned with the patient's best interests in the eyes of the nurse, it can threaten the core values and ethics of nurses, which can lead to moral distress.

The mean moral distress intensity for all items in the nurse was 1.01 ± 0.53, and the mean moral distress frequency for all items in the nurse was 1.19 ± 0.61, indicating that both the intensity and frequency of moral distress for nurses were at a mild level, which indicated that nurses did not frequently encounter conflict events that cause moral distress in clinical settings. **Table 3** shows that entries 4, 3, 7, 22, and 5 are the main causes of higher frequency of moral dilemmas, and entries 4, 11, 3, 7, and 22 are the main causes of higher intensity of moral dilemmas. The provision of therapeutic measures and care to patients with uncertain outcomes and the failure to safeguard the patient's right to information due to family demands were the main sources of high frequency and intensity of ethical dilemmas for nurses, which is consistent with the findings of Gutierrez [2]. In a study by Meltzer [6], the greatest source of moral distress was also identified as being related to end-of-life care and communication about medical decisions, which may be explained by the fact that with advances in medical technology and the increasing sophistication of end-stage life-support treatment, long-term survival of critically ill or brain-dead patients is possible, but this situation also poses new challenges to the professional goals and ethical consistency of health care professionals, as life-support treatment not only requires a heavy

Table 3. Root causes of moral distress.

Number		Moral distress frequency		Moral distress intensity	
		Mean ($\overline{X} \pm s$)	rank	Mean ($\overline{X} \pm s$)	rank
1	Inability to provide optimal care to patients due to health care policies or pressure from patients to reduce the cost of treatment.	1.29 ± 0.99	7	1.38 ± 0.96	6
2	Witness medical staff offering "false hope" to patients	0.71 ± 0.85	17	0.80 ± 0.90	19
3	Even though I don't think that is in the best interest of the patient, I still provide life support treatment to the patient in accordance with the family's wishes.	1.74 ± 1.07	2	1.63 ± 0.93	3
4	I administer life-saving treatments to patients even when I know the outcome will only prolong their lives.	2.43 ± 1.11	1	1.99 ± 1.05	1
5	Comply with the family's request to not discuss death with the terminally ill patient when they ask about it.	1.31 ± 1.09	5	1.35 ± 1.05	7
6	Follow doctor's orders for tests or treatments that I consider unnecessary for the patient.	1.20 ± 0.99	9	1.26 ± 1.00	10
7	When no one makes a decision to discontinue treatment, treatment is continued for patients who are hopelessly dependent on ventilators to keep them alive.	1.67 ± 1.19	3	1.55 ± 1.11	4
8	When I discover that a physician or nursing colleague has made a medical error and not reported it, I let it go.	0.65 ± 0.85	20	0.83 ± 1.03	18
9	Assist physicians who I believe are not competent to do their job.	1.30 ± 1.03	6	1.41 ± 1.08	5
10	Was assigned to care for patients I felt I could not care for.	0.90 ± 0.88	14	1.02 ± 1.01	15
11	Witness doctors performing painful procedures on patients simply to improve their skills.	0.71 ± 0.88	16	1.82 ± 1.01	2
12	Providing patients with care that does not relieve pain because physicians fear that increasing the dose of analgesics will cause the patient to die.	0.78 ± 0.90	15	0.85 ± 0.96	16
13	Follow the physician's request to not talk to the patient or family about their prognosis.	1.13 ± 1.01	10	1.08 ± 0.96	14
14	Increasing the dose of paroxysmal hypnotics in comatose patients, even though I think it may hasten the patient's death.	0.53 ± 0.82	21	0.72 ± 1.01	21
15	Comply with requests from involved health care professionals or leaders to ignore ethical issues identified.	0.57 ± 0.82	22	0.70 ± 0.96	22
16	Although I did not agree with the family's decision, I complied with the family's wishes for the patient's care to avoid medical disputes.	1.23 ± 0.99	8	1.34 ± 1.03	9
17	Work with colleagues who are unable to meet the treatment needs of their patients.	1.08 ± 0.91	11	1.22 ± 1.03	11
18	Witnessed a decline in the quality of medical care due to poor communication among colleagues.	1.08 ± 0.86	12	1.20 ± 0.98	12
19	I turned a blind eye to the failure to provide adequate information in securing informed consent from patients.	0.68 ± 0.83	19	0.80 ± 0.92	20

Continued

20	Witness the suffering of patients due to interruptions in the continuity of care by medical staff.	0.71 ± 0.81	18	0.84 ± 0.96	17
21	Work with colleagues who I believe are not up to par professionally.	1.02 ± 0.88	13	1.19 ± 1.03	13
22	Comply with family requests to conceal medical conditions from terminally ill or cancer patients.	1.54 ± 1.11	4	1.35 ± 1.04	8
All items		1.01 ± 0.53		1.19 ± 0.61	

financial burden on the family in terms of human and material resources, but also results in a waste of limited medical resources [20]. With the popularization of the concept of euthanasia, respecting the dignity and value of the patient's life so that the patient can leave this world peacefully without any physical or mental pain is in line with the ethical goals, and in the cultural context of traditional Eastern filial piety, even if the family understands that the fact that resuscitation can only achieve prolonged survival time has been meaningless and will only bring meaningless suffering to the patient, the family is hesitant to give up active treatment or not. not make a decision, often the case of family members insisting on resuscitation occurs, causing the patient to suffer unnecessary mental and physical torture, meaningless in terms of length and quality of life, creating an ethical dilemma for health care workers who witness the patient's end-of-life suffering, thus affecting the quality of clinical care and the professional identity and values of nursing staff. In addition, it is very common in clinical practice for families to request that health care professionals not inform cancer patients of their diagnosis and prognosis [21] [22], and the issue of cancer patients' right to know is one of the most frequent ethical issues encountered by clinical caregivers [23].

Nurses with more years of work experience have higher levels of moral dilemma. In a study by Fella *et al.* [24] on the correlation between moral dilemmas and secondary traumatic stress syndrome in 206 nurses in psychiatric hospitals, the results were consistent. The analysis may be due to the fact that nurses with long working years have accumulated valuable nursing experience due to their own extensive knowledge and previous working experience, and have consolidated their knowledge and enhanced their business ability at the same time through continuous theoretical and operational examinations in the department and partnership with physicians, and have the ability to identify unreasonable treatment and nursing measures for patients in the clinic, which can easily lead to inner emotional-cognitive conflicts and experience moral distress frequently. The higher the title and salary, the lower the moral dilemma score of nurses, and in order to follow the trend of salary reform, many hospitals have now fully started to implement contract management with equal pay and equal treatment for the same work, even so, there are still differences in salaries between contract nurses and nurses on staff, and the results of some studies have shown that the level of moral dilemma of nurses formally on staff is higher than that of nurses

on contract [25].

The moral dilemma scores of nurses in the emergency department and ICU were higher than those in general departments, and in a survey of nurses' moral distress in tertiary hospitals in Tai'an by Sun Xia [15] showed that the emergency department ICU had the highest moral dilemma scores of nurses compared to other departments. Clinical departments such as, emergency and intensive care units, are the departments with the highest concentration of acute and critically ill patients, the largest number of diseases, and the heaviest resuscitation and management tasks in hospitals, and are also the departments prone to doctor-patient disputes, and in 2004 the Institute of Medicine released a report titled "Keeping Patients Safe: Changing the Work Environment" explaining that the work environment of nurses and the lack of nurses can lead to patient harm and nurse physical and mental exhaustion [26] and therefore experience high levels of ethical dilemmas. Hiler *et al.*'s [27] survey of 328 nurses in ICUs in the United States showed that providing ineffective and aggressive care to terminally ill patients was the main clinical event that led to nurses' ethical dilemmas, as well as "causing harm to patients at the end of their lives rather than providing comfort and dignity "Thus, nurses were described as victims of "aggressive care," and the nurses' perception that the intense nursing tasks in the ICU, their inability to ensure that patients receive the best care and provide timely psychological comfort while understaffed, were also important factors in the moral dilemma. For special departments with heavy nursing tasks in ICUs and emergency departments, it is suggested that managers can flexibly allocate manpower according to patient admissions, flexibly schedule shifts, and appropriately improve the nurse-patient ratio; respect nurses' professional autonomy and create a favorable ethical atmosphere; provide professional psychological counseling or online supportive counseling services, discuss, analyze, and exchange views on the ground regarding events that tend to cause nurses' ethical dilemmas, and strengthen nurses' psychological empowerment and reduce the psychological pressure brought by ethical events to nurses.

5. Conclusion

The results of this study confirmed that ethical dilemmas cause a certain degree of distress to clinical nurses, and in order to solve this problem of ethical distress, effective communication is the key to resolving ethical dilemmas when nurses face conflicts of ethical principles between different subjects of interest, and one study found that fostering active and cooperative relationships between nurses and doctors can effectively reduce the degree of ethical dilemmas. Faced with the unchangeable cultural status quo, nurses can change a new attitude, reacquaint themselves with and accept the Eastern "filial piety" culture and understand how it affects the medical decisions of family members; they can fully discuss with patients and their families. Nurses can interact, communicate and build trust with patients and their families in order to find solutions in the best

interest of patients and to reduce the mental burden of the psychological environment caused by the occurrence of moral dilemmas, so as to reduce the nurses' sense of alienation and increase their professional identity and job satisfaction, with the ultimate goal of ensuring patient safety and improving nursing quality.

6. Limitations of the Study

This study only investigated the current situation of moral distress among clinical nurses in the tertiary hospitals in Wuhan region, and did not investigate other regions, sub-hospitals, and other health care providers due to the limitation of human and material resources. Future studies could investigate other health care institutions such as nursing homes and community health centers.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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