Jordan Journal of Nursing Research,
DOI: https://doi.org/10.14525/JJNR.181

Jordan Journal of Nursing Research

https://jjnr.just.edu.jo/jjnr

Ethical Dilemmas Experienced by Intensive Care Nurses and Their Psychosocial Impacts: A Descriptive Phenomenological Study

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ARTICLE INFO

Article History:
Received: November 2, 2025
Accepted: April 26, 2026

ABSTRACT

Background: There are several ethical dilemmas experienced by nurses in intensive care units with significant psychosocial impacts. ***Purpose*****:** This study aimed to identify the ethical dilemmas experienced by intensive care nurses and their psychosocial impacts. ***Methods*****:** The Descriptive Phenomenological Approach was employed, and data was collected through face-to-face interviews conducted in a hospital located in the Eastern Black Sea Region of Türkiye. The interviews were carried out between June 1 and July 30, 2024. The sample consisted of 20 nurses. Thematic analysis was used to analyze the data. ***Results*****:** The experiences of the nurses were categorized under four main themes and subcategories. The theme *"Ethical Reasoning Based on Ethical Principles"* included non-maleficence, beneficence, privacy, respect for autonomy, and aesthetics. The theme *"Ethical Dilemmas"* encompassed maintaining life and withdrawing life support. The theme *"Emotional and Psychosocial Reactions"* included emotional responses, coping strategies, and impact on social life. The theme *"Working Conditions and Managerial Issues"* covered understaffing and challenges in care, intra-team communication issues, and excessive overtime workload. ***Conclusion*****:** This study reveals that intensive care nurses frequently encounter significant ethical dilemmas in clinical decision-making, particularly regarding life-sustaining treatments. These dilemmas are accompanied by emotional and psychosocial challenges, including burnout, stress, and desensitization. Additionally, heavy workload, insufficient staffing, and managerial constraints further complicate the implementation of ethical decisions. ***Implications for Nursing*****:** The findings reveal that ethical dilemmas encountered in clinical practice are central to nurses' decision-making processes and indicate the need to integrate ethics-based decision-making, case-based discussions, and structured guidelines into nursing education and in-service training programs, as well as to strengthen organizational support mechanisms that assist nurses in managing ethical challenges.

Keywords: Intensive care nurses, Ethical dilemmas, Moral distress, Psychosocial impacts, End-of-life care.

What does this paper add?

1. This study demonstrates that ethical dilemmas in intensive care nursing extend beyond clinical decision-making and are closely intertwined with nurses' emotional and psychosocial experiences.
2. It reveals that decisions regarding the continuation or

withdrawal of life-sustaining treatment involve complex ethical reasoning shaped by professional values, emotional burden, and contextual constraints.

3. The findings provide context-specific insights from Türkiye, highlighting how working conditions and managerial factors influence nurses' ability to implement ethical decisions in intensive care settings.

Introduction

Recent scientific and technological advancements in healthcare have placed increasing responsibilities on nurses (Ali et al., 2022). While fulfilling these roles, nurses frequently encounter ethical dilemmas in clinical practice (Jansen et al., 2020). An ethical dilemma arises when an individual faces two or more options and struggles to determine which option is morally preferable (Türken & Çalım, 2022). Such dilemmas are characterized by the absence of clear right answers and the lack of definitive rules for resolution (Sepehrirad et al., 2021).

In nursing practice, ethical dilemmas may emerge from various sources, including social and political factors (e.g., ambiguity in job descriptions, euthanasia, abortion, and organ transplantation), institutional constraints (e.g., cost management, shortages of materials and staff, and communication problems), personal factors (e.g., feelings of helplessness in alleviating patient suffering, insufficient knowledge, and paternalistic attitudes), and patient-related issues (e.g., refusal of care) (Albert et al., 2020; Ly, 2023). Due to their continuous and close interaction with patients, nurses are often the first to recognize emerging ethical concerns. In addressing these dilemmas, fundamental ethical principles, such as non-maleficence, beneficence, respect for autonomy, justice, equality, confidentiality, and privacy, serve as essential guides for clinical decision-making (Jørgensen & Kollerup, 2022).

Intensive care units (ICUs) are highly complex clinical environments characterized by high mortality and morbidity rates, where ethical issues frequently arise (Esmaeili et al., 2024). Nurses working in ICUs face particularly demanding and multifaceted challenges.

Common ethical dilemmas in ICUs include decision-making during medical procedures, disclosure of information and obtaining informed consent, decisions regarding cardiopulmonary resuscitation, issues related to brain death and organ transplantation, initiation and continuation of life support, inequitable distribution of medical resources, and communication problems between physicians and nurses (Luca et al., 2021; Şişman et al., 2023). For intensive care nurses, ethical dilemmas commonly arise from end-of-life care decisions, continuation or withdrawal of life support, provision of futile or non-beneficial treatments, conflicts regarding patient autonomy, and the equitable allocation of limited resources (Esmaeili et al., 2024; Ramírez-Elvira et al., 2021). A central dilemma in this context involves the tension between "preserving life at all costs" and "alleviating suffering caused by the ineffective prolongation of life" (Palmryd et al., 2025).

Studies have shown that ICU nurses who face ethical dilemmas experience significant psychological distress, including burnout, emotional desensitization, feelings of failure, hopelessness, fear, anxiety, and moral distress, as well as a decline in empathy and compassion (Esmaeili et al., 2024; Haahr et al., 2020; Ramírez-Elvira et al., 2021). In addition to psychological effects, nurses may experience identity loss, social isolation, resignation, professional disillusionment, and decreased job performance (Esmaeili et al., 2024). Ethical dilemmas may also manifest in physical symptoms, such as headaches, stomach pain, insomnia, and weight changes (Jansen et al., 2020). These multidimensional impacts can adversely affect both nurses' well-being and the quality of patient care. Therefore, identifying the contexts in which ethical dilemmas arise and their psychosocial consequences is essential for developing supportive organizational strategies and promoting a healthy work environment (Khoshmehr et al., 2020).

The body of literature addressing ethical challenges in healthcare has expanded considerably. However, most studies focus on healthcare professionals in countries with well-established healthcare systems and strong institutional structures, such as the United States, Norway, and other European countries (Haahr et al., 2020; McIntosh, 2020; Różyńska et al., 2024; Schaufel et al., 2024). These studies provide valuable insights, but also indicate that ethical experiences are closely shaped by organizational, legal, and sociocultural contexts. Accordingly, there is a growing need for context-sensitive and comparative research across different healthcare systems (Grosek et al., 2020; Grosek et al., 2021).

In Türkiye, healthcare services are organized within a centralized system (Kaya et al., 2025). Intensive care nurses often work under conditions, such as high patient-to-nurse ratios, extended working hours, and resource limitations, which may influence ethical decision-making processes (Waterfielld & Barnason, 2022). Additionally, hierarchical structures within healthcare teams may further complicate ethical responsibilities (Abdulqader et al., 2025). These contextual characteristics suggest that ethical dilemmas experienced by ICU nurses may differ across settings, highlighting the importance of examining these experiences within Türkiye's healthcare system.

This study aims to explore the ethical dilemmas experienced by intensive care nurses in Türkiye and their psychosocial impacts. The findings are expected to contribute to the existing literature by providing context-specific insights, enhancing understanding of coping mechanisms, and informing interventions to strengthen nurses' psychological resilience.

Method

Study Design

This study employed a descriptive phenomenological design (Husserlian approach). Descriptive phenomenology focuses on describing individuals' lived experiences as they are consciously perceived, without imposing theoretical interpretations (Giorgi, 2009; Husserl, 1960).

In line with this approach, the researchers sought to capture participants' experiences of ethical dilemmas as expressed in their own accounts. To ensure methodological rigor, phenomenological reduction (epoché) was applied, whereby researchers bracketed their prior assumptions and approached participants' narratives with openness (Giorgi, 2009).

Throughout the research process, reflexive awareness was maintained to minimize the influence of researchers' prior clinical and theoretical perspectives and to allow meanings to emerge from participants' descriptions.

The study was conducted in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (Tong et al., 2007).

Sample

The study participants were nurses working in adult intensive care units at a state hospital in the Eastern Black Sea Region of Türkiye. A purposive sampling approach was used to ensure that participants had direct experience with the phenomenon under investigation while achieving maximum variation in age, gender, professional experience, education level, and organizational position.

To facilitate access in a demanding clinical setting, snowball sampling was used as a complementary recruitment strategy. Initial participants were identified by the researchers, and additional participants were recruited through peer referral. All referred individuals were screened against the predefined inclusion criteria prior to enrollment.

Inclusion criteria were willingness to participate, at least one year of experience in adult intensive care units, and the ability to articulate personal experiences. Exclusion criteria included nurses working in pediatric or neonatal intensive care units and individuals unwilling or unable to participate.

To minimize potential sampling bias, diversity was monitored in terms of unit type, professional experience, gender, and educational background. A total of 20 nurses who met the inclusion criteria were included in the study (n = 20).

Data Collection

Data was collected through semi-structured, in-depth interviews conducted between June 1 and July 30, 2024, at a hospital in the Eastern Black Sea Region of Türkiye. Interviews continued until data saturation was reached, defined as the point at which no new concepts or insights emerged (Fusch & Ness, 2015; Lewis, 2015). Data was gathered using a researcher-developed semi-structured interview form and a questionnaire (Table 1). The questionnaire included sociodemographic variables (age, gender, marital status, education level) and professional characteristics (work experience, job satisfaction, ethics training). The interview guide was developed based on the literature and expert input from two academics experienced in qualitative research (Haahr et al., 2020; Sepehrirad et al., 2021; Türken & Çalım, 2022). Interviews included open-ended questions exploring experiences of ethical dilemmas and their psychosocial impacts, supported by follow-up and probing questions. Prior to data collection, participants were informed about the study, confidentiality, and audio recording, and verbal consent was obtained. The researchers had no prior professional or personal

relationship with the participants, and no supervisory or hierarchical relationship existed that could influence participation. Interviews were conducted face-to-face in a private room, lasted 40-90 minutes, and were audio-recorded and transcribed verbatim. A pilot interview was conducted to assess the clarity of the questions, and minor revisions were made accordingly.

Table 1. Semi-Structured Interview Form

Which ethical principles are the most prioritized and important to you as an intensive care nurse?
What ethical dilemmas have you experienced or encountered?
What approach did you follow in the case of an experienced or encountered ethical dilemma/conflict?
Has the ethical dilemma/conflict you experienced in the intensive care unit affected your social life?
What emotions did you experience when faced with an ethical dilemma/conflict? What methods did you use to cope with these emotions?

Data Analysis

Data was analyzed using thematic analysis following the six-phase framework proposed by Clarke and Braun (2017), which allows for the systematic identification, analysis, and reporting of patterns within qualitative data. An inductive approach was adopted, allowing themes to emerge from participants' narratives rather than being restricted to predefined categories. Audio recordings were transcribed verbatim, and transcripts were read repeatedly to ensure familiarity with the data and to gain a deeper understanding of participants' experiences. The consistency between audio recordings and transcripts was verified. Data analysis was conducted collaboratively by the research team. Two researchers (MA and CUS) independently coded the transcripts, and initial codes were compared and refined through discussion. All authors contributed to the development and refinement of themes, ensuring that the analysis remained grounded in participants' accounts. During coding and theme development, attention was paid to staying close to participants' language and meanings, in line with the descriptive phenomenological approach adopted in this study. To enhance credibility and reduce individual bias, an external qualitative research expert reviewed the codes and themes. The analysis process followed the stages of familiarization, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final report (Clarke & Braun, 2017).

Data Accuracy and Trustworthiness

Trustworthiness was ensured in accordance with Lincoln et al.'s (1985) criteria of credibility, dependability, confirmability, and transferability. To enhance credibility, all interviews with participants were audio-recorded and transcribed verbatim. The research team repeatedly reviewed and compared transcripts with the audio recordings to verify that they accurately reflected the interview content. During the coding and theme development processes, careful attention was paid to remaining faithful to participants' expressions, and themes were supported with direct quotations.

Regarding dependability, the data analysis process was conducted systematically, and all analytical decisions (such as code merging, theme development, and category naming) were discussed and agreed upon during joint evaluation meetings held by the research team. Throughout the study, methodological and analytical decisions were documented, and an audit trail was maintained.

To ensure confirmability, the semi-structured interview guide, coding process, and developed themes were reviewed by an independent external expert with experience in qualitative research. The external expert assessed the consistency between the data and the codes and themes and provided feedback to minimize potential researcher subjectivity. In addition, the data was independently analyzed by the three researchers, and consensus was reached through comparison and discussion of the codes.

Transferability was supported by purposive sampling and the detailed description of the study group characteristics. Providing detailed information on participants' demographic and professional

characteristics was intended to enhance the transferability of the findings to similar contexts.

Research Team and Reflexivity

The research team consisted of two Associate Professors (PhD) and one intensive care nurse (MSc). One of the researchers (MA) works in the Department of Psychiatric Nursing, while the other (CUS) is affiliated with the Department of Surgical Nursing. The interviewer (MG) holds a Master's degree in Psychiatric Nursing and has worked as a charge nurse in an intensive care unit. Two of the researchers (MA and CUS) have previous experience as intensive care nurses. Among the researchers, two are female and one is male, and all have conducted qualitative research. Additionally, two researchers (MA and CUS) have received training in qualitative research methods from an expert in the Department of Psychology at the University of Oxford and continue to take advanced courses in this field.

The research team adopted a reflexive approach throughout data collection and analysis to ensure awareness of and management of potential researcher biases. Bracketing was approached as an ongoing reflexive process rather than a single preparatory step, and researchers continuously monitored the potential influence of their prior clinical experiences throughout data analysis. The researchers' prior experience working as intensive care nurses was recognized as a potential source of bias during data interpretation. Therefore, leading questions were avoided during the interviews, and a data-driven, consensus-based approach was adopted during analysis rather than relying on individual interpretations. In this process, reflective notes were maintained to document researchers' assumptions, analytical decisions, and emerging interpretations, and these notes were used as a tool to support reflexivity and enhance analytical rigor. In addition, the influence of researchers' assumptions on the findings was mitigated through external expert review. Data saturation was evaluated through concurrent data collection and analysis. As the interviews progressed, it became apparent that no new codes or themes emerged, and that existing themes were repeated. To confirm saturation, additional interviews were conducted; when no new conceptual content emerged, the data collection process was concluded.

Ethical Considerations

Ethical approval was obtained from the Scientific Research Ethics Committee of Karadeniz Technical University Faculty of Health Sciences (Date: 22.03.2024, No: E-13562490-050.01.04-496049). Permission to conduct the study was granted by the Scientific Research Evaluation Board of the Provincial Health Directorate under the Ministry of Health of the Republic of Türkiye (Date: 22.05.2024, No: E-97634879-799-244304009). Participants were informed that they could withdraw from the study at any time without providing any reason, and informed consent was obtained. The study was conducted in accordance with the Declaration of Helsinki (as revised in Brazil, 2013). Confidentiality was maintained throughout the study by assigning participants codes. No personal identifiers were included in the interview transcripts, and any potentially identifying information was removed during transcription. Audio recordings and transcripts were stored on password-protected computers accessible only to the research team. Study findings were reported in aggregate, and direct quotations were anonymized to prevent the identification of individual participants.

Results

The findings are presented in two sections. The first section covers the sociodemographic characteristics of the nurses, while the second section presents the themes.

1. Sociodemographic characteristics of nurses;

The mean age of the 20 participants was 28.80 ± 3.08 years (range: 25–35 years), with 13 (65%) being female, 11 (55%) married, and all (100%) holding a bachelor's degree. The average work experience was 5.6 ± 3.13 years (range: 2-13 years), and 12 participants (60%) reported being satisfied with their nursing profession. 15 participants (75%) reported receiving ethics training during or after their undergraduate education (Table 2).

1. Themes;

Based on the data analysis, the ethical dilemmas and psychosocial challenges experienced by the nurses were grouped under four main themes: "ethical reasoning based on ethical principles," "ethical dilemmas," "emotional and psychosocial responses," and "working conditions and management issues" (Table 3).

Table 2. Individual and Professional Characteristic of Nurses

Nurses No	Nurse 1	Nurse 2	Nurse 3	Nurse 4	Nurse 5	Nurse 6	Nurse 7	Nurse 8	Nurse 9	Nurse 10	Nurse 11	Nurse 12	Nurse 13	Nurse 14	Nurse 15	Nurse 16	Nurse 17	Nurse 18	Nurse 19	Nurse 20
AGE	32	34	33	26	27	26	26	25	28	30	35	28	29	29	28	33	27	29	26	25
GENDER	Female	Male	Male	Male	Male	Male	Male	Male	Female	Female	Male	Female	Female	Female	Female	Female	Male	Female	Male	Male
MARRIAGE STATUS	Single	Single	Single	Married	Single	Married	Married	Single	Married	Married	Single	Single	Single	Single	Married	Single	Single	Single	Married	Married
EDUCATION STATUS	Under graduate	Under graduate	Under graduate	Under graduate	Under graduate	Under graduate	Under graduate	Under graduate	Under graduate	Under graduate	Under graduate	Under graduate	Under graduate	Under graduate	Under graduate	Under graduate	Under graduate	Under graduate	Under graduate	Under graduate
WORKING YEAR	12 Years	13 Years	7 Years	5 Years	5 Years	3 Years	3 Years	3 Years	3 Years	6 Years	11 Years	4 Years	4 Years	5 Years	5 Year	8 Year	5 Year	5 Year	3 Year	2 Year

Table 3. Themes identified through interviews with nurses

Theme	Subtheme	Codes	Quotations
1. Ethical Principles and Values	i. Non-maleficence, Beneficence	Patient safety, Decision making, Patient benefit, Vulnerable patient, Ethical responsibility	"Patients sometimes pull out catheters and drains. In such cases, we may have to restrain them for patient safety." (Nurse 3) "We make decisions that may be beneficial for intubated patients who are unable to make decisions for themselves." (Nurse 8) "Our patients are so vulnerable… Having them in front of our eyes, considering their benefit at every need, is entirely the responsibility of us intensive care nurses." (Nurse 11) "Generally, all our patients are close to death. However, I never think of them as dying today or tomorrow. I provide all the care that will benefit them." (Nurse 15)
	ii. Ensuring privacy	Physical environment, Patient's emotions/feelings, Privacy during care	"The physical structure of intensive care units, in particular, can affect the ability to maintain privacy." (Nurse 2) "When performing a procedure on the patient, I close the curtains, thinking about the emotions the patient may feel during the procedure." (Nurse 7) "During care, I had to briefly uncover the upper body of an intubated patient. At that moment, I noticed a change in the vital signs." (Nurse 9)
	iii. Respect for autonomy	Patient's request, Treatment without consent	"I had decided to shave my intubated patient's beard due to hygiene requirements; perhaps this was something he wouldn't have wanted." (Nurse 1) "The dilemma I struggle with the most is providing treatment or performing procedures without consent on unconscious patients." (Nurse 16)
	iv. Aesthetics	Palliative care, Dependent patients, Aesthetic sensitivity	"Although our patients are near death, it is our duty to prepare them for a comfortable and peaceful death." (Nurse 4) "I never think of them as dying. I don't work with that mindset. Providing care to patients in the terminal stage, keeping them clean, is more important than medication treatment. After all, all the patients here are dependent on care." (Nurse 20) "I am practicing nursing in the truest sense. But at the same time, I also feel like they're my children. I have to think of everything for them. I need to suction now, I need to feed them now. They are my patients. I pay a lot of attention." (Nurse 18)
1. Ethical Dilemmas	i. Life-sustaining treatment	Right to life, Relationship with family, Struggle to revive	"We had a terminal cancer patient. I felt even more upset as I saw the pain they were going through. One day, they arrested. But our struggle to revive them started with such determination. Every person deserves to live." (Nurse 19) "We had a patient who had suffered brain death. They lived like that for a whole month. Yes, if we had turned off all the machines, they would have died. However, the happiness on their family's faces every time they saw them is indescribable. They had to live until their body gave up—and they did." (Nurse 17)
	ii. Discontinuation of life support	Causing pain or suffering to elderly patients, Comorbidity and aging, Resource scarcity	"I call every day the elderly patient spends in bed a torture. I believe it would be better for them to pass away." (Nurse 3) "We had a very frail patient over 95 years old. When they arrested, it was decided not to intervene, considering the

			risk of rib fractures and the presence of comorbidities. Maybe this decision was logical, but it was that day that I realized how much I feared aging and being ill for the first time." (Nurse 5) "Sometimes all our beds are full. At those times, I feel like we are being unfair to especially younger patients who need intensive care." (Nurse 1)
III. Emotional and Psychosocial Reactions	i.Emotional responses	Mental fatigue, Burnout, Desensitization, Loss of empathy, Emotional suppression, Stress, Emotional strain, Sympathy, Crossing personal boundaries	"The intensive care unit is a unique setting where all kinds of emotions are experienced intensely. At times, it can be very challenging. The most exhausting aspect for me is the psychological side. Sometimes, it becomes mentally draining." (Nurse 6) "I often experience both physical and mental exhaustion. This sometimes leads me to feel burned out. It really makes me feel intense and drained." (Nurse 4) "As an intensive care nurse, the thing I feared most was becoming desensitized to death. Over time, I realized that the loss of a patient no longer affects me the way it used to. Those moments have somehow become part of a routine. The sadness and empathy I once felt have been replaced by a sense of emptiness, which made me question myself both as a person and professionally." (Nurse 5) "We send many patients off to death in the ICU. Every farewell is the mourning of a family, the end of a life story. Completely suppressing my emotions does not make me a more 'effective' nurse." (Nurse 8) "I feel very upset for my patients whose general condition is poor. I always hope their condition improves. Every patient who doesn't meet my expectations makes my day completely bad." (Nurse 18) "The elderly patient is in the ICU. I tell myself that if they die, they won't suffer much pain or distress, they'll be free. At the same time, I think about their relatives waiting for good news outside. I get so caught up in it that I start to feel stressed." (Nurse 10) "We had a young patient who had been in a car accident. I was so happy that they survived. When they woke up, they told me they couldn't feel their legs. I walked away without showing my emotions. I started crying. Sometimes, my psychology gets really tested." (Nurse 14) "I try to understand my patient and help them. While caring for them, I empathize, but sometimes I take it too far into sympathy. I realize that while trying to meet their needs even more, I'm wearing myself out. When I go home, my mind is still with them, and I continue thinking about them, which actually wears me out even at home." (Nurse 2)
	ii.Coping mechanisms	Listening to music, Spending time with family, Reading boks, Smoking, Stress management, Physical activity, Walking	"Listening to music relaxes me so much. I forget all my troubles at the hospital." (Nurse 3) "As soon as I leave the hospital, I try to spend time with my family. I realize the value of the time I spend with them more with every shift I work in the ICU." (Nurse 17) "To stop my thoughts, I read a book at the hospital, one at home, and another outside. While reading each one, I think about the flow of the other. This is the only way I can manage to stop my thoughts." (Nurse 15) "After I started working in the ICU, smoking became the only way to relieve my stress. Every moment, whether I felt depressed, stressed, or happy, I would complete it with a cigarette." (Nurse 6) "Walking, both when I arrive at the hospital and when I leave, is an escape for me. My steps in the open air relax both my body and mind; it feels like they take away my fatigue and the chaos in my head." (Nurse 4)
	iii. Impact on social life	Response to work stress, Social withdrawal, Feelings of burnout, Work-related thought suppression	"I even get stressed when I see someone from the hospital while walking on the street. We work in such a stressful department that it feels like we're always about to talk about the hospital." (Nurse 5) "If the hospital is being talked about in the environment I'm in, I immediately distance myself from that place. I can't tolerate it." (Nurse 12)

IV. Working conditions and management issues	i. Insufficient staff and care challenges	Insufficient number of nurses, Workload, Psychological burden, Workforce shortage	"Due to the insufficient number of nurses, I can't provide enough care for my patients. Not being able to give the attention each one needs is really challenging for me." (Nurse 18) "We have too many patients, and the psychological aspect is heavy. I want to provide quality care, but nurse recruitment is insufficient, the workload is high, and the number of nurses is low." (Nurse 5)
	ii.Team communication issues	Lack of team communicationDifficulty in decision-making	"I feel like I can't make the right decision for my patients due to the lack of communication within the team." (Nurse 2) "Sometimes I know something needs to be done, but when I don't get the necessary support from the team, I find myself in an ethical dilemma about doing what is right." (Nurse 20)
	iii. Overtime, Workload	The relationship between fatigue and decision-making, Workload and boundaries, Workload and ethical decisions	"Working overtime makes it harder to make the right decisions due to the accumulated fatigue, and this puts me in an ethical dilemma." (Nurse 8) "When I have to work overtime, while I want to provide the best care for my patients, my fatigue and increased workload make it difficult to make the right decisions. Sometimes, while I have patients who need more attention, I am forced to push my own limits. This situation leaves me in a dilemma both ethically and personally." (Nurse 16)

Theme 1. Ethical Reasoning Based on Ethical Principles

This theme explores how intensive care nurses engage in ethical reasoning when confronted with ethical dilemmas in clinical practice. Nurses described ethical principles—non-maleficence, beneficence, respect for privacy, autonomy, and aesthetic values—not merely as abstract professional norms, but also as dynamic and sometimes conflicting reference points that shape decision-making in ethically challenging situations. Situations involving patient safety and invasive interventions frequently required nurses to balance beneficence and non-maleficence. While certain practices were perceived as clinically necessary, they simultaneously generated ethical discomfort. Nurses reflected on the moral tension of acting in what they perceived as the patient's best interest while questioning the potential harm. One nurse expressed this conflict by stating, "*Even when we believe we are doing something for the patient's benefit, there are moments when we wonder whether we are actually causing more harm*" (Nurse 11). Another participant emphasized that such dilemmas were rarely clear-cut, noting, "*Sometimes we make decisions thinking they are right, but we are never completely sure if this is what the patient would have wanted*" (Nurse 8). Repeated exposure to these situations intensified ethical uncertainty over time (Nurse 15). Respect for privacy emerged as a core ethical concern, particularly within the physical and organizational constraints of the intensive care environment. Although nurses made deliberate efforts to preserve patient dignity, they reported ethical unease when privacy could not be fully ensured. One participant explained, "*Sometimes, despite all our efforts, the environment does not allow us to protect the patient's privacy as we would want to*" (Nurse 2). Similarly, another nurse highlighted the emotional weight of performing procedures under conditions that limited personal space and autonomy, describing these moments as ethically troubling rather than routine tasks (Nurse 9). Ethical reasoning was further complicated by challenges related to respect for autonomy, especially when caring for unconscious or sedated patients. Nurses described distress associated with making decisions on behalf of patients who could not express their preferences. One participant stated, "*Providing care without knowing what the patient would choose creates a constant ethical struggle for us*" (Nurse 1). Aesthetic values, particularly in palliative and end-of-life care, also played a significant role in nurses' ethical reasoning. Participants emphasized the importance of maintaining comfort, cleanliness, and dignity, even when curative treatment was no longer possible. However, they also described the emotional challenge of reconciling these values with the realities of intensive care. One nurse reflected, "*Ensuring comfort and dignity at the end of life feels ethically right, but it is emotionally very demanding*" (Nurse 18). At the same time, another noted that such care often required navigating between professional responsibility and personal emotional boundaries (Nurse 20).

Theme 2. Ethical Dilemmas

Ethical dilemmas were particularly pronounced in situations involving life-sustaining treatment and the discontinuation of life support. Nurses described experiencing moral tension when clinical interventions were maintained despite limited prospects for recovery. In such cases, ethical decision-making extended beyond clinical indicators and became deeply intertwined with the emotional needs of patients' families. An RN said:

Although the continuation of mechanical support for brain-dead patients was ethically and medically contentious, it often provided emotional relief for relatives, as seeing the patient connected to life-support devices sustained the perception that the patient was still alive (Nurse 17).

Ethical dilemmas were also shaped by nurses' personal reflections and emotional responses. One nurse described how witnessing a decision not to intervene for an elderly patient became a turning point in their own self-awareness, leading them to recognize a deep-seated fear of aging and vulnerability (Nurse 5). This illustrates how ethical dilemmas in intensive care not only affect professional judgment, but also evoke profound personal and existential reflections. Additionally, systemic constraints intensified ethical conflicts in clinical decision-making. Nurses reported that limited intensive care capacity and high patient demand forced them to make ethically distressing choices regarding the allocation of resources. An RN said:

The difficulty of deciding which patient should receive care when all intensive care beds were occupied, highlights the ethical burden of prioritizing certain patients over others under conditions of scarcity (Nurse 1).

Theme 3. Emotional and Psychosocial Responses

This theme describes the emotional burden and psychosocial consequences experienced by intensive care nurses due to sustained exposure to ethical dilemmas, patient suffering, and the demanding nature of intensive care environments. Nurses reported a wide range of emotional reactions, coping strategies, and disruptions to their social lives, reflecting both the immediate and cumulative impact of their professional experiences. Participants described intense emotional reactions arising from their daily clinical practice. Emotional exhaustion, stress, and burnout were frequently reported, particularly in relation to repeated exposure to patient death and suffering. An RN said:

> The psychological dimension of intensive care work was more exhausting than its physical demands, highlighting the persistent emotional toll associated with patient care (Nurse 4).

Over time, some nurses reported becoming desensitized to death and suffering, noting that experiences that were once emotionally overwhelming gradually became normalized. One participant reflected on this process, stating that "*The repeated loss of patients no longer evoked strong emotional reactions, which led to feelings of emptiness and emotional detachment*" (Nurse 5). Several nurses described deliberately suppressing their emotions in order to continue functioning professionally. However, this strategy was often experienced as psychologically burdensome rather than protective. One participant explained that "*Pushing emotions aside during work hours did not eliminate distress, but instead caused emotions to resurface later in more overwhelming ways*" (Nurse 8). Experiences involving young patients or severe trauma were reported to be particularly distressing, evoking strong emotional reactions that nurses found difficult to regulate within the clinical setting (Nurse 14). Difficulties in maintaining appropriate emotional boundaries were also evident. Some nurses reported becoming excessively emotionally involved with patients, particularly in prolonged or end-of-life care situations. One participant noted that "*Intense empathy sometimes crossed professional boundaries, causing emotional strain that extended beyond the workplace*" (Nurse 2). Similarly, exposure to ethically complex and emotionally charged situations contributed to feelings of being psychologically overwhelmed and trapped within the work environment (Nurse 18). Nurses reported using a range of coping strategies to manage emotional strain. Adaptive coping mechanisms included spending time with family members, which participants described as a critical source of emotional support and psychological relief (Nurse 17). Others used cognitive distraction techniques, such as "Reading books, to distance themselves from intrusive work-related thoughts and regain a sense of mental control" (Nurse 15).

In contrast, some nurses described relying on maladaptive coping strategies to manage stress. Smoking was frequently mentioned as a means of

momentary relief during or after work shifts, although participants acknowledged that this behavior did not resolve underlying emotional distress and, over time, became habitual (Nurse 6). These accounts highlight the complexity of coping processes and the coexistence of both adaptive and maladaptive strategies among intensive care nurses. The emotional demands of intensive care work were also reported to significantly impact nurses' social lives. Participants described social withdrawal and avoidance behaviors, particularly in contexts where work-related topics were discussed. One nurse noted that hearing conversations about the hospital or encountering colleagues outside the workplace triggered stress, leading them to distance themselves from social environments associated with work (Nurse 5). Another participant reported that persistent emotional fatigue reduced their tolerance for social interaction, resulting in a preference for isolation during non-working hours (Nurse 10).

Theme 4. Working Conditions and Management Issues

This theme highlights the structural and organizational factors that shape nurses' ethical decision-making and professional experiences in intensive care settings. Participants emphasized that challenging working conditions, limited resources, and management-related issues not only affected the quality of care, but also intensified ethical dilemmas and emotional strain.

Nurses consistently reported that insufficient staffing levels and high patient workloads limited their ability to provide individualized and high-quality care. Participants described experiencing moral distress when they were unable to allocate adequate time and attention to each patient due to workforce shortages.

An RN stated:

> "The psychological burden of caring for a large number of critically ill patients, combined with insufficient nurse recruitment, made it increasingly difficult to uphold professional and ethical standards in daily practice" (Nurse 5).

Inadequate communication within the healthcare team also emerged as a significant factor complicating ethical decision-making. Nurses described situations in which they were aware of the ethically appropriate course of action, but felt unable to act due to insufficient support or collaboration from other team members. One participant explained that: *"The absence of effective communication created uncertainty and hesitation, leading to ethical discomfort and delayed decision-making"* (Nurse 20).

Extended working hours and mandatory overtime further exacerbated ethical and professional challenges. Nurses reported that accumulated fatigue impaired their ability to make sound clinical and ethical decisions. An RN stated:

> "Feeling torn between the desire to provide optimal care and the physical and psychological limits imposed by excessive workload… prolonged shifts forced them to push personal boundaries and contributed to ethical and personal dilemmas" (Nurse 16).

Overall, these findings suggest that ethical dilemmas in intensive care settings are not solely individual or patient-related, but are deeply embedded in organizational and systemic conditions. This highlights the importance of improving staffing policies, communication structures, and working conditions to support ethical practice in clinical settings.

Discussion

In this study, the ethical dilemmas experienced by nurses working in intensive care units and their psychosocial effects were investigated using a descriptive phenomenological approach.

Ethical Reasoning in Ethical Dilemmas

Nurses' professional practices are shaped by the principles of non-maleficence, beneficence, respect for privacy, respect for autonomy, and aesthetic values. In modern medical ethics, particularly within liberal democratic societies, healthcare practices are generally guided by four fundamental principles: respect for patient autonomy, beneficence, non-maleficence, and justice/fairness (Wickremsinhe, 2025). In the Türkiye context, core ethical obligations include informing patients, respecting privacy, ensuring autonomy in decision-making, maintaining the confidentiality of personal information, and the right to safe care (Ünsal et al., 2024). In addition, alternative ethical frameworks emphasize that these principles may be complemented by values, such as human dignity, integrity, vulnerability, precaution, and solidarity, particularly in complex care settings (Wang, 2025).

High levels of unconsciousness, intubation, and

severe physical limitations among intensive care patients create significant challenges in applying the principles of privacy and autonomy. Ethical discomfort and uncertainty arise when patients are unable to protect their privacy or participate in decision-making. In situations where autonomy cannot be exercised directly, nurses must balance beneficence with respect for patient rights while incorporating family perspectives within ethical and legal frameworks (Afenigus & Sinshaw, 2025). Ethical decision-making in intensive care settings is therefore influenced not only by clinical imperatives, but also by patient vulnerability and family members' emotional expectations. This finding is consistent with the study by Wocial et al. (2020), which indicated that patient incapacity in intensive care settings may shift ethical responsibility to healthcare professionals and surrogate decision-makers, thereby increasing moral uncertainty and role-related stress. Research on surrogate decision-making and patient vulnerability in critical care has shown that when patients are unable to exercise autonomy, tensions arise between preserving patient dignity, adhering to legal frameworks, and responding to family expectations (Fleming et al., 2023; Goss et al., 2023). Such situations have been identified as significant sources of ethical strain and moral distress among intensive care nurses (Palmryd et al., 2025).

Aesthetic values hold an important place in intensive care nursing practice. These values reflect nurses' capacity for empathy, compassion, and emotional sensitivity, emphasizing that care extends beyond technical procedures to include deeply human interactions. Maintaining aesthetic sensitivity in highly technological, stressful intensive care environments may positively influence both patients' care experiences and nurses' professional meaning-making processes (Różyńska et al., 2024). Intensive care nurses operate at the intersection of life-and-death decision-making, where ethical principles and professional values serve as essential guiding frameworks. Decisions in these contexts depend not only on clinical expertise, but also on a strong ethical foundation.

Ethical Dilemmas

Nurses experience significant ethical conflicts when deciding whwther to continue or withdraw life-sustaining treatments. Such dilemmas arise from the nature of intensive care settings, where patients frequently face life-threatening conditions and uncertain prognoses. Balancing efforts to relieve patients' pain and improve quality of life with the obligation to sustain life represents a substantial challenge. Some nurses view the withdrawal of life-sustaining treatment as a more ethical option, particularly in elderly patients. In contrast, others emphasize that continuing mechanical life support in cases of confirmed brain death may provide emotional comfort to family members. Professional judgments in these situations are shaped not only by clinical data, but also by ethical considerations and the emotional needs of patients' relatives. As a result, nurses must balance patient rights, medical necessity, and emotional factors in their decision-making processes.

Ethical dilemmas involve situations requiring a choice between two or more conflicting values (Türken & Çalım, 2022). The literature identifies sustaining life, futile treatment, informed consent and information disclosure, justice and resource limitations, and challenges related to professional roles and hierarchy as primary ethical concerns in intensive care nursing (Kalaycıoğlu et al., 2024). The findings of the present study are consistent with these reports, as participants similarly described dilemmas related to life-sustaining treatment decisions, informed consent processes, and role-related tensions within hierarchical structures. Frequently reported problems also include disagreements among physicians regarding treatment decisions, conflicts between nurses' personal values and institutional pressures, threats to professional dignity, violations of patient rights, financial and profit-oriented constraints, ethical concerns in end-of-life care, limited resource allocation, and witnessing unethical or illegal practices (Bruun et al., 2022; Poškutė et al., 2022). In line with these studies, nurses in the present research also emphasized interprofessional disagreements, institutional pressures, and challenges related to end-of-life care as significant sources of ethical conflict. Owing to their continuous, close contact with patients, nurses are particularly exposed to ethical conflicts in daily clinical practice.

Informed consent and information disclosure represent another critical area of ethical tension. Caring for unconscious or non-communicative patients requires nurses to balance the protection of patient rights with adherence to physicians' directives. Shih et al. (2025) emphasized that deficiencies in interprofessional communication may overshadow nurses' ethical

responsibilities within the healthcare team. Limited physical and technological resources in intensive care units contribute to moral distress, particularly when prioritization is required. Such decisions may position nurses between their personal ethical values and systemic pressures.

Institutional hierarchy and practices extending beyond formal job descriptions may create conditions conducive to ethical violations. Nurses may be required to perform procedures traditionally considered physicians' responsibilities, leading to conflicts related to professional identity. Similar ethical tensions have been reported by Liu et al. (2022).

Emotional and Psychosocial Responses

Intensive care nurses exhibit pronounced emotional and psychosocial responses when confronted with ethical dilemmas and employ various coping strategies to manage these experiences. Emotional difficulties include burnout, empathy fatigue, stress, and desensitization. Coping mechanisms range from relatively adaptive strategies, such as listening to music and spending time with family, to maladaptive behaviors, including smoking. Work-related stress often extends beyond the clinical setting, leading to social withdrawal and reluctance to discuss work-related issues, reflecting the spillover of ethical stress into personal life.

The intensive care environment is inherently high-stress due to continuous monitoring of critically ill patients, rapid clinical decision-making, and frequent involvement in end-of-life care (Esmaeili et al., 2024). Nurses in intensive care units report higher levels of stress and burnout compared to those in other clinical settings (Alharbi & McKenna, 2025; Ren et al., 2023). Repeated exposure to patients with low survival prospects and ethically complex treatment decisions places nurses in a vulnerable position where professional responsibilities intersect with moral distress.

Nurses commonly experience emotions, such as empathy, guilt, and anxiety, when facing ethical dilemmas. While empathy strengthens the nurse–patient relationship, sustained emotional intensity may increase exhaustion. Nurses often describe pushing their emotional limits to maintain professional functioning, particularly when witnessing patient suffering or participating in family decision-making processes. Over time, this emotional labor may lead to reduced professional satisfaction and disengagement from work (Gunnlaugsdóttir et al., 2024; Heradstveit et al., 2023).

Psychosocial factors further compound these emotional challenges. High workload, social isolation, and limited access to social support negatively affect nurses' psychosocial well-being. The demanding nature of intensive care nursing, characterized by constant emergencies and ethical pressure, can disrupt family relationships and personal life, consistent with previous research (Cecere et al., 2023).

Ethical dilemmas intensify feelings of helplessness and moral distress, complicating decision-making processes and reducing professional satisfaction. Prolonged exposure to unresolved ethical stress is associated with increased intentions to leave the profession, with implications for workforce sustainability (Cerela-Boltunova et al., 2025). Nurses frequently perceive insufficient institutional and managerial support, contributing to a sense of isolation in ethical decision-making (Afenigus & Sinshaw, 2025). Emotional and psychosocial responses to ethical dilemmas in intensive care nursing affect not only clinical decision-making, but also nurses' psychological well-being and professional sustainability.

Working Conditions and Management Issues

Working conditions and management-related factors substantially influence intensive care nurses' professional satisfaction, ethical practice, and quality of care. High patient-to-nurse ratios and inadequate staffing are central structural problems that increase workload and limit the capacity to deliver safe, ethically sound care. Excessive workload compromises time management, increases the risk of errors, and negatively affects patient safety (Chen et al., 2019). This finding is consistent with previous studies indicating that heavy workload and staff shortages in intensive care units contribute significantly to moral distress and compromise ethical decision-making (Esmaeili et al., 2024; Ramírez-Elvira et al., 2021).

Communication problems within healthcare teams further complicate clinical and ethical decision-making. Similar findings have been reported in the literature, where ineffective interprofessional communication has been associated with ethical conflicts and increased moral distress among intensive care nurses (Haahr et al., 2020). Time pressure and heavy workloads restrict effective communication, leading to coordination

difficulties and ethical tension among team members. Insufficient communication under high workload conditions heightens conflict and undermines collaborative decision-making (Keller et al., 2020; Nemati-Vakilabad et al., 2025). Nurses strive to uphold ethical values despite limited resources, reflecting a persistent gap between professional ideals and actual working conditions.

Staff shortages and extended working hours disrupt work–life balance and contribute to professional dissatisfaction and increased turnover intentions (Alansari et al., 2025). Institutional constraints—including material shortages, unclear role definitions, and cost-related pressures—constitute systemic sources of ethical dilemmas, consistent with earlier findings in the Turkish context (Aydoğdu et al., 2022). These conditions often require nurses to prioritize tasks under suboptimal circumstances, thereby intensifying moral distress.

Managerial factors represent another critical dimension. Limited managerial support, restricted participation in decision-making processes, and hierarchical organizational structures weaken nurses' sense of professional autonomy and organizational belonging. Excluding nurses from managerial decision-making negatively affects motivation and intra-team communication (Alluhaybi et al., 2023; McKenna & Jeske, 2021). Feelings of being secondary in interactions with physicians and administrators further contribute to ethical conflict and professional frustration.

Insufficient access to continuous professional development and ethics-related education represents a managerial shortcoming, particularly in highly specialized settings, such as intensive care units. Nurses face not only clinical and ethical challenges, but also organizational barriers that limit the effective implementation of ethical decisions. Ethical decision-making in intensive care nursing is closely intertwined with structural and managerial conditions.

While many of the present findings align with existing literature on ethical dilemmas in intensive care settings, several distinctions emerge. Unlike studies conducted in healthcare systems characterized by decentralized governance and greater institutional autonomy, this study's findings highlight the influence of centralized organizational structures and hierarchical dynamics in shaping nurses' ethical experiences in the Türkiye healthcare context. Additionally, the emphasis on aesthetic values and the emotional dimension of care suggests a more relational and context-sensitive understanding of ethical practice that has received comparatively less attention in prior research. These context-specific elements contribute to a more nuanced understanding of how ethical dilemmas are experienced in different healthcare systems.

Implications for Nursing

The findings of this study highlight several practical and organizational implications for nursing practice. Nurses assume a central ethical role within the care process, underscoring the importance of continuous ethical education, institutional support, and shared responsibility in ethical decision-making. Intensive care nurses confront multidimensional ethical dilemmas that cannot be addressed solely through individual ethical awareness; therefore, effective management requires organizational support, active ethics committees, and continuous professional education.

Given that ethical dilemmas directly influence job satisfaction and the quality of patient care, strengthening the ethical infrastructure of healthcare systems remains essential. Institutional responsibility plays a critical role in enhancing nurses' ethical resilience, and structured workplace support mechanisms should be implemented to mitigate psychosocial strain.

Ethics consultation services, reflective practice sessions, psychosocial support programs, and regular ethics training may help reduce moral distress and emotional burden among nurses. In addition, improving staffing levels, strengthening leadership practices, promoting nurse participation in decision-making processes, and ensuring access to professional development opportunities may reduce ethical strain, enhance job satisfaction, and support the delivery of high-quality patient care.

Recommendations for Future Research

Future studies are recommended to examine ethical dilemmas experienced by nurses in different clinical settings and healthcare systems to enhance the transferability of the findings. Longitudinal and intervention-based studies also contribute to a better understanding of how ethical decision-making processes and coping strategies evolve and how targeted educational or organizational interventions may support nurses in managing ethical challenges.

Conclusion

This study demonstrates that intensive care nurses strive to uphold fundamental ethical principles, such as non-maleficence, beneficence, respect for privacy, and autonomy; however, they frequently encounter complex ethical dilemmas in clinical practice, particularly in life-sustaining treatment decisions. These dilemmas are accompanied by emotional and psychosocial challenges, including stress, burnout, and desensitization, and may extend beyond the clinical environment to affect nurses' social and personal lives.

The findings also indicate that organizational conditions, such as high workload, inadequate staffing, limited resources, and communication challenges within healthcare teams, appear to shape nurses' experiences of implementing ethically sound decisions. These factors are experienced as placing nurses in a difficult position between professional values and practical constraints within the healthcare system. Overall, the study contributes to a deeper understanding of how intensive care nurses experience ethical dilemmas and how these experiences are reflected in their psychological well-being and professional practice.

Strengths and limitations

This study has several notable strengths. Qualitative research focusing specifically on ethical dilemmas in intensive care settings is limited, and, to our knowledge, no prior study has directly explored intensive care nurses' experiences of ethical dilemmas alongside their psychosocial challenges. The interviews were conducted face-to-face by a psychiatric nursing specialist with expertise in ethical sensitivity and psychosocial assessment, which facilitated in-depth data collection. In addition, the research team included experienced qualitative methodologists, strengthening the rigor of the data analysis.

Nevertheless, this study has several limitations that should be considered when interpreting the findings. First, the use of snowball sampling may have introduced selection bias, as participants were recruited through peer referrals, potentially leading to the inclusion of nurses with similar experiences or perspectives. Second, the data was based on self-reported accounts obtained through interviews, which may be subject to recall bias and social desirability bias, particularly given the ethical sensitivity of the topics discussed.

Third, the study was conducted at a single center, limiting the sample's contextual diversity. Consequently, the findings may not fully represent the experiences of intensive care nurses working in different institutional settings or regions of Türkiye. Finally, although qualitative research does not aim for statistical generalization, the transferability of the findings is constrained by the specific organizational, cultural, and clinical context in which the study was conducted.

Despite these limitations, the study provides valuable insights into the ethical dilemmas and psychosocial challenges experienced by intensive care nurses. It offers a foundation for future multi-center and longitudinal qualitative research.

Ethical Approval

This study was approved by the Scientific Research Ethics Committee of Karadeniz Technical University Faculty of Health Sciences with approval date: 22.03.2024, No: E-13562490-050.01.04-496049. All procedures were conducted in accordance with the Declaration of Helsinki. Informed consent was obtained from all participants prior to their inclusion in the study.

Informed Consent

Informed consent was obtained from all individual participants included in the study.

Data Availability

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Conflict of Interests

The authors declare that they have no conflict of interests.

Funding or Sources of Financial Support

The authors declare that this study has received no financial support.

Author Contributions

Study Design: **MA, CUŞ, MG**. Data Collection: **MG**. Data Analysis: **MA, CUŞ, MG**. Study Supervision: **MA, CUŞ**. Manuscript Writing: **MA, CUŞ, MG**. Critical Revision for İmportant İntellectual Content: **MA**.

REFERENCES

Abdulqader, A., Ali, S., Alamoudi, F., & Shaban, M. (2025). Still just the nurse? A critical inquiry into nurses' struggles for autonomy in interprofessional hospital teams. *BMC Nursing, 24*. https://doi.org/10.1186/s12912-025-03967-0

Afenigus, A., & Sinshaw, M. (2025). Ethical dilemmas and decision-making in emergency and critical care nursing in Western Amhara region, Northwest Ethiopia: A multi-method qualitative study. BMC Nursing, 24, Article 2958. https://doi.org/10.1186/s12912-025-02958-5

Alansari, A., Omri, A., & Singh, K. (2025). Staff shortages linked to burnout, depression, and anxiety among outpatient nurses: A cross-sectional analysis at Hamad General Hospital, Qatar. *BMC Nursing, 24*, Article 3758. https://doi.org/10.1186/s12912-025-03758-7

Albert, J.S., Younas, A., & Sana, S. (2020). Nursing students' ethical dilemmas regarding patient care: An integrative review. *Nurse Education Today, 88*, 104389. https://doi.org/10.1016/j.nedt.2020.104389

Alharbi, B., & McKenna, N. (2025). A systematic review of mindfulness-based interventions to reduce ICU nurse burnout: Global evidence and thematic synthesis. *BMC Nursing, 24*, Article 3507. https://doi.org/10.1186/s12912-025-03507-w

Ali, N., Al-Rashwan, S., & Al-Dwaikat, T. (2022). Nurses' perceptions of their competency levels and the related professional and clinical factors. *Jordan Journal of Nursing Research, 1*(2), 1-10. https://doi.org/10.14525/JJNR.v1i2.04

Alluhaybi, A., Wilson, A., Usher, K., & Durkin, J. (2023). Impact of nurse manager leadership styles on work engagement: A systematic literature review. *Journal of nursing management, 2023*, 5090276. https://doi.org/10.1155/2023/5090276

Aydogdu A.L.F. (2022). Ethical dilemmas experienced by nurses while caring for patients during the COVID-19 pandemic: An integrative review of qualitative studies. *Journal of Nursing Management, 30*(7), 2245-2258. https://doi.org/10.1111/jonm.13585

Bruun, H., Milling, L., Mikkelsen, S., & Huniche, L. (2022). Ethical challenges experienced by prehospital emergency personnel: a practice-based model of analysis. *BMC Medical Ethics, 23*(1), 80. https://doi.org/10.1186/s12910-022-00821-9

Cecere, L., De Novellis, S., Gravante, A., Petrillo, G., Pisani, L., Terrenato, I., …, & Gravante, F. (2023). Quality of life of critical care nurses and impact on anxiety, depression, stress, burnout and sleep quality: A cross-sectional study. *Intensive and Critical Care Nursing, 79*, 103494. https://doi.org/10.1016/j.iccn.2023.103494

Cerela-Boltunova, O., Millere, I., & Nagle, E. (2025). Moral distress, professional burnout, and potential staff turnover in ıntensive care nursing practice in Latvia—Phase 1. *International Journal of Environmental Research and Public Health, 22*(8), 1261. https://doi.org/10.3390/ijerph22081261

Chen, Y.C., Guo, Y.L., Chin, W.S., Cheng, N.Y., Ho, J.J., & Shiao, J.S. (2019). Patient-nurse ratio is related to nurses' ıntention to leave their job through mediating factors of burnout and job dissatisfaction. *International Journal of Environmental Research and Public Health, 16*(23), 4801. https://doi.org/10.3390/ijerph16234801

Clarke, V., & Braun, V. (2017). Thematic analysis. *The Journal of Positive Psychology, 12*(3), 297-298. http://dx.doi.org/10.1080/17439760.2016.1262613

Esmaeili, M., Navidhamidi, M., & Varasteh, S. (2024). Coping strategies of intensive care unit nurses reducing moral distress: A content analysis study. *Nursing Ethics. 31*(8), 1586-1599. https://doi.org/10.1177/09697330241246089

Fleming, V., Prasad, A., Ge, C., Crawford, S., Meraj, S., Hough, C.L., Lo, B., Carson, S.S., Steingrub, J., White, D.B., & Muehlschlegel, S. (2023). Prevalence and predictors of shared decision-making in goals-of-care clinician-family meetings for critically ill neurologic patients: A multi-center mixed-method study. *Critical Care (London, England), 27*(1), 403. https://doi.org/10.1186/s13054-023-04693-2

Fusch, P.I., & Ness, L.R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report, 20*(9), 1408-1416.

Giorgi, A. (2009). *The descriptive phenomenological method in psychology: A modified Husserlian approach*. Duquesne University Press.

Goss, A.L., Voumard, R.R., Engelberg, R.A., Curtis, J.R., & Creutzfeldt, C.J. (2023). Do they have a choice? Surrogate decision-making after severe acute brain injury. Critical Care Medicine, *51*(7), 924-935. https://doi.org/10.1097/CCM.0000000000005850

Grosek, Š., Kučan, R., Grošelj, J., Oražem, M., Grošelj, U.,

Erčulj, V., Lajovic, J., Borovečki, A., & Ivanc, B. (2020). The first nationwide study on facing and solving ethical dilemmas among healthcare professionals in Slovenia. *PLOS ONE, 15*(7), e0235509. https://doi.org/10.1371/journal.pone.0235509

Grosek, Š., Kučan, R., Grošelj, J., Oražem, M., Grošelj, U., Erčulj, V., Lajovic, J., Ivanc, B., Novak, M., Prpić Massari, L., Matanović, S.M., Čerfalvi, V., Meštrović, J., & Borovečki, A. (2021). How health care professionals confront and solve ethical dilemmas: A tale of two countries—Slovenia and Croatia. *Croatian Medical Journal, 62*(2), 120-129. https://doi.org/10.3325/cmj.2021.62.120

Gunnlaugsdóttir, T., Jónasdóttir, R., Björnsdóttir, K., & Klinke, M. (2024). How can family members of patients in the intensive care unit be supported? A systematic review of qualitative reviews, meta-syntheses, and novel recommendations for nursing care. *International Journal of Nursing Studies Advances, 7*, 100251. https://doi.org/10.1016/j.ijnsa.2024.100251

Haahr, A., Norlyk, A., Martinsen, B., & Dreyer, P. (2020). Nurses experiences of ethical dilemmas: A review. *Nursing Ethics*. 27(1):258-272. https://doi.org/10.1177/0969733 019832941

Heradstveit, S.H., Larsen, M.H., Solberg, M.T., & Steindal, S.A. (2023). Critical care nurses' role in the decision-making process of withdrawal of life-sustaining treatment: A qualitative systematic review. *Journal of Clinical Nursing*, 32, 6012-6027. https://doi.org/10.1111/jocn.16728

Husserl, E. (1960). *Cartesian meditations: An introduction to phenomenology* (D. Cairns, Trans.). Springer.

Jansen, T.L., Hem, M.H., Dambolt, L.J., & Hanssen, I. (2020). Moral distress in acute psychiatric nursing: Multifaceted dilemmas and demands. *Nursing Ethics*, *27*(5), 1315-1326. https://doi.org/10.1177/0969733019877526

Jørgensen, L., & Kollerup, M.G. (2022). Ethical dilemmas in nursing documentation. *Nursing Ethics*, *29*(2), 485-497. https://doi.org/10.1177/09697330211046654

Kalaycıoğlu, O., Sert-Özen, A., & Yeşildağ, A.Y. (2024). To stay or leave? Consequences of ethical dilemma experienced by nurses in the intensive care units. *Journal of Business Ethics*. https://doi.org/10.1007/s10551-024-05915-5

Kaya, A., Yeşildağ, A.Y., Kaya, Y., Sevim, F., & Bostan, S. (2025). Exploring employment preferences and brain drain tendencies of Turkish medical students: Implications for the health sector. *Health Professions Education*, 12(1), Article 6. DOI:10.55890/2452-3011.1378

Keller, S., Yule, S., Zagarese, V., & Parker, H. (2020). Predictors and triggers of incivility within healthcare teams: A systematic review of the literature. *BMJ Open, 10*, e035471. https://doi.org/10.1136/bmjopen-2019-035471

Khoshmehr, Z., Barkhordari-Sharifabad, M., Nasiriani, K., & Fallahzadeh, H. (2020). Moral courage and psychological empowerment among nurses. *BMC Nursing, 19*(1), 43. https://doi.org/10.1186/s12912-020-00435-9

Lewis, S. (2015). Qualitative inquiry and research design: Choosing among five approaches. *Health Promotion Practice, 16*, 473-475. doi:10.1177/1524839915580941

Lincoln, Y.S., Guba, E.G., & Pilotta, J. (1985). *Naturalistic inquiry*. Sage Publications.

Liu, Y., Wang, X., Wang, Z., Zhang, Y., & Jin, J. (2023). Ethical conflict in nursing: A concept analysis. *Journal of Clinical Nursing*, 32, 4408-4418. https://doi.org/10.1111/jocn.16563

Luca, C.E., Cavicchioli, A., & Bianchi, M. (2021). Nurses who assume the role of advocate for older hospitalized patients: A qualitative study. *SAGE Open Nursing, 7*, https://doi.org/10.1177/23779608211030651

Ly, D. (2023). Patient refusal of nursing care: An ethical dilemma for bedside nurses. *Clinical Nurse Specialist, 37*(1), 5-8. https://doi.org/10.1097/NUR.0000000000000723

McIntosh, .T. (2020). V.I.P. care: Ethical dilemmas and recommendations for nurses. *Nursing Ethics, 27*(3), 809-820. https://doi.org/10.1177/0969733019878833

McKenna, J., & Jeske, D. (2021). Ethical leadership and decision authority effects on nurses' engagement, exhaustion, and turnover intention. *Journal of Advanced Nursing, 77*, 198-206. https://doi.org/10.1111/jan.14591

Nemati-Vakilabad, R., Ebadi, E., Homaei, A., Hoseini, S., & Mirzaei, A. (2025). The relationship between perceived nursing workload and occupational fatigue in clinical nurses: The moderating role of nursing teamwork. *Journal of Clinical Nursing, 34*, 4132-4141. https://doi.org/10.1111/jocn.17616

Palmryd, L., Rejnö, Å., Alvariza, A., & Godskesen, T. (2025). Critical care nurses' experiences of ethical challenges in end-of-life care. *Nursing Ethics, 32*(2), 424-436. https://doi.org/10.1177/09697330241252975

Poškutė, M., Bartkienė, A., Fatkulina, N., & Gefenas, E. (2022). The contribution of professional autonomy in advancing ethical behaviour: A narrative review of studies in nursing. *Journal of Nursing Management, 30*(7), 2301-2307. https://doi.org/10.1111/jonm.13842

Ramírez-Elvira, S., Romero-Béjar, J.L., Suleiman-Martos, N., Gómez-Urquiza, J.L., Monsalve-Reyes, C., Cañadas-De la Fuente, G.A., & Albendín-García, L. (2021). Prevalence, risk factors, and burnout levels in intensive care unit nurses: A systematic review and meta-analysis. *International Journal of Environmental Research and Public Health, 18*(21), 11432. https://doi.org/10.3390/ijerph182111432

Ren, Y., Ding, D., Yun, L., Ning, W., & Qin, F. (2023). Does perceived organizational support moderate the relationship between work frustration and burnout among intensive care unit nurses? A cross-sectional survey. *BMC Nursing, 22*, Article 180. https://doi.org/10.1186/s12912-023-01180-5

Różyńska, J., Zawiła-Niedźwiecki, J., Maćkiewicz, B., & Czarkowski, M. (2024). Tough clinical decisions: Experiences of Polish physicians. *HEC Forum, 36*(1), 111-130. https://doi.org/10.1007/s10730-022-09491-x

Schaufel, M.A., Schanche, E., Onarheim K.H., Forthun, I., Hufthammer, K., Engelund, I., & Miljeteig, I. (2024). Stretching oneself too thin and facing ethical challenges: Healthcare professionals' experiences during the COVID-19 pandemic. *Nursing Ethics*. *31*(8):1630-1645. https://doi.org/10.1177/09697330241230683

Sepehrirad, E., Heidarzadeh, M., Asl, Z.E., Abbasian, Z., & Ashtari, S. (2021). The relationship between moral sensitivity, ethical climate, and job strain with patient privacy from the viewpoint of operating room staff. *Iranian Journal of Nursing and Midwifery Research, 26*(2), 183-187. https://doi.org/10.4103/ijnmr.IJNMR_22_20

Shih, Y., Wang, C., Ding, J., Zhou, Y., & Lu, Q. (2025). Cultural and ethical barriers to implementing end-of-life advance care planning among oncology nursing professionals: A content analysis of open-ended questions. *BMC Medical Ethics, 26*, Article 61. https://doi.org/10.1186/s12910-025-01261-x

Şişman, H., Alptekin, D., & Akpolat, R. (2023). Yoğun bakım ünitelerinde çalışan hemşirelerin etik karar verebilme düzeylerinin ölçülmesi [Determining the ethical decision making levels of nurses working in intensive care units]. Türkiye Biyoetik Dergisi, *10*(4), 174-181. https://izlik.org/JA32DG26EJ

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19*(6), 349-357. https://doi.org/10.1093/intqhc/mzm042

Türken, H., & Çalım, S. İ. (2022). Ethical dilemmas experienced by midwives working in the delivery room. *Nursing Ethics, 29*(5), 1231-1243. https://doi:10.1177/09697330221081952

Ünsal, B., Arıca, E., & Akarsu, R. (2024). Ethical issues after the earthquake in Turkey: A qualitative study on nurses' perspectives. *International Nursing Review, 72*. https://doi.org/10.1111/inr.13048

Wang, Y. (2025). On value compatibility: Reflections on the ethical framework for pandemic healthcare distribution. *Medicine, Health Care and Philosophy, 28*, 303-313. https://doi.org/10.1007/s11019-025-10261-y

Waterfield, D., & Barnason, S. (2022). The integration of care ethics and nursing workload: A qualitative systematic review. *Journal of Nursing Management, 30*(7), 2194-2206. https://doi.org/10.1111/jonm.13723

Wickremsinhe, M. (2025). Ethical principles in health. In *Diverse voices in health law and ethics* (Chapter 2). Bristol University Press. https://bristoluniversitypress.co.uk/asset/13516/blad-romanis-diverse-voices-in-health-law-and-ethics.pdf

Wocial, L., Slaven, J., Montz, K., Monahan, P., Hickman, S., Callahan, C., Helft, P., Sachs, G., Inger, L., Burke, E., & Torke, A. (2020). Factors associated with physician moral distress caring for hospitalized elderly patients needing a surrogate decision-maker: A prospective study. *Journal of General Internal Medicine, 35*, 1405-1412. https://doi.org/10.1007/s11606-020-05652-1