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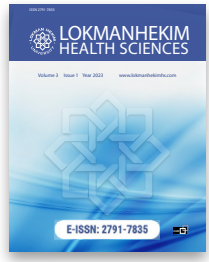

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ORIGINAL ARTICLE

Experiences of Neonatal Intensive Care Nurses on the Concept of Moral Distress: A Descriptive Qualitative Research

Yenidoğan Yoğun Bakım Hemşirelerinin Ahlaki Sıkıntı Kavramına İlişkin Deneyimleri: Tanımlayıcı Nitel Araştırma

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Abstract

Introduction: In this study, it was aimed to examine the experiences of neonatal intensive care nurses regarding the concept of moral distress, how they were affected by moral distress, how they coped with moral distress, and solution proposals for moral distress.

Methods: This research was conducted between September 2021 and December 2021 using an inductive qualitative design. The research was carried out with 18 neonatal intensive care nurses providing tertiary care in a university hospital. Interviews were conducted over Zoom Meeting using a semistructured in-depth interview form. The data were collected after obtaining permission from the ethical committee and written consent from the nurses. The data were analyzed using the content analysis method. The article was written in accordance with the consolidated criteria for reporting qualitative research control list.

Results: All participants were females, and their ages ranged from 20 to 40 years. The majority of nurses are undergraduates (77%) and single (88%). The total working time of nurses in the profession varies between 2 and 18 years, and nurses work an average of 45.3 h per week. Nurses gave an average of 7.6 points out of 10 for their moral distress situation. As a result of the content analysis, themes were determined under four main categories: (1) the causes of moral distress, (2) the effects of moral distress, (3) nurses' coping with moral distress, and (4) solution suggestions for moral distress.

Discussion and Conclusion: It was determined that neonatal intensive care nurses had a high level of moral distress. In this sense, it is recommended to develop individual and institutional coping strategies that will facilitate handling.

Keywords: Ethics; Moral distress; Neonatal intensive care; Nursing; Qualitative research

Moral distress occurs when a health care professional knows the ethically right action but is unable to follow through due to interpersonal, institutional, regulatory, or legal constraint.[1] The American Association of Critical-Care Nurses (AACN) defines moral distress as "an experience that occurs when you do something that goes against

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your personal and professional values when you know it is morally right but you cannot take that action."[2] Moral distress is a condition encountered in many clinical settings and is particularly common in critical care areas. Intensive care units are risky environments in terms of moral distress due to different personal moral judgments among team members regarding the treatment and care of patients.[3]

Neonatal intensive care units are critical care areas where moral distress can occur frequently.[4] Many review studies in the literature reported that moral distress arises with the provision of neonatal palliative care.[4–6] Nurses responsible for the treatment and care of premature and complex newborns with medical, cardiac, and surgical disorders in neonatal intensive care units are one of the health professionals who experience moral distress. Neonatal nurses are advocates of babies and families and are absolutely aware of how interventions affect infants.[4,7] Nurses may face moral distress due to personal reasons, inter-team communication problems, or institutional management problems.[8]

Moral distress causes physical (heart palpitations, diarrhea, headache, etc.) and psychological (frustration, nervousness, hopelessness, etc.) problems in nurses.[8] The AACN draws attention to the fact that moral distress is a serious professional problem that causes nurses to experience both physical and emotional stress, negatively affects the quality, quantity, and cost of nursing care, and causes nurses to consider leaving their jobs.[2] It has been reported in the literature that nurses cannot effectively cope with moral distress.[3,6]

Moral distress experienced by neonatal nurses who care for a sensitive group such as newborns can affect the quality of newborn care, the cost of care and treatment, and most importantly, the health of newborns and nurses. For this reason, it is of great importance to investigate the situations in which nurses working in the neonatal intensive care unit experience moral distress, its effects, coping methods, and solutions. In a study in which studies on the concept of moral distress in pediatric intensive care units were compiled, it was emphasized that there was a need for data reflecting the views of nurses on the subject.[6] Although it has been observed that moral distress in nursing has been investigated in many areas, no study has been reached on the experiences of neonatal nurses who can provide palliative care to extremely premature infants. It is thought that this study will close the gap in this field. This study was conducted qualitatively to examine the experiences of neonatal intensive care nurses regarding the concept of moral distress in detail. The research questions guiding the study are as follows:

1. In which situations do neonatal intensive care nurses experience moral distress?
2. What are the effects of moral distress on neonatal nurses?
3. How do neonatal nurses cope with moral distress?
4. What are the individual and institutional solutions for neonatal intensive care nurses to reduce moral distress?

Materials and Methods

This research was carried out in a descriptive qualitative design. This study was guided by the consolidated criteria for reporting qualitative research (COREQ).[9]

Study Design and Sampling

This research was conducted between September 2021 and December 2021 using an inductive qualitative design. The sample of this descriptive study consisted of 18 nurses working in the neonatal intensive care unit of a university hospital. Due to the pandemic, online interviews were held with nurses. When the interviews were conducted with all nurses, the data collection process was terminated. Nurses who agreed to participate voluntarily, worked in the neonatal intensive care unit of the relevant hospital for at least 6 months, did not have a history of an acute stressful experience, and did not use any medication related to psychotic disorders in the last 6 months were included in the study. The exclusion criteria were determined as the nurse's unwillingness to participate in the research, wanting to leave the research at any stage, and not meeting the inclusion criteria. The study was completed with all nurses working in relevant neonatal intensive care units.

Research Team and Reflexivity

Members of the research team are lecturers (assistant professor) of the faculty of health sciences, department of nursing, pediatric health, and diseases nursing. The first researcher previously worked as an intensive care nurse in an accredited hospital for 1 year. Researchers have been trained in qualitative research methods and have conducted research and publications using these methods.

Data Collection

A semistructured interview form was created by the researchers by scanning the relevant literature.[10–15] In the first part of the interview form, there were four questions about the sociodemographic data of the nurses, 4 questions about their professional characteristics, and 1 question for scoring their own moral distress levels. In the sec-

ond part, there were 4 semistructured basic open-ended questions about the concept of moral distress. A pilot session was conducted to test the semistructured interview questions. After the pilot session, alternative topic titles were added under the open-ended questions in line with the relevant literature, and it was ensured that the questions were clear and understandable.

Due to the nature of qualitative research, an introductory meeting was held with the participants before the data were collected to establish a relationship of trust and cooperation between the researcher and the participant. A separate online interview was conducted for each nurse using the semistructured questionnaire, which was finalized after the pilot application. Before starting the interview, the knowledge level of the nurses about the concept of "moral distress" was tested, and an explanation was given about the concept. Online interviews were held at the time that the nurses deemed appropriate. Interviews were conducted by two researchers and a nurse. The second researcher took part in the interview as a moderator. Each online interview took 20–25 min.

At the beginning of the interview, the participant's consent to be voice recorded and to participate in the research voluntarily was repeated verbally. Before the interview ended, the notes taken by the moderator were reviewed with the nurses and the interview was summarized. When the data collection process was completed, the video recordings were transcribed independently by the researchers, and the data were coded. Then, categories and themes were created with a common view by both researchers. Expert opinion on the themes was obtained from three researchers who are experts in the field of qualitative research and newborns, and the findings were finalized.

Data Analysis

The data obtained from semistructured interviews were analyzed using inductive, thematic analysis. The thematic analysis provides a systematic and flexible approach and guides the objective analysis of data.[16] Voice recordings of the interviews (only the sections on moral distress) were transcribed word-for-word by two researchers. The transcribed interviews were analyzed and coded. Themes that can explain these codes under certain categories have been created. Six stages of the thematic analysis were followed: initial acquaintance with the data, assigning precodes, searching for themes, reviewing themes, defining and naming themes, and producing the report.[6] Finally, the researchers checked the consistency of the codes and themes to reach a consensus. The presence of at least 10 participants under the same category indicates that data saturation has been reached. All participants were interviewed to increase the diversity of codes under categories. The data were coded by two researchers. After the analysis of the data, feedback was received from 11 participants about the findings. All the participants who shared feedback stated that the research findings were appropriate and did not give any additional opinions.

Ethical Consideration

Ethical approval was obtained from the Non-Invasive Clinical Research Ethics Committee of the University (Date: October 2021, Decision No.: 2021/093) before starting the study. Consent regarding participation in the study was obtained from each participant and confirmed in the voice recordings. The researchers were assured that the data would be anonymous and that confidentiality would be protected. The study was conducted in accordance with the principles of the Declaration of Helsinki.

Results

Table 1 contains the descriptive data of the participants. All participants are women, and their age ranges from 20 to 40 years. The majority of nurses are undergraduates (77%) and single (88%). The total working period of nurses in the profession varies between 2 and 18 years. Nurses provided 7.6 points out of 10 for their moral distress situation (Table 1). The average monthly working hours of the participants were 45.3 h, and the number of newborns they cared for in one shift was determined to be 3 or 4. All nurses providing tertiary health care in the neonatal intensive care unit where the study was conducted have end-of-life palliative care experience.

After the content analysis, themes were determined under four main categories (causes of moral distress, effects of moral distress, coping with moral distress, and solution suggestions) (Fig. 1). Frequency and percentage statistics for the relevant categories and themes are given in Table 2. It was determined that moral distress was caused mostly by the problems related to the intensive care organization and the difficult patient. It has been determined that the psychosocial effects of moral distress are more, and half of the nurses plan to change clinics or professions because they cannot effectively cope with moral distress. Nurses mainly offered institutional solutions for moral distress.

1. Data on Situations Causing Moral Distress

Analysis of the data obtained during the nurse interviews revealed that neonatal intensive care nurses experienced

Table 1. Descriptive data of the participants

Participant number	Age (years)	Gender	Education level	Marital status	Years of working in nursing	Moral distress score*
P1	38	Female	Bachelor's degree	Married	18	4
P2	23	Female	High school	Single	3	9
P3	29	Female	High school	Single	6	10
P4	23	Female	Associate degree	Single	3	9
P5	20	Female	Associate degree	Single	2	10
P6	23	Female	Bachelor's degree	Single	2	7
P7	23	Female	Bachelor's degree	Single	2	8
P8	24	Female	Bachelor's degree	Single	3	8
P9	25	Female	Bachelor's degree	Single	2	8
P10	26	Female	Bachelor's degree	Single	5	7
P11	40	Female	Bachelor's degree	Married	13	5
P12	24	Female	Bachelor's degree	Single	2	7
P13	22	Female	Bachelor's degree	Single	2	9
P14	27	Female	Bachelor's degree	Single	5	4
P15	25	Female	Bachelor's degree	Single	2	8
P16	23	Female	Bachelor's degree	Single	2	9
P17	26	Female	Bachelor's degree	Single	4	7
P18	23	Female	Bachelor's degree	Single	2	8

*: Nurses rated their moral distress level out of 10 points.

moral distress in various situations. There was one nurse (Participant 1) who reported that he did not experience any moral distress. Nurses reported moral distress due to drug applications, nonbeneficial treatment/futile care, lack of knowledge and competence in staff, problems with intensive care organization, difficult patients, and ethical dilemmas.

Some statements of the participants regarding the drug applications theme are as follows:

Participant 2: '*Sometimes we use high-risk drugs for babies. We apply other drugs to reduce the side effects of these drugs. Of course, we have to legally make the drugs that are on the doctor's request. However, due to the risk of drug toxicity, this situation creates moral distress for me.*'

Participant 13: '*Sometimes we apply sedatives to calm our restless babies. This doesn't feel right to me and it creates moral distress for me. Instead of sedatives, applications such as bathing and swaddling the baby can be used.*'

A sample statement of a participant for the theme nonbeneficial treatment/futile care is as follows:

Participant 16: '*Sometimes I have moral distress about treatment methods (intubating or extubating etc.). … If I had the authority, I would take the baby out of the machine without waiting for the morning. Interventions that I think are unnecessary may cause moral distress to me as they will disrupt the baby's comfort.*'

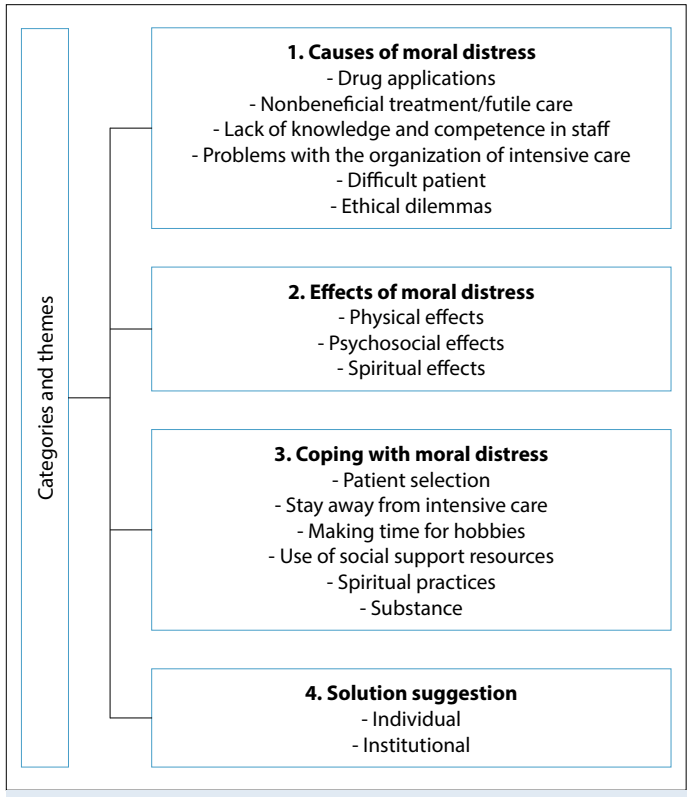

Figure 1. Categories and themes.

Some statements of the participants regarding the lack of knowledge and competence in staff, problems with the organization of intensive care, and difficult patient contact are as follows:

Table 2. Frequencies and percentages for categories and themes

Categories and themes	n	%
1. Causes of moral distress		
Drug applications		
Administering a sedative	2	11.1
Drug Intoxication risk	2	11.1
Malpractice	1	5.5
Nonbeneficial treatment/futile care	3	16.6
Lack of knowledge and competence in staff	2	11.1
Problems with the organization of intensive care		
Irregular diagnosis and treatment procedures and care hours, delayed written requests	5	27.7
Lack of multidisciplinary approach in end-of-life care	1	5.5
Insufficient number of incubators and/or nurses in intensive care and work-centered work	5	27.7
Frequent change of intensive care staff/orientation process of new staff	2	11.1
Difficult patient	7	38.8
Ethical dilemmas	2	11.1
2. Effects of moral distress		
Physical effects		
Pain (abdominal, back, leg, headache, etc.), fatigue	9	50
Insomnia, bad dreams	8	44.4
Nausea, stomach problems	3	16.6
Psychosocial effects		
Mistrustful, obsessive mood	9	50
Fear of making mistakes, anxiety	4	22.2
Unhappiness, inner restlessness	5	27.7
Despair	2	11.1
Burnout, compassion fatigue	3	16.6
Introversion, not wanting to communicate	5	27.7
Sadness/pity	5	27.7
Disruption in social relations (partner, mother/father, child, friend, etc.)	6	33.3
Damage to self-integrity	2	11.1
Spiritual effects		
Questioning the meaning of life/spirituality	4	22.2
Desire to do no harm/be more useful	6	33.3
Fair treatment, account of conscience	5	27.7
Advocating your newborn	3	16.6
3. Coping with moral distress		
Patient selection (desire to care for babies with good prognosis and light emotional burden)	4	22.2
Staying away from intensive care		
Using frequent permission	1	5.5
Plans for clinic or job change	9	50
Spending time for hobbies (doing sports, listening to music, reading, traveling, etc.)	6	33.3
Using social support resources	2	11.1
Spiritual practices		
Praying, believing in destiny	4	22.2
Crying	4	22.2
Thinking logically	2	11.1
Substance use		
Cigarette	8	44.4
Pain relievers	4	16.6
4. Solution suggestions		
Individual		
Setting career goals for professional development	2	11.1
Investing in spirituality for personal growth	1	5.5
Institutional		
Multidisciplinary joint decision-making in neonatal care/team collaboration	4	22.2
Using evidence-based scientific knowledge in neonatal care	2	11.1
Patient-centered work with sufficient number of health staff	10	55.5
Critical making/experience sharing on neonatal care with senior nurses	5	27.7
In-service training (ethics, legal responsibilities, coping with stress, patient advocacy, etc.)	8	44.4
Creating a corporate culture (social activities outside of work, team solidarity, etc.)	7	38.8

Participant 9: '*… applying heavy treatments (eg, ecmo) to babies with a very high probability of dying after a few days and not seeing their effectiveness forces the nurse psychologically. The benefit-harm dilemma creates moral distress.*'

Participant 3: '*We cared for a premature newborn. It's now 6 months old. We could not transfer him to another unit due to severe infection. We took him to the isolated room. It was a baby that required total palliative care. There is an unfavorable expectation for its prognosis. This is tough patient for us. Because it is different from the patients in the neonatal intensive care unit, we sometimes experience a feeling of inadequacy as a nurse while giving care. On the other hand, we cannot accept other babies who can receive health services in our intensive care unit due to the lack of space. Because we have reserved the isolated room for this baby. Due to the insufficient number of nurses, the nurse who takes care of this baby has to take care of other babies. This increases the risk of transmission of infection. The possibility of infecting newborns in intensive care puts me in moral distress*.'

Participant 8: '*Even the inability to hold an orally-fed baby in a mother's arms creates moral distress. I would like to have kangaroo care. Most of the time it is not possible*.'

2. Data on the Effects of Moral Distress

In the content analysis, it was determined that neonatal intensive care nurses were affected by moral distress. The effects of moral distress were examined in three themes: physical, psychosocial, and spiritual.

A sample statement from a participant regarding the theme of physical effects is as follows:

Participant 5: '*For a while, I was experiencing abdominal pain during patient delivery with the fear of mistakes. I think I experienced this because of moral distress. At that time, I also had complaints of pain in my waist and back, and cramps in my legs*.'

Some participant statements regarding the psychosocial effects theme are as follows.

Participant 17: '*There is no anger, but it is an inner restlessness for no reason, I will cry if someone touches, my eyes fill with tears, even now. Withdrawal from helplessness, not wanting to talk to anyone. ….*

'Participant 10: '*Moral distress causes me to experience emotions such as sadness, unhappiness, hopelessness.*'

Participant 18: '*… It's like I've come out of my own personality. I had to be faultless. … So I became the dominant and obsessive type. This preoccupation also affects my private life.*'

Participant 11: '*For example, I have a fight with my husband over thinking about this place. I can't spare time for him*.'

Participant 7: '*… My behavior and personality have changed. It's like I'm not my own movement, but a reflection of others. I have become a particularly obsessive person who does not admit fault*.'

Participant 1: '*I constantly confirm the work I do while giving care. Sometimes I am afraid, I feel anxiety while giving care. These cause fatigue and burnout.*'

Some statements of the participants regarding the spiritual effects theme are as follows:

Participant 2: '*… Even though we have certain beliefs (God, religion, etc.), the fact that a baby suffers like this as soon as it is born and cannot defend itself against all the interventions makes me question the meaning of life.*'

Participant 9: '*… Caring for such difficult patients and experiencing loss in return causes the work done to be questioned constantly. … I am motivated to do no harm and to be more helpful.*'

Participant 3: '*Sometimes, there is no consensus among the team about the repeated resuscitation of a baby who is extremely premature and whose prognosis is getting worse day by day. ... The fact that we have a life in our hands and that we are uncertain about what is right creates moral distress and causes us to question spirituality*.'

3. Data on Coping with Moral Distress

Some of the statements of nurses under the themes of patient selection, staying away from intensive care, spending time for hobbies, using social support resources, spiritual practices, and substance use in the category of coping with moral distress are as follows:

Participant 2: '*Sometimes I don't want to look after babies with heavy emotional burdens to reduce my moral distress. I am relieved to care for a healthier baby with a better prognosis.*'

Participant 13: '*I read personal development books to deal with this distress. I'm walking. I do social activities to distance myself from the hospital environment. But I don't know how long I can cope with this problem. I'm thinking of moving to another field in the future. I have thoughts of leaving the profession or moving to another unit*.'

Participant 15: '*Consistently confirming myself negatively affects professional motivation. When I experience intense*

moral distress, I want to go on leave and get away from the intensive care setting.'

Participant 1: '*I can cope with moral distress because of my faith. Because I'm a bit fatalistic. Even if I do all the treatments in the world, the child will die when the time is up. It's about my own belief*.'

Participant 14: '*I tried to deal with moral distress by crying. I was trying to increase my stress management, but it's more comforting to sit in a corner and cry. I started to pray, I invoke often*.'

Participant 7: '*To deal with moral distress, excessive smoking is something I have observed in myself and many of my friends. According to the severity of the problem, the frequency of smoking also increases*.'

4. Data on Suggestions for Solutions for Moral Distress

In the analysis of the interview contents, the suggested solutions of the nurses for moral distress were examined under two themes: individual and institutional. Some statements of the participant regarding these themes are as follows:

Participant 6: '*Multidisciplinary joint decision must be made. The use of available scientific evidence in decision-making increases personal satisfaction with the job. … In this sense, professional development and continuous self-renewal can reduce moral distress*.'

Participant 2: '*The institution can provide more in-service training (for example, comprehensive nursing care in complex treatment procedures such as Ecmo). ... Sharing experience with senior nurses is also good for me*.'

Participant 11: '*There should be seminars on coping with stress in in-service training. ... I need information to learn about my rights and responsibilities on ethical and moral issues. … What should be done to improve the quality of care in the service can be discussed by holding multidisciplinary sessions*.'

Participant 13: '*There may be corporate events that will distract from work stress. It should be the corporate culture*.'

Participant 18: '*Adequate staff, suitable working conditions, harmony within the team can alleviate the moral distress experienced*.'

Participant 8: '*The care given to newborn babies should be organized in a way that does not disturb them all the time. … Tasks should be organized in team cooperation, taking into account the best interests of the baby. … Supporting the development of the newborn by working patient-centered will reduce moral distress*.'

Discussion

In the neonatal intensive care unit, the concept of "moral distress" is used as an umbrella term to describe different forms of distress.[17] Burton et al.[18] determined that neonatal intensive care nurses define moral distress correctly and experience moral distress from patient-focused and nurse-focused factors. In this study, although the majority of nurses reported moral distress, they could not define the concept correctly and used it to express different problems.

Neonatal intensive care nurses experience moral distress for a variety of reasons.[19] In neonatal care, the results of some treatments are not beneficial, and these treatments may harm the baby. Nurses may experience moral distress in providing care they cannot conscientiously object to and perceive as futile.[4,5,20] A systematic review of moral distress in both neonatal and pediatric intensive care found that nurses often experienced moral distress about the disproportionate use of technologies that were not perceived to be in the best interest of the patient.[6] In addition to perceived futile care, great differences in perspective on life-or-death decisions are considered high risk for moral distress.[11,21] In a study, it was reported that nurses with limited knowledge about the clinical outcome of end-of-life resuscitation experience more moral distress than assistant doctors.[22] In a study investigating the factors contributing to the moral distress experienced by 15 nurses directly or indirectly involved in the resuscitation of extremely premature infants, it was determined that nurses perceived a lack of power and influence in the neonatal resuscitation decision-making process.[23] In this study, nurses' reporting of moral distress about perceived futile care and lack of a multidisciplinary approach in end-of-life care is compatible with the literature. In this sense, it was thought that moral distress and lack of power and influence might be related.

It has been reported that factors such as lack of staff, professional hierarchies and power dynamics, pressure to get things done on time and efficiently instead of responding to the emotional needs of patients, and poor cooperation are associated with moral distress.[21] In a study by Karabudak et al.,[24] it was reported that newborns in need of intensive care could not be hospitalized due to organizational problems as an ethical problem. Welborn[25] reported that neonatal nurses experienced moral distress due to the professional ethical dilemma (being useful/do no harm). In this study, nurses' reporting of moral distress about problems related to intensive care organizations (lack of personnel, lack of multidisciplinary approach, etc.) and ethical problems is compatible with the literature.

The fact that nurses reported moral distress about lack of knowledge and competence in staff and difficult patients contributed to the literature.

Nurses who experience high moral distress may experience physical problems such as muscle pain, fatigue, insomnia, and stomach problems.[14,15,26] Garten et al.[27] reported that end-of-life care nurses in the pediatric intensive care unit experienced moral distress due to "lack of clearly defined and agreed upon therapeutic goals" and that they had physical problems such as pain, shortness of breath problems, and psychosocial problems like sleep difficulty/distressing dreams, and irritability. Moral distress has been associated with frustration, anger, guilt, sadness, anxiety, insecurity, personal integrity damage, feelings of helplessness, failure, shame, suffering, fatigue, burnout, depression, and compassion fatigue in the literature.[3,7,21,26] In this study, the physical and psychosocial effects reported by nurses were found to be compatible with the literature. However, it has been determined that moral distress affects nurses spiritually as well. It has been reported that moral distress has a positive role in advocating the interests of the newborn population and increasing the quality of care.[17] In this sense, it is noteworthy that nurses in this study care about investing in spirituality individually for the solution of moral distress.

Caring for extremely premature infants and being the cause of pain rather than alleviating pain may make nurses question their role as compassionate health professionals.[28] It has been reported that the negative effects of moral distress on nurses cause situations such as avoiding contact with certain patients or being emotionally distant from patients.[10] Gallagher et al.[29] reported that nurses face unexpected difficulties in maintaining their professionally defined roles as a result of the highly complex and ever-changing decision-making processes involved in caring for extremely premature infants. Thus, moral distress contributes to loss of integrity and self-esteem, job dissatisfaction, burnout, and even quitting the job.[10] Hally et al.[12] reported that approximately half of the neonatal intensive care nurses consider leaving a clinical position due to moral distress, and many nurses who experience high levels of moral distress change their clinics. A study by Hamric and Blackhall[30] showed that nurses with high moral distress were more likely to leave their nursing positions than nurses with low moral distress. As a result, high levels of moral distress can lead to compromising health care quality, avoidance behaviors among staff toward patients, frequent leave requests and/or retirement of health care staff, low staff morale and motivation, and maladaptive work of the health care team.[21,31] In this study, nurses' selecting patients and staying away from intensive care to cope with moral distress were found to be compatible with the literature. Therefore, it was determined that the majority of nurses used ineffective methods (leaving the clinic/profession, crying, and smoking) in coping with moral distress. It was thought that spending time for hobbies, using social support resources, and spiritual practices should be used more effectively in coping with moral distress due to the high mean scores of the nurses' moral distress self-assessment.

Given the complexity of moral distress, it is necessary to reduce the negative effects of moral distress with a multidisciplinary approach involving a multidisciplinary team.[3,17] It is reported that nurses who experience moral distress will experience less disappointment with the adoption of a multidisciplinary team approach and increasing doctor–nurse cooperation.[30,32,33] In this study, it is compatible with the literature that nurses offer institutional solutions in the form of a multidisciplinary approach and team cooperation.

Interventions that mitigate the harmful effects of moral distress are suggested in the literature.[3,17,34] These interventions can be listed as informational in-service training (end of life care, etc.), case-based multidisciplinary opinion sharing/discussion meetings, individual narrative writing or group sessions, activities to increase moral resilience (stress management, moral courage and emotional intelligence training, ethics, self-awareness, etc.).[3,15,23,34,35] Hawes et al.[36] reported that holding sessions in which health care professionals can discuss the mourning process for the loss of a newborn reduces the stress of caring for dying infants and contributes to the well-being of the staff. In addition, Willsher[32] emphasized the importance of sharing with nurses experienced in moral distress. Cronqvist et al.[37] reported that nurses should be supported through mentoring to develop knowledge of moral action. Sezer and Ceran[14] reported that nurses should be able to recognize situations that may cause moral distress in an individual sense and train themselves to produce situation-specific solutions. Sezer and Ceran[14] also suggested to the managers of the institutions that they should develop training and support programs to prevent moral distress. In this study, nurses' individual and institutional solution suggestions for moral distress are compatible with the literature. Some nurses emphasized that they increased their moral resilience through religious belief, fatalistic perspective, and religious practices.

Strengths and Limitations

The strength of this study is that it is the first qualitative study in Türkiye to examine nurses' experiences regarding the concept of moral distress. The fact that the results cannot be generalized to the population due to the nature of qualitative research is the limitation of this research. Another limitation of the study is that only nurses were interviewed but the factors affecting moral distress were not examined.

Conclusions

Moral distress is common in neonatal intensive care nurses. Moral distress negatively affects nurses' biopsychosocial and spiritual well-being. It is important for nurses to cope with the negative effects of moral distress by developing individual and institutional strategies. When the negative effects of moral distress are dealt with effectively, it is thought that moral distress is an important phenomenon in improving the health care provided to newborns and in gaining the professional maturity of nurses. Understanding neonatal intensive care nurses' experiences of moral distress and their solutions is the basis for developing targeted strategies to create a culture of moral resilience.[18,31] The results of this research revealed the importance of supporting nurses in coping with the negative effects of moral distress and taking institutional precautions for moral distress. In this sense, it is recommended to develop individual and institutional coping strategies that will facilitate coping.

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