Electronic Journal of General Medicine
2022, 19(6), em404
e-ISSN: 2516-3507
https://www.ejgm.co.uk/

MODESTUM

Original Article

OPEN ACCESS

The effect of communication skills training on nurses' moral distress: A randomized controlled trial

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Citation: Dehghani A, Sobhanian M, Faseleh Jahromi M. The effect of communication skills training on nurses' moral distress: A randomized controlled trial. Electron J Gen Med. 2022;19(6):em404. https://doi.org/10.29333/ejgm/12313

ARTICLE INFO

Received: 31 May 2022

Accepted: 20 Jul. 2022

ABSTRACT

Background: Moral distress is one of the ethical concepts in healthcare which leads to negative consequences in patients and health care providers. Communication problems could result in moral distress in nurses. This study aimed to examine the effect of communication skills training on nurses' moral distress.

Methods: This is a randomized-controlled trial study. 53 nurses working in Jahrom University of Medical Sciences in southern Iran were selected randomly. Data were collected using the Hamric moral distress. Data were analyzed using SPSS 21.

Findings: The results of Mann-Whitney test showed significant difference in the moral distress of nurses between the intervention and control groups ($p<0.001$) one month after the intervention. Wilcoxon test showed that the mean of moral distress in nurses was significantly lower after the intervention ($p<0.001$).

Conclusion: The findings of this study indicate that program of communication skills training reduced moral distress in nurse.

Keywords: training, communication skills, moral distress, nursing

INTRODUCTION

Nursing profession is based on ethics [1]; consequently, nurses should be sensitive to a variety of ethical issues such as patients' and colleagues' rights, confidentiality, conflict of interest, privacy, informed consent, euthanasia, moral distress, etc., which are related to their responsibilities and management of ethical issues in clinical practice. Since nurses spend more time in patients' beds and communicate in-depth with patients, ethical care is important, which sometimes takes precedence over clinical aspects of nursing [2].

Moral distress is one of the most important issues in nursing professional ethics. It was first expressed the concept of moral distress [3]. In general, moral distress is defined as the feeling of mental and emotional distress caused by inability to perform appropriate moral action due to real or mental obstacles and limitations [4,5]. In Iran, studies have shown a high level of moral distress in nurses [6]. Results of [7] showed that one out of three nurses experiences moral distress. It was also reported high level of moral distress in nurses [8].

Nurses' moral distress affects not only their selves but also patients and health care providers [9]. The effects of moral distress on nurses include nightmares, insomnia, palpitations, anger, depression, burnout, leaving the profession, minimal interaction with the patient and lower quality of care, which also affect patients and create various organizational problems such as increasing complaints and financial problems [10-15].

The causes of moral distress in nurses are different and can be considered as communicational including inability to communicate effectively and professionally among health care professionals or lack of effective communication between health care professionals and service recipients; organizational including lack of equipment and organizational support and budget constraints, and causes related to patients and medical treatments (invasive treatments, dying patients, unnecessary clinical tests, and inadequate treatment [16-18]. As a result, lack of communication skills seems to be one of the reasons that causing moral distress in nurses.

Communication between the nurse and the patient forms the core of care in nursing [19]. This relationship is professional and based on mutual trust and respect. Therefore, nurses need to be trained to communicate effectively and efficiently. Communication skills training is considered as one of the main ways to improve quality of care, and good communication between health care professionals and clients promotes patient health, increases satisfaction and reduces complaints of the medical team [20], which can reduce moral distress in health care professionals. Studies have shown poor communication skills in healthcare providers [21-24]. According to the Agency for Healthcare Research and Quality, 10.8% of patients believe that health care providers sometimes or never listen to them carefully, do not clearly explain what they are saying. They do not respect and do not spend enough time with them. Some patients experience inappropriate behavioral responses due to asking questions or expressing

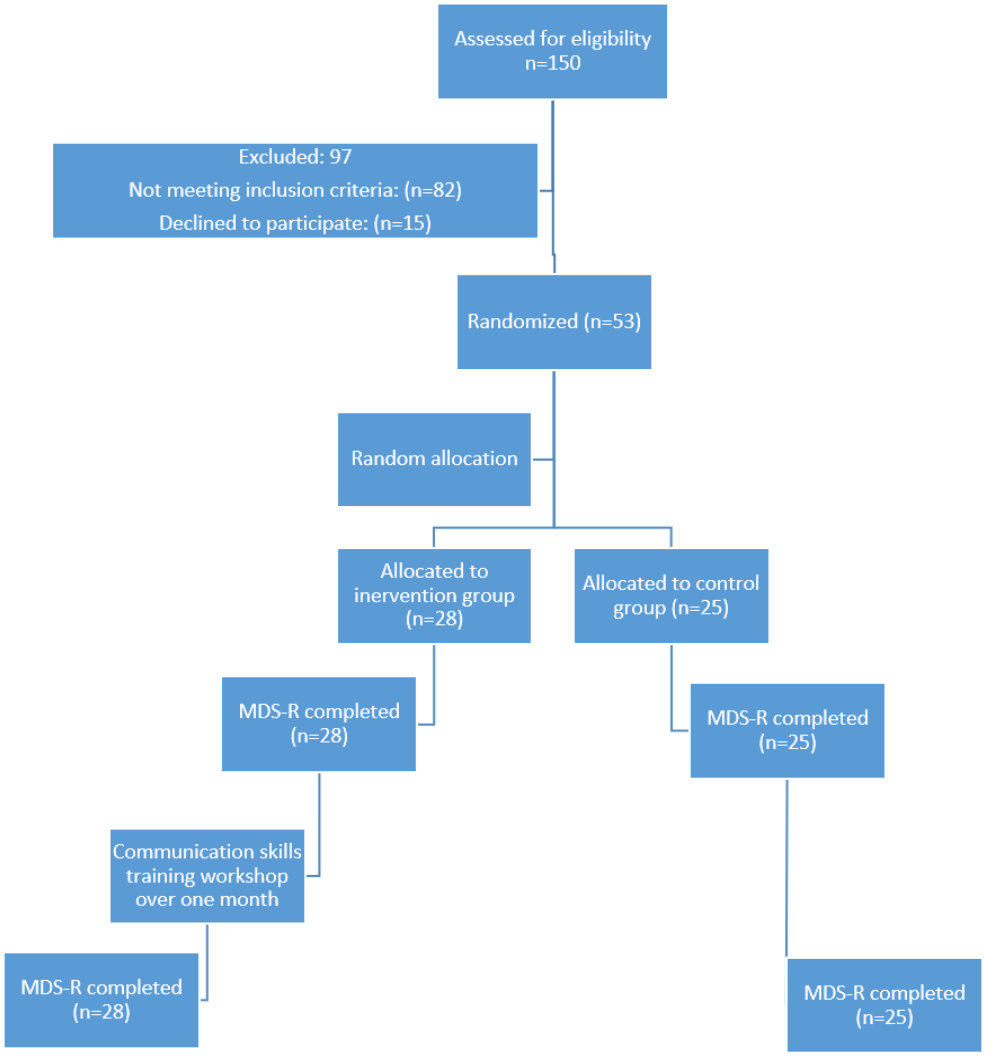

Figure 1. Consort flow diagram of the study

their concerns during interactions with caregivers [25]. It was also found that nurses spend little time talking to patients [26]. Effective communication has a considerable impact on healthcare outcome. The study [27] has found communication as an effective tool in improving patients' outcomes. The study [28] emphasizes the importance of the nurse-patient relationship as an essential part of treatment. As studies [29-32] have shown that ineffective communication is still a barrier to health care. On the other hand, poor communication with patients will lead to various problems including hiding patients' problems and needs, disrupting acquisition of correct information, reducing patients' satisfaction and obedience, and finally increasing moral distress among caregivers [33].

Objective

This study aimed to investigate the effect of communication skills training on nurses' moral distress.

METHODS

Study Design, Setting, and Participants

This study is a randomized controlled trial (ref number: IRCT20191125045491N1). This study was conducted to examine the effect of communication skills training on nurses' moral distress at Motahari Teaching Hospital affiliated to Jahrom University of Medical Sciences from November 2020 to March 2021. The statistical population of this study included all nurses working at Motahari Teaching Hospital affiliated to Jahrom University of Medical Sciences in Iran (**Figure 1**).

Inclusion criteria were the following:

1. Willingness to participate in the study,
2. At least one year of working experience, and
3. Having an average of moderate to high moral distress.

Exclusion criteria were the following:

1. Mental illness that can disrupt educational and communication processes during the study,
2. Absence of more than two sessions in communication skills training workshops,
3. Attend in communication skills training workshops in the last six months,
4. Working in CCU and ICU wards, neonatal intensive care unit, dialysis, supervising office, and eye surgery at the time of the study,
5. Illness or using psychotropic drugs, and
6. Participating in other interventional studies with ethical or communication issues at the same time.

Sample size was calculated 40 nurses using sample size formula in [34] and considering α=0.05, β=0.2, and d=.901.

$$N = \frac{(S_1^2 + S_2^2)^2 \left(Z_{1-\frac{\alpha}{2}} + Z_{1-\beta}\right)^2}{(\bar{X}_1 - \bar{X}_2)^2}. \quad (1)$$

Considering dropout of some subjects from the study, 53 nurses entered the study. For recruitment, all eligible nurses completed the moral distress questionnaire. Based on the results, from those with moderate to high moral distress, 53 nurses were randomly selected by computer software and then randomly divided into the two groups of control and intervention (control group, n=25 and intervention group, n=28). Both groups completed the Hamric 2012 moral distress scale-revised (MDS-R) before the intervention.

Communication skills were taught to the intervention group in four two-hour sessions over a month. The content of the workshop was selected based on communication issues affecting moral distress and the educational content extracted from the literature, and personal experience of the investigator and using participants' experiences in the workshop. In the first session, basic concepts of communication, factors affecting communication, preparation for communication, communication steps, and effective communication skills were taught.

In the second session, strategies of exchanging medical information among health care professionals, appropriate feedback techniques, communication with patients with special needs and transfer of medical information to the patient and his family were explained. In the third session, barriers to communication, anger management skills, and ability to say "no" and to dealing with an aggressive patient were explained. In the fourth session, the importance of ethics in communication with others and expressing point of views and exchanging scientific opinions was taugt. Then nurses' moral distress was re-evaluated by the MDS-R one month after the intervention.

Data Collection

Data were collected using a questionnaire which consists of two parts. The first part includes demographic and occupational characteristics such as age, gender, marital status, educational level, ward, and employment duration. The second part of questionnaire, the Hamric 2012 MDS-R, consists of 21 statements describing situations resulting in moral distress in clinical practice. Respondents rated each situation on two dimensions:

1. how frequently they experience (0=never to 4=very frequently) and
2. how disturbing it is or would be for them (0=none to 4=great extent).

Total scores for each situation were computed (range 0-16), and total score of moral distress or MDS was calculated (range 0-336). Hamric revised the original scale 21 situations using a Likert scale of 0-4 rating frequency and level of disturbance for each situation in health care settings and with different professionals including physicians, nurses and other professionals. An inter-rater agreement of 88% was achieved, and reliability was obtained 0.88 using Cronbach's alpha of in nurses and physicians [35]. It was examined psychometric properties of Persian version of the questionnaire [36]. Content validity and reliability of Persian version have also been assessed in some studies [37-39].

Data Analysis

Data were analyzed using SPSS version 21 for Windows. The normality of the data was tested using two sample Kolmogorov-Smirnov tests. If the data distribution was normal, parametric tests were used such as paired t-test and independent t-test, otherwise non-parametric tests were used such as Mann-Whitney and Wilcoxon. p-value<0.05 was considered statistically significant.

Ethical Considerations

The study was approved by the Research Ethics Committee at Jahrom University of Medical Sciences, Fars, Iran with ref number: IR.jums.rec.1398.057. In addition, the study was registered at the Iranian Registry of Clinical Trials. The study was conducted in accordance with the ethical principles of the Declaration of Helsinki and the guidelines of the Iranian Ministry of Health and Medical Education. In this study, the selected participants were thoroughly informed about the purpose and process of the study. Moreover, they were ensured that participation and withdrawal from the project are voluntary. Finally, an informed consent form was obtained from each participant.

RESULTS

In this study, 53 nurses with moderate to high level of moral distress were randomly selected and assigned into the control and intervention groups (control group n=25, and intervention group n=28).

According to **Table 1**, prior to the intervention, the control and intervention groups were homogenous in terms of demographic and occupational variables (age, gender, marital status, educational level, and ward and employment duration).

In this study, assumptions of the analysis of moral distress in the control group included normal distribution, before and after the study, but after the intervention the distribution of the moral distress in the intervention group, did not include the normal distribution (based on the Kolmogorov-Smirnov test). In data analysis if the data distribution was normal, parametric tests such as paired t test and independent t-test were used, and otherwise non-parametric tests such as Mann-Whitney and Wilcoxon were used.

Table 2 shows moral distress of nurses in the intervention and control groups before and one month after the intervention. The results of independent t-test showed no significant difference in the MDS of the nurses between the intervention and control groups before the intervention (p=0.30). while the results of Mann-Whitney test showed significant difference in the MDS of the nurses between the intervention and control groups one month after the intervention (p<0.001).

Wilcoxon test showed that the mean of MDS in the nurses after the intervention was significantly lower than before the intervention (p<0.001); However, the results of the paired-t test did not show a significant difference in the average MDS of the control group nurses after the intervention compared to before the intervention (p=0.223).

Table 1. Demographic information of the subjects in the intervention and control groups

Characteristics		Control group (n=28)	Intervention group(n=25)	p-value
Ward	Internal	12 (42.9)	11 (44.0)	0.92
	Pediatric	8 (28.6)	6 (24.0)	
	Emergency	8 (28.6)	8 (32.0)	
Sex	Male	8 (28.6)	9 (36.0)	0.56
	Female	20 (71.4)	16 (64.0)	
Marital status	Single	14 (50.0)	12 (48.0)	0.88
	Married	14 (50.0)	13 (52.0)	
Age	20-25	4 (14.3)	5 (20.0)	0.382
	26-30	9 (32.1)	12 (48.0)	
	31-35	10 (35.7)	4 (16.0)	
	>35	5 (17.9)	4 (16.0)	
	SD±Mean	30.89±5.14	29.32±4.72	
Employment duration	<5	10 (35.7)	14 (56.0)	0.315
	6-10	11 (39.3)	6 (24.0)	
	>10	7 (25.0)	5 (20.0)	
	SD±Mean	7.61±5.01	6.12±5.01	

Table 2. Moral distress of nurses in the intervention and control groups before and one month after the intervention

Moral distress	Control group (n=28)	Intervention group (n=25)	p-value
Before the intervention	178.0±32.62	166.56±39.43	0.30
One month after the intervention	171.89±39.87	89.28±53.84	<0.001
Difference	-6.11±25.90	-77.28±54.73	<0.001
p-value	0.223	<0.001	

DISCUSSION

In this study, the effect of communication skills training on nurses' moral distress was investigated. The results showed that communication skills training leads to a significant difference in nurses' MDS after the intervention between the two control and intervention groups. While there was no significant difference between MDS of nurses in the intervention and control group before the study. Therefore, the difference after the intervention shows that moral distress in the intervention group has decreased due to participating in the communication skills training workshop. In explaining this result, it could be said healthcare professionals experience moderate to high levels of moral distress, as indicated by many studies [6, 8, 40]. The study [41] also found that nurses were more likely to develop moral distress due to the professional nature and close relationship with patients than other members of the medical team.

On the other hand, many studies such as [9, 29-32] reported failure of communication skills in health care personnel and nurses. As a result, one of the reasons of nurses' moral distress is communication problems and defects in communication skills. Therefore, the intervention in the present study is based on educational activities such as discussing about basic concepts of communication, effective communication skills, barriers to communication, strategies of exchanging medical information among health care professionals, appropriate feedback techniques and the importance of ethics in communicating with others. Communication skills training with the approach of reducing moral distress gave nurses more understanding of the factors contributing to moral distress and helped them to use strategies to prevent and reduce severity and frequency of moral distress.

In line with the present study, the study [42] developed an educational model (10-month, 96-hour educational program including three sections: Training, simulation, and a mentored clinical practicum) to reduce nurses 'moral distress in the intensive care unit and showed that enhancing the nurses' ability to communicate with patients reduced moral distress and its consequences. This study was in line with the present study in terms of the effect of educational intervention on moral distress but did not correspond in terms of the type of educational program and the duration of the intervention. The study [43] indicated that applying Peplau's interpersonal relations theory has led to positive outcomes such as patient-to-nurse trust, stress reduction, and increased patients' satisfaction with nursing care, which could result in moral distress reduction. It was found nurses 'ethical empowerment as an effective program in reducing nurses' moral distress [44]. This study was also in line with the present study in terms of the effect of educational intervention on moral distress. Contrary to the present study, the study [45] did not find communication skills training to medical residents and nurses students as an effective way to improve the quality of communication with critically ill patients. The reason may be the curriculum content and less encounter of medical students to critically ill patients in hospitals. On the other hand, this result is different because the present study was conducted on experienced nurses, but the participants in the above study were medical residents and nursing students. Also, contrary to the results of the present study, Elizabeth et al. didn't find educational program as an effective intervention in reducing nurses' moral distress [46]. The reason might be their curriculum content, which included a one-hour educational program. Therefore, according to the findings of the research, and the confirmation of the hypothesis of the effect of communication skills training on nurses' moral distress, communication skills training should be included in the nursing curriculum content to improve effective communication skills, reduce moral distress and its negative sequences and improve their performance.

Limitations

This was a two-group study with a rather small sample size. Further studies required with a larger sample size. Other limitations include:

1. Dificulty of access to nurses due to busy schedule and poor cooperation in filling out questionnaires which was addressed by visiting them several times.
2. Limited training hours to four two-hour sessions in one month, which tried to explain the goals of the research and encouraged nurses to pay attention to educational content to access the accurate response.
3. Failure to address other variables affecting moral distress

CONCLUSION

According to the findings of this study, which showed a significant difference in the MDS of nurses between the intervention and control groups one month after the intervention, it is concluded that communication skills training program reduced nurses' moral distress. It is recommended to use communication skills training to reduce nurses' moral distress. It is also suggested to investigate the effect of communication skills on other ethical issues and identifying and implementing other strategies to reduce moral distress.

Author contributions: AD & MS: conception, design, collection, analysis, and interpretation of the data, and revision & **AD, MS, & MFJ:** writing and and final approval of the article. All authors have agreed with the results and conclusions.

Funding: The research was supported by a grant from Jahrom University of Medical Sciences, Fars, Iran with grant number: 400000180.

Acknowledgements: The authors would like to thank to those who helped in Faculty of Nursing from Jahrom University of Medical Sciences, and all nurses at Motahari Educational Hospital who cooperated in this study.

Declaration of interest: No conflict of interest is declared by authors.

Data sharing statement: Data supporting the findings and conclusions are available upon request from the corresponding author.

REFERENCES

1. Novhi E, Farahbakhsh F. The importance of ethics in education and the level of complying with it from the perspective of nursing students at Kerman University of Medical Sciences. J Educ Ethics Nurs. 2016;5(1):1-7. https://doi.org/10.52547/ethicnurs.5.1.1
2. Borhani F, Abbaszadeh A, Kohan M, Fazael MA. Nurses and nursing students' ethical reasoning in facing with dilemmas: a comparative study. J Med Ethics Hist Med. 2010;3(4):71-81.
3. Deschenes S, Kunyk D. Situating moral distress within relational ethics. Nurs Ethics. 2020;27(3):767-77. https://doi.org/10.1177/0969733019884621PMid:31802709
4. Asayesh H, Mosavi M, Abdi M, Masoud MP, Jodaki K. The relationship between futile care perception and moral distress among intensive care unit nurses. J Med Ethics Hist Med. 2018;11 (2): 2 -6.
5. Whitehead PB, Herbertson RK, Hamric AB, et al. Moral distress among healthcare professionals: Report of an institution wide survey. J Nurs Scholarsh. 2015;47(2):117-25. https://doi.org/10.1111/jnu.12115 PMid:25440758
6. Rabiee S, Khatiban M, Cheraghi MA. Nurses distress in intensive care unit: A survey in teaching hospitals. Iran J Med Ethics Hist Med. 2012;5(2):58-69.
7. Deady R, McCarthy J. A study of the situations, features, and coping mechanisms experienced by Irish psychiatric nurses experiencing moral distress. Perspect Psychiatr Care. 2010;46(3):209-20. https://doi.org/10.1111/j.1744-6163.2010.00260.x PMid:20591128
8. Houston S, Casanova MA, Leveille M, Schmidt KL, Barnes SA, Trungale KR, et al. The intensity and frequency of moral distress among different healthcare disciplines. J Clin Ethics. 2013;24(2):98-112. PMID:23923809
9. Moshtagh M, Mohsenpour M. Moral distress situations in nursing care. Clin Ethics. 2019; 14(3):141-5. https://doi.org/10.1177/1477750919851058
10. Keighobadi F, Sadeghi H, Keighobadi F, Tabaraei Y. The relationship between moral distress and emotional exhaustion in nurses. IJME. 2014;7(3):36-47.
11. Motaghedi H, Donyavi R, Mirzaian B. Effectiveness of mindfulness based cognitive therapy on the distress tolerance of nurses and job burnout. J Nurs Midwifery Sci. 2016;3(4):3-12. https://doi.org/10.18869/acadpub.jnms.3.4.3
12. Fumis RR, Junqueira Amarante GA, de Fátima Nascimento A, Vieira Junior JM. Moral distress and its contribution to the development of burnout syndrome among critical care providers. Ann Intensive Care. 2017;7(1):71. https://doi.org/10.1186/s13613-017-0293-2 PMid:28639161 PMCid:PMC5479870
13. Austin CL, Saylor R, Finley PJ. Moral distress in physicians and nurses: Impact on professional quality of life and turnover. Psychol Trauma: Theory Res Pract Policy. 2017;9(4):399. https://doi.org/10.1037/tra0000201 PMid:27797570
14. Fernandez-Parsons R, Rodriguez L, Goyal D. Moral distress in emergency nurses. J Emerg Nurs. 2013;39(6):547-52. https://doi.org/10.1016/j.jen.2012.12.009 PMid:23414814
15. Borhani F, Abbaszadeh A, Mohamadi E, Ghasemi E, Hoseinabad-Farahani MJ. Moral sensitivity and moral distress in Iranian critical care nurses. Nurs Ethics. 2017;24(4):474-82. https://doi.org/10.1177/0969733015604700 PMid:26419438
16. Ersoy N, Akpinar A. Turkish nurses' decision making in the distribution of intensive care beds. Nurs Ethics. 2010;17(1):87-98. https://doi.org/10.1177/0969733009349992 PMid:20089628
17. Henrich NJ, Dodek PM, Alden L, Keenan SP, Reynolds S, Rodney P. causes of moral distress in the intensive care unit: A qualitative study. J Crit Care. 2016;35(9):57-62. https://doi.org/10.1016/j.jcrc.2016. 04.033 PMid:27481736
18. Mahmoudi H, Soori Laki A, Boulhasani M, Sepahvand MJ. The relationship between use of communication skills and job satisfaction of nurses. Daneshvar Med. 2012;20(101):77-82.
19. Kourkouta L, Papathanasiou IV. Communication in nursing practice. Mater Socio Med. 2014;26(1):65. https://doi.org/10.5455/msm.2014.26.65-67 PMid:24757408 PMCid: PMC3990376
20. Baghianimoghadam M, Esfandiari R, Nazari M. Comparison of the effect of written or speech communication skills training of health staff on clients' satisfaction of Shiraz Health Centers. TB. 2012;11(1):32-40.
21. Hemsley B, Balandin S, Worrall L. Nursing the patient with complex communication needs: Time as a barrier and a facilitator to successful communication in hospital. J Adv Nurs. 2012;68(1):116-26. https://doi.org/10.1111/j.1365-2648.2011.05722.x PMid:21831131

22. Gillett K, O'Neill B, Bloomfield JG. Factors influencing the development of end-of-life communication skills: A focus group study of nursing and medical students. Nurs Educ Today. 2016;36(100):395-400. https://doi.org/10.1016/j.nedt.2015.10.015 PMid:26530442
23. Ali M. Communication skills 1: Benefits of effective communication for patients. Nurs Times. 2017;113(12):18-9.
24. Kwame A, Petrucka PM. Communication in nurse-patient interaction in healthcare settings in sub-Saharan Africa: A scoping review. Int J Africa Nurs Sci. 2020;12(1):100198. https://doi.org/10.1016/j.ijans.2020.100198
25. Grissinger M. Disrespectful behavior in health care: Its impact, why it arises and persists, and how to address it_part 2. Pharmacol Ther. 2017;42(2):74. PMID:28163550 PMCID:PMC5265230
26. Fakhr-Movahedi A, Rahnavard Z, Salsali M, Negarandeh R. Exploring nurse's communicative role in nurse-patient relations: A qualitative study. J Caring Sci. 2016;5(4):267-76. https://doi.org/10.15171/jcs.2016.028 PMid:28032071 PMCid:PMC5187547
27. Greenhalgh J, Gooding K, Gibbons E, Dalkin S, Wright J, Valderas J, et al. How do patient reported outcome measures (PROMs) support clinician-patient communication and patient care? A realist synthesis. J Patient-Rep Outcomes. 2018;2(1):42. https://doi.org/10.1186/s41687-018-0061-6 PMid:30294712 PMCid:PMC6153194
28. Gibson F. Children with cancer: Communication, an essential component of care. Principle of nursing in oncology: New challenges. Springer; 2019. p. 329.
29. Khodadadi E, Ebrahimi H, Moghaddasian S, Babapour J. The effect of communication skills training on quality of care, self-efficacy, job satisfaction and communication skills rate of nurses in hospitals of Tabriz, Iran. J Caring Sci. 2013;2(1):27-37. https://doi.org/10.5681/jcs.2013.004 PMID:25276707 PMCID:PMC4161104.
30. Hekmat Afshar M, Jooybari L, Sanagou A, Kalantari S. Study of factors affecting moral distress among nurses: a review of previous studies. J Educ Ethics Nurs. 2012;1:22-7.
31. Wang YY, Wan QQ, Lin F, Zhou WJ, Shang SM. Interventions to improve communication between nurses and physicians in the intensive care unit: An integrative literature review. Int J Nurs Sci. 2018;5(1):81-8. https://doi.org/10.1016/j.ijnss.2017.09.007 PMID:31406806 PMCID:PMC6626231
32. Coombs MA. Concerns about care and communication are key causes of moral distress in intensive care staff. Aust Crit Care. 2017;30(2):107-8. https://doi.org/10.1016/j.aucc.2017.01.007 PMid:28292414
33. Vermeir P, Vandijck D, Degroote S, Peleman R, Verhaeghe R, Mortier E, et al. Communication in healthcare: A narrative review of the literature and practical recommendations. Int J Clin Pract. 2015;69(11):1257-67. https://doi.org/10.1111/ijcp.12686 PMid:26147310 PMCid:PMC4758389
34. Mohammadi J, Ghazanfari F, Amir A. The effectiveness of ethics training on nurses ethical distress. J Med Educ Dev. 2016;8(20):99-105.
35. Trotochaud K, Coleman JR, Krawiecki N, McCracken C. Moral distress in pediatric healthcare providers. J Pediatr Nurs. 2015;30(6):908. https://doi.org/10.1016/j.pedn.2015.03.001 PMid:25869472
36. Shoorideh FA, Ashktorab T, Yaghmaei F, Alavi Majd H. Relationship between ICU nurses' moral distress with burnout and anticipated turnover. Nurs Ethics. 2015;22(1):64-76. https://doi.org/10.1177/0969733014534874 PMid:24948793
37. Rahimi Golsefid S, Jan Mohamadi S, Seyd Fatemi N, Haghani H. Effectiveness of end-of-life care education on the moral distress of nurses in neonatal intensive care units. Iran J Pediatr Nurs. 2019;5(2):75-82. https://doi.org/10.21859/jpen-050211
38. Ameri M, Safavibayatneed Z, Kavousi A. Moral distress of oncology nurses and morally distressing situations in oncology units. Aust J Adv Nurs. 2016;33:6-12.
39. Mahdavi Fashtami S, Mohammadeh Zadeh Zarankesh S, Esmaeilpour Bandboni M. Moral distress among emergency department nurses: frequency, intensity, effect. Med Sci. 2016;26(4):248-55.
40. Abbaszadeh A, Borhani F, Kalantary S. The moral distress of nurses in health centers in the city of Bam in 1390. Med Ethics J. 2011;5(17):119-40.
41. Peter E, Liaschenko J. Perils of proximity: A spatiotemporal analysis of moral distress and moral ambiguity. Nurs Inq. 2004;11(4):218-25. https://doi.org/10.1111/j.1440-1800.2004.00236.x PMid:15601410
42. Grace PJ, Robinson EM, Jurchak M, Zollfrank AA, Lee SM. Clinical ethics residency for nurses: An education model to decrease moral distress and strengthen nurse retention in acute care. JONA. 2014;44(12):640-6. https://doi.org/10.1097/NNA.0000000000000141 PMid:25393140
43. Cheraghi F, Khatiban M, Borzou R, Hosayni P, Vatandost S. Application of Peplau's theory of interpersonal relations in nursing practice: A systematic review study. SJNMP. 2017;3(2):1-11. https://doi.org/10.29252/sjnmp.3.2.1
44. Abbasi S, Ghafari S, Shahriari M, Shahgholian N. Effect of moral empowerment program on moral distress in intensive care unit nurses. Nurs Ethics. 2019;26(5):1494-504. https://doi.org/10.1177/0969733018766576 PMid:29695198
45. Curtis JR, Back AL, Ford DW, Downey L, Shannon SE, Doorenbos AZ, et al. Effect of communication skills training for residents and nurse practitioners on quality of communication with patients with serious illness: A randomized trial. JAMA. 2013;310(21):2271-81. https://doi.org/10.1001/jama.2013.282081 PMid:24302090 PMCid:PMC4310457
46. Elizabeth A, Leonard. Evaluating a pilot project on nursing moral distress, PhD in Nursing Practice, Drexel University, USA, 2017.