DOI: https://doi.org/10.53350/pjmhs211572162

ORIGINAL ARTICLE

Relationship between Moral Distress and Virtue-oriented Ethical Behavior in Nurses Working in Government Hospitals in Bojnourd and Nursing Homes in Bojnourd and Mashhad in 2017

FATEMEH KHORASHADIZADEH[1], NAJMEH VALIZADEH ZARE*[2], SAMIRA MOHAJER[3], MASOUMEH TAHERPOUR[4], SOGHRA DARABI[5]

[1] *Assistant Professor of Nursing, School of Nursing and Midwifery, North Khorasan University of Medical Sciences, Bojnourd, Iran*
[2] *Assistant Professor of Nursing, Evidence-Based Research Center, Mashhad University of Medical Sciences, Mashhad, Iran*
[3] *Assistant Professor of Nursing, School of Nursing and Midwifery, Khorasan Razavi University of Medical Sciences, Mashhad, Iran*
[4] *Faculty Instructor, Faculty of Health, North Khorasan University of Medical Sciences, Bojnourd, Iran*
[5] *Master's student, School of Nursing and Midwifery, North Khorasan University of Medical Sciences, Bojnourd, Iran*
Email Corresponding author:valizadehn2@mums.ac.ir

ABSTRACT

Introduction: Nurses experience a variety of morally distressing situations while caring for the elderly. Ethical behavior can be a way to reduce moral distress. Therefore, the present study aimed to determine the relationship of ethical behavior with severity and frequency of moral distress among nurses working in government hospitals in Bojnourd and nursing homes in Bojnourd and Mashhad.

Materials and Methods: The present descriptive-analytical study was conducted based on the census method on 454 nurses working in Bojnourd teaching hospitals and nursing homes in Bojnourd and Mashhad. Data collection tools included Corley's moral distress scale and the questionnaire of ethical conduct components based on the theory of virtue ethics developed by Nikkhah et al. (2015). The validity and reliability of this questionnaire have been confirmed, and ethical considerations were taken into account. Data were analyzed in SPSS software (version22) using descriptive statistics, tables, and graphs.

Results: In the current study, the majority of participants (80.8%) were female with a mean age of 7.75±31.68 years. Moreover, virtue-oriented ethical conduct was negatively and weakly correlated with the severity and frequency of moral distress (r=-0.11). The scores of severity and frequency of moral distress in nurses were obtained at 2.6 and 2.4, respectively. There was also a strong positive correlation between the frequency and severity of moral distress (r =0 .848). The score of ethical behavior in nurses was calculated at 4.1.

Conclusion: Virtue-oriented ethical behavior in the organization can be effective in reducing nurses' moral distress. Therefore, in order to reduce moral distress in nurses, it is suggested that managers devote special attention to the promotion of virtue-oriented ethical behavior. Moreover, appropriate incentive policies should be designed and programmed to promote virtue-oriented ethical behavior in any organization.

Keywords: Moral distress, Ethical behavior, Theory of virtue ethics, Nurse, Elderly, Statement of the problem

INTRODUCTION

Nurses as the largest component of the healthcare workforce spend most of their time with patients, and their health status is of paramount importance since their physical and mental health exerts a direct effect on the health of patients(Fiedler & Stein, 2005). The ethical challenges are among the significant **factors affecting** nurses' general health. When nurses face moral dilemmas and decide and act contrary to their own moral beliefs or those of the institution, they often experience moral distress in evaluating the measures they implemented(Burston, 2017).

In his study, Pauly (2009) reported moderate levels of moral distress and stated that moral distress severity and its consequences are inversely related to the perception of ethical climate. Based on the findings of the referred study, a proper understanding and insight in this field are essential for nurses to improve the ethical climate in their workplace and is beneficial to nurses and patients(Pauly, Varcoe, Storch, & Newton, 2009). Moral distress occurs when the health care provider feels certain of the ethical course of action but is constrained from taking that action. The following issues are among the major obstacles to the implementation of appropriate actions: lack of adequate time, authorities in opposition to the idea, medical restrictions, institutional policies, and ethical considerations(Mobley, Rady, Verheijde, Patel, & Larson, 2007).

Along the same lines, Russell (2012) stated that moral distress is a complex and multifaceted phenomenon with ambiguous consequences(Russell, 2012). Moral distress brings about adverse consequences for both nurses and patients(Joolaee, Jalili, Rafiee, & Haggani, 2011). Hemric et al. (2012) pointed out that the source of moral stress for nurses in health environments is a conflict between the nurse's willingness to perform proper and ethical practices on one hand and the organization's laws on authorized and unauthorized actions on the other hand(Hamric, Borchers, & Epstein, 2012). In the same context, Joolaee et al. (2012) assessed the relationship between moral distress and job satisfaction and reported that the high level of moral distress among nurses gives rise to job dissatisfaction (Joolaee, Jalili, Rafii, Hajibabaee, & Haghani, 2012).

Caregivers and nurses with moral distress are presented with some symptoms, such as headaches, indigestion, anger, sense of guilt, depression, burnout, low self-esteem, job dissatisfaction, and turnover(Harrowing & Mill, 2010). Constant exposure to moral stress can predispose nurses to burnout and dissatisfaction and

jeopardize their professional reputations(Huffman & Rittenmeyer, 2012). Therefore, the nursing profession has a morally stressful nature, and professional nurses should integrate ethical behavior into their practices(Smith & Godfrey, 2002). Ethical behavior is one of the fundamental characteristics of professional nursing(Crall, 2011). One of the major theories of ethical behavior is virtue-oriented ethics(Bertland, 2009). Nursing ethics incorporates virtue-oriented approaches (ethics of justice and care); therefore, these principles can pave the ground for ethical healthcare and nursing(Cannaerts, Gastmans, & Casterlé, 2014).

In their study, Nikkhah Farkhani et al. (2015) stated that ethical behavior is an integral part of the care process and is one of the requirements of the nursing profession. In critical and sensitive situations, virtuous nurses are even willing to sacrifice their lives to take care of patients. It reflects the high level of self-sacrifice among nurses(Nikkhah Farkhani, Rahimnia, Kazemi, & Shirazi, 2015). Ethical issues pertaining to nursing home care are quite different from those pertaining to hospital care, and these ethical challenges reported in the nursing homes make things worse for the elderly. This situation requires a different ethical framework that puts emphasis on changing individual rights to meet the needs of the elderly according to their living standard and share various responsibilities among residents, family members, and employees.

To have a completely desirable program to reflect ethical behaviors, we should have a positive view of accepting a myriad of ethical challenges and various issues related to the elderly and consider the presence of nurses in the ongoing process of these guidelines. In order to relate to everyday practices, it seems necessary to provide a broad definition of ethics. Extensive efforts will then be needed to extract and formulate ethical questions and behaviors related to the elderly and the needed core values(Van der Dam, Abma, Kardol, & Widdershoven, 2012). Old age is defined as a stage of life from the 60s onward. According to the World Health Organization, life expectancy is on a rise, and the world's elderly population will exceed two billion by 2052 ("World Health Organization, ‘aging well’must be a global priority. News release," 2017). Based on the released data from the 2016 Census, 9.27% of Iran's population were over 60 years old (2016).

The increase in the elderly population and the early hospital discharge of the elderly with chronic diseases signify that nursing homes need to hire new geriatric nurses. From the perspective of these nurses, maintaining the general health of the elderly is of paramount importance. And all nurses should be trained in the prevention, identification, and correction of elder abuse which occurs across socio-economic settings and groups. The elderly, especially those with dementia, are often ignored and not respected in today's society(Mauk, 2010). Old age is also one of the main sources of ethical issues about geriatric nurses. Organizational changes and education can counteract these characteristics. More extensive training in the care of the elderly, higher job skills, and pain management in the elderly are among the required essential solutions(Rees, King, & Schmitz, 2009).

Therefore, considering the incidence of moral stress in care and failure to retrieve a study on moral stress while caring for the elderly, the current study assessed the relationship between moral distress and virtue-oriented ethical behavior among nurses working in public hospitals in Bojnourd and Nursing homes in Bojnourd and Mashhad.

MATERIALS AND METHODS

The present descriptive-analytical study was conducted based on the census method on 500 nurses working in Bojnourd public hospitals and nursing homes in Bojnourd and Mashhad. The inclusion criteria were as follows: 1) a bachelor's degree or higher, 3) a minimum of three months of work experience in the specified ward of public hospitals and nursing homes in Bojnourd, and 4) no history of severe stress, such as accidents and death of loved ones in the previous month. It took one month to collect the questionnaires, out of which 46 papers were excluded from the study due to some deficiencies. The researcher referred to all government hospitals in Bojnourd and nursing homes affiliated to welfare organizations in Bojnourd and Mashhad and the eligible participants were selected according to the inclusion criteria.

After explaining the objectives of the study, informed consent was obtained from all participants. Thereafter, the questionnaires were distributed among the nurses by referring to various centers in different working shifts. Participants were asked to complete the questionnaires at home within a maximum of 3 days. At the end of the allotted time, the completed questionnaires were collected from the participants. Data collection tools in this study were as follows: demographic information questionnaires, Corley's moral distress scale, and the questionnaire of ethical conduct components based on the theory of virtue ethics developed by Nikkhah et al(Nikkhah Farkhani et al., 2015).

Corley's moral distress scale consists of 21 questions and the relevant options in each item assess the severity and frequency of moral distress. The items are rated on a six-point Likert scale. In terms of intensity, the items are scored from 0 (not at all) to 5 (very high) and in terms of frequency, they are scored from 0 (never) to 5 (repeatedly). Therefore, the score 0-35 is low level, 36-71 is moderate and 72-105 is high level. A forward-backward translation procedure was used to translate the questionnaire from English to Persian and then translated back to English and has been used in various studies. The validity of the Corley's questionnaire in Iran was confirmed by the content validity method, and its reliability coefficient was verified using the test-retest method rendering a Cronbach's alpha of 93%. Moreover, due to the special conditions of service provision in Iran, Joolaee et al. (2012) made some modifications to this questionnaire, and it was tailored to existing problems in Iranian hospitals. Its validity was confirmed by the content validity method, and its reliability was verified by internal consistency method (α=0.86)(Joolaee et al., 2012).

The third questionnaire encompasses the components of nurses 'ethical behavior using the theory of virtue ethics, which includes three areas of nurses' ethical behavior with patients, nurses 'ethical behavior with patient companions, and nurses' ethical behavior with the treatment group. The validity of this questionnaire has been confirmed by Nikkhah et al. (2015) (Nikkhah Farkhani et al., 2015). Its items are sorted on a five-point Likert scale

ranging from strongly disagree=1 to strongly agree=5 (Nikkhah Farkhani et al., 2015). In the current study, the questionnaires were approved by 10 faculty members, geriatricians, and experts in professional ethics. The reliability of the questionnaires was assessed by the test-retest method. Cronbach's alpha coefficient was reported to be 0.753 and higher than 0.7; therefore, the questionnaires had good reliability. The collected data were analyzed in SPSS software (version 22) using descriptive and analytical statistics.

RESULTS

The total 454 nurses working in teaching hospitals in Bojnourd and nursing homes in Bojnourd and Mashhad were allocated to 9 groups: surgery (17.6%), intensive care (13.0%), pediatric and neonatal (6.4%), gynecology (4.6%), internal medicine (20.0 %), emergency (17.6%), psychiatry (2.6%), burn (2.4%), and nursing home (15.2%). The mean age of nurses participating in this study was 31.68±7.75 years. In terms of gender, 19.2% of nurses were male, and 80.8% of them were female. In addition, the frequency distribution of moral distress showed that the severity of moral distress among nurses was at a moderate level (77.8%; Table 1).

Table 1. Frequency distribution of moral distress severity among nurses working in hospitals in Bojnourd and nursing homes in Bojnourd and Mashhad

Degree of moral distress	Frequency(n)	Percentage (%)
Low	41	10.3
Moderate	311	77.8
High (72-105)	48	12.0
Total	400	100.0

As illustrated in Table 1, the mean score of moral distress severity was 2.6 in 77.8% of the nurses, which indicates the moderate severity of moral distress and highlights the importance and necessity of research on nurses' moral distress.

Table 2. Frequency distribution of moral distress frequency in nurses working in Bojnourd hospitals and nursing homes in Bojnourd and Mashhad

Moral distress severity Score	Frequency(n)	Percentage (%)
low	50	13.9
moderate	280	77.8
high	30	8.3
Total	360	100.0

Based on the results depicted in Table 2, the frequency of moral distress was at a moderate level in 77.8% of nurses, highlighting the importance of performing research on nurses' moral distress.

Table 3. Frequency distribution of nurses working in hospitals in Bojnourd and nursing homes in Bojnourd and Mashhad

Department	Frequency(n)	Percentage (%)
Bojnourd teaching hospitals	383	84.7
Nursing homes in Mashhad	54	11.9
Nursing homes in Bojnourd	15	3.3
Total	452	100.0

Table 3 demonstrates the frequency distribution of nurses working in Bojnourd hospitals and nursing homes in Bojnourd and Mashhad, with teaching hospitals in Bojnourd showing the highest frequency in the study (Table 3).

Table 4. Mean and standard deviation of variables of severity and frequency of moral distress and ethical behavior of nurses working in Bojnourd hospitals and nursing homes in Bojnourd and Mashhad

Variable	Mean± standard deviation
Moral distress severity score(0-5)	2.61±.674
Moral distress frequency score(0-5)	2.45±.710
Ethical Behavior Score (1-5)	4.11±.469
Age of nurses (year)	31.68 ± 7.75
History of nursing (year)	8.1±6.52

Table 5. Relationship between the severity and frequency of moral distress among nurses working in Bojnourd hospitals and nursing homes in Bojnourd and Mashhad

Variable	n	Pearson correlation coefficient	P-value
Moral distress severity	400	.848	.000
Moral distress frequency			

Table 6. Relationship between moral distress and ethical behavior among nurses working in Bojnourd hospitals and nursing homes in Bojnourd and Mashhad

Variable	n	Pearson correlation coefficient
Moral distress frequency	373	-.111
Ethical behavior		

As presented in Table 4, the mean scores of severity and frequency of moral distress in 77.8% of the participating nurses were obtained at 2.6 and 2.4 out of a total score of 0-5. It signifies that moral distress is moderate, and highlights the importance and necessity of research on nurses' moral distress.

The results of the above table point to the strong statistical relationship between the frequency and severity of moral distress. It can be interpreted that the frequency and confrontation with stress factors can predispose nurses to moral stress and affect their perceived severity of distress.

As depicted in Table 6, there is a weak and inverse relationship between moral distress and nurses 'ethical behavior. It can be concluded that virtue-oriented ethical behavior in the organization can be effective in reducing nurses' moral distress.

DISCUSSION

The mean score of moral distress severity among 77.8% of the participating nurses was obtained at 2.6 (from 0-5), pointing to the moderate severity of moral distress. The frequency of moral distress in 77.8% of nurses was reported as 2.4 out of a total score of 0-5, which denotes a moderate level of moral distress. The severity and frequency of moral distress were higher in nurses working in acute wards of hospitals, such as intensive care and emergency departments, compared to other departments, while we have the least severity and frequency of moral distress in nursing homes and psychiatric wards. It can be argued that the nurses working in the intensive care unit and the emergency department experience higher levels of distress since they take care of seriously-ill patients.

It can be argued that nurses working in nursing homes and psychiatric wards experience less distress since they do not deal with acutely ill patients who need

special less, rather they engage in managerial and supervisory care services. In a descriptive-analytical study conducted by Vaziri et al. (2015) on the phenomenon of moral distress among Iranian nurses, the mean score of nurses' moral distress was obtained at 3.56-5.83 from a total score 0-6, which indicated a moderate level of moral distress severity among nurses. Moreover, in the mentioned study, the nurses in emergency departments and intensive care units showed the highest level of moral distress(Vaziri, Merghati-Khoei, & Tabatabaei, 2015). In line with the present study, the referred study demonstrated the highest moral distress and a moderate to high level of moral distress in nurses.

Nonetheless, inconsistent with the present study, Silén et al. (2011) reported a low level of moral distress severity among the nurses under the study(Silén, Svantesson, Kjellström, Sidenvall, & Christensson, 2011). It is possible that personal characteristics affect the degree of moral distress experienced by different individuals. The discrepancy between the two aforementioned studies can be ascribed to differences in the applied instruments, cultures, and study population. In their study, Van der Dam et al. (2012) pointed out that caregivers experience numerous ethical issues in their everyday practice, including three categories of behavior towards the elderly person, different views on the meaning of good care, and the organizational environment. They added that ethical issues about long-term care (nursing home) are completely different from those involving acute care (hospital)(Van der Dam et al., 2012). In agreement with the current study, the mentioned study pointed to different types and levels of moral distress among nurses working in different wards.

In their study, Piers et al. (2012) stated that moral distress is more common among nurses working in acute geriatric wards (hospitals), compared to their counterparts who work in nursing homes. They added that the provision of futile and inadequate care in the end-of-life stage contributes greatly to moral distress in these wards(Piers et al., 2012). In accordance with the current study, in the referred research, the mean score of severity and frequency of moral distress was higher among nurses working in hospitals, compared to those in nursing homes. It can be interpreted that due to the shortage of nursing staff, workload, and the presence of critically ill patients in hospitals, nurses are not able to adequately perform their responsibilities; therefore, they experience higher levels of moral distress.

Consistent with the present study, Oh and Chris (2013) indicated that the majority of nurses experience moral distress and burnout in difficult care situations, which can affect their job status and relationships(Oh & Gastmans, 2015). The level of ethical behavior in all nurses was obtained at 4.1, and the scores were assessed as excellent. The reluctance to report ethical issues among nurses might have affected the result. In addition, the mean score of ethical behavior in nursing homes was 4.15. The highest mean scores were obtained at 4.45 and 4.32 in psychiatric and pediatric wards, while the lowest scores of ethical behavior were reported as 4.00 and 4.02 in burn and emergency wards.

In the same context, Zahra Nikkhah Farkhani et al. (2015) conducted a study to present a model of nurses' ethical behavior using the theory of virtue ethics in Mashhad hospitals. This study aimed to identify the dimensions and components of nurses' ethical behavior and present the relevant model in the Public Health Services Network. The results of this study showed that the majority of components and sub-components of ethical behavior are manifested in virtue ethics. The referred study demonstrated that nurses who use virtue-oriented ethical behavior in their work environment are profitable for the organization in any work environment(Nikkhah Farkhani et al., 2015). This study is similar and consistent with the present study.

In the present study, nurses' ethical behavior was inversely and weakly correlated with the severity and frequency of moral distress among nurses. The reluctance to report ethical issues in nurses might have affected the results, and the weak relationship can be ascribed to the lack of uniformity in the number of participants in the groups. In their article, Beikmoradi et al. (2012) stated that moral distress was at a moderate level among nurses working in intensive care units, and moral distress has a very negative effect on the professional performance and ethical behavior of nurses. The subjects experienced the severity of moral distress in the same way, and the personal characteristics of the nurse did not affect the severity of moral distress(BEIKRNORADI, RABIEE, KHATIBAN, & CHERAGHI, 2012). In accordance with the present study, the highest levels of moral distress were reported in some parts of the mentioned study; moreover, moral distress and clinical practice were found to be correlated. In their study, Piers et al. (2012) reported that nurses who have a high level of self-sacrifice and work ethic are more likely to experience stress(Piers et al., 2012). This part of the mentioned study was not in agreement with the current study.

At first glance, these views seem contradictory since education is one of the fundamental issues in coping with moral conflicts. The results of the current study indicated that higher levels of moral competence result in greater moral sensitivity; consequently, the nurses considerately implement ethical principles in their workplace. In these nurses, sensitivity and learning skills to adapt to moral distress can be used as an effective treatment. These nurses are necessary to influence the performance and ethical behavior of the unqualified care team. Apart from teaching adaptive mechanisms, they are of utmost importance in organizational support of ethical activities(Piers et al., 2012).

The discrepancy between the two aforementioned studies can be ascribed to differences in the applied instruments, cultures, and study population. The score of severity and frequency of moral distress in men was significantly higher, compared to those of women, which can be attributed to unequal number of participants in each group. The mean score of the severity and frequency of moral distress was higher in postgraduate nurses, compared to nurses with bachelor's degrees. It can be argued that a higher level of education can raise the awareness and change the attitude of nurses, which in

turn, leads to higher moral sensitivity and experience of higher levels of moral distress.

Furthermore, the severity of moral distress was higher among nurses with longer work experience and registered nurses. It can be interpreted that these nurses take on more responsibilities, manage working shifts, and are more in touch with doctors and patients' companions. The severity of moral distress was also higher in critical care nurses (requiring 7-8 hours of care). It can be argued that these nurses experience higher levels of moral distress since they take care of critically ill and vulnerable patients, most of whom are in their final stage of life. In line with the present research, in a study conducted by Jakobsen et al. (2010) entitled "Preserving dignity in caring for older adults", it was stated that nurses who are involved in end-of-life care, such as intensive care units and emergencies where mortality is high, experience higher levels of moral distress(Jakobsen & Sørlie, 2010).

Ohnishi et al. pointed out that the frequency of moral stress is correlated with the type of ward, and the level of nurses' moral distress is higher in wards where invasive nursing care is provided(Ohnishi et al., 2010). These results are consistent with the findings of the present study, which demonstrated that moral distress is higher in intensive care and emergency departments, compared to other wards. In agreement with the current study, in their article, Faramarzpour et al. (2015) found a significant relationship between the mean score of moral distress severity and the characteristics of the workplace(Faramarzpour, Borhani, & Bagheri, 2015). On the other hand, inconsistent with the present research, in the study carried out by Vaziri et al., no relationship was detected between moral distress and demographic characteristics, such as gender, age, marital status, work experience, and employment status(Vaziri et al., 2015).

In the present study, it can be concluded that the negative relationship of moral distress severity and education level, type of employment, and age may be due to the role of experience in achieving effective solutions that help nurses overcome the moral distress they experience. The score of nurses' ethical behavior was obtained at 4.1 from a total score of 1-5, and the scores were assessed to be high. Nurses working in psychiatric and pediatric wards had the highest level of ethical behavior, while burn, geriatric, and emergency departments had the lowest levels of ethical behavior. The mean score of virtue-oriented ethical behavior was higher among women. The mean score of the severity and frequency of moral distress was higher in postgraduate nurses, compared to nurses with bachelor's degrees.

Pauly et al. (2009) stated that understanding values and ethics was correlated with demographic characteristics, such as education(Pauly et al., 2009). In line with the present research, in their study, Adib Hajbagheri et al. (2015) reported that nurses' knowledge and behavior had a significant relationship with their education(ADIB, Safa, & AMINOLROAYAEE, 2015). It can be interpreted that education raises nurses' awareness and improves their judgment, thinking, and ethical behavior. It can also be argued that educational level affects the attitudes and ethical behaviors which are part of the interpersonal relationship. Therefore, attitude change, ethical behavior, and judgment can affect the desired perception. It is recommended that training classes on ethical issues and elderly care be held for all nurses to increase the quality of care.

Nurses with a master's degree had a higher ethical behavior and improved ethical climate, as compared to their counterparts who hold a bachelor's degree. Nonetheless, contrary to the current study, Behcecik et al. (2003) showed that education level was not related to ethical behavior score(Bahcecik & Oztürk, 2003). It is noteworthy that in the present study, a number of 412 hold a bachelor's degree, and this difference may have affected the results. In general, the assessment of nurses' ethical behavior scores and nurses' demographic characteristics indicated that ethical behavior was correlated with employment type, gender, education level, marital status, and gender. Nonetheless, it was not correlated with other demographic variables (e.g., place of work, number of children, type of work shift, income, and the number of hours involved in caring).

In agreement with the present study, Aminzadeh (2017) suggested that demographic variables were significantly correlated with moral courage, work conscience, and moral distress(Aminizadeh, Arab, & Mehdipour, 2017). On the other hand, in their study, Ulrich et al. (2007) stated that none of the demographic characteristics had a significant relationship with moral climate and ethical behaviors(Ulrich et al., 2007). This discrepancy can be ascribed to different societies and cultures or a lack of organizational support for nurses when dealing with ethical issues. One of the notable limitations of the current study was the noncooperation of nurses in filling out questionnaires out of fear of losing their job position. This problem was solved by justifying the respondents. Moreover, the majority of nurses did not take the questionnaires home and were inclined to fill them out only in hospitals and nursing homes, and this might have reduced the accuracy of their responses.

CONCLUSION

In the present study, the nurses experienced a moderate level of severity and frequency of moral distress. Moreover, using the Pearson correlation coefficient, a strong relationship was detected between the intensity and frequency of moral distress (r=0.848). It can be interpreted that the frequency and confrontation with stressors can predispose nurses to moral stress and affect their perceived severity of distress. Moreover, a weak and inverse relationship was detected between moral distress and virtue-Oriented ethical behavior of nurses in hospitals and nursing homes. It can be argued that the nurses who had a high level of ethical behavior score in the wards experienced less moral distress. Since ethical behavior varies from person to person and can be influenced by beliefs, cultures, and spirituality, this finding cannot be ignored.

Given the rapid growth in the elderly population, it should be noted that since older people succumb to illness and do not seek medical attention, they usually consider illness to be a natural part of old age and their families do not fulfill the health needs of the elderly and seek medical care only when they become seriously ill. Even health

professionals ignore the elderly, giving priority to children and adults, which in turn, give rise to morally wrong behaviors. Therefore, since the people who care for the elderly cannot assess the consistency of their thoughts with the human rights of the elderly, they usually suffer from moral distress. This situation is especially manifested in the case of older adults admitted to emergency departments and geriatric acute wards where a high rate of moral distress has been reported(Piers et al., 2012).

Although the current study did not provide much about the moral distress of geriatric nurses, we can state that virtue-oriented ethical behavior in the organization can be effective in reducing the moral distress of nurses. Therefore, in order to reduce moral distress in nurses, it is recommended that managers devote special attention to the promotion of virtue-oriented ethical behavior. Moreover, appropriate incentive policies should be designed and programmed to promote virtue-oriented ethical behavior in any organization.

Acknowledgments: This study was extracted from a master's thesis on gerontological nursing (IR.nkums.REC.1396.1). The authors' deepest appreciations go to the Vice-Chancellor for Research of Bojnourd University of Medical Sciences for financially supporting this dissertation. Our sincere gratitude is also extended to the officials and nurses working in government hospitals in Bojnourd and nursing homes in Bojnourd and Mashhad who cooperated in performing this research project.

REFERENCES

1. ADIB, H. M., Safa, A., & AMINOLROAYAEE, Y. E. (2015). NURSES'KNOWLEDGE OF ETHICAL AND LEGAL ISSUES IN ELDERLY CARE.
2. Aminizadeh, M., Arab, M., & Mehdipour, R. (2017). Relationship moral courage to moral distress in nurses the intensive care unit. Iranian Journal of Medical Ethics and History of Medicine, 10(1), 131-140.
3. Bahcecik, N., & Oztürk, H. (2003). The hospital ethical climate survey in Turkey. JONA'S healthcare law, ethics and regulation, 5(4), 94-99.
4. BEIKRNORADI, A., RABIEE, S., KHATIBAN, M., & CHERAGHI, M. A. (2012). Nurses distress in intensive care unit: a survey in teaching hospitals.
5. Bertland, A. (2009). Virtue ethics in business and the capabilities approach. Journal of Business Ethics, 84(1), 25-32.
6. Burston, A. (2017). Moral distress and the Australian aged care worker: A mixed methods study.
7. Cabella, B., Vilela, G. H. F., Mascarenhas, S., Czosnyka, M., Smielewski, P., Dias, C., . . . Andrade, R. (2016). Validation of a new noninvasive intracranial pressure monitoring method by direct comparison with an invasive technique. In intracranial pressure and brain monitoring XV (pp. 93-96): Springer.
8. Cannaerts, N., Gastmans, C., & Casterlé, B. D. d. (2014). Contribution of ethics education to the ethical competence of nursing students: Educators' and students' perceptions. Nursing ethics, 21(8), 861-878.
9. Crall, J. (2011). Ethical behavior of supervisors: effects on supervisee experiences and behavior.
10. Faramarzpour, M., Borhani, F., & Bagheri, P. (2015). Job satisfaction of nurses from clinical practice in Jiroft University Hospitals. Iran Journal of Nursing, 28(97), 77-86.
11. Fiedler, N., & Stein, L. (2005). Psychosocial stressors and psychiatric disorders in the workplace. . Philadelphia: Elsevier Sounder.
12. Hamric, A. B., Borchers, C. T., & Epstein, E. G. (2012). Development and testing of an instrument to measure moral distress in healthcare professionals. AJOB Primary Research, 3(2), 1-9.
13. Harrowing, J. N., & Mill, J. (2010). Moral distress among Ugandan nurses providing HIV care: a critical ethnography. International journal of nursing studies, 47(6), 723-731.
14. Huffman, D. M., & Rittenmeyer, L. (2012). How professional nurses working in hospital environments experience moral distress: a systematic review. Critical Care Nursing Clinics, 24 *.100-91 ,(1)*
15. Jakobsen, R., & Sørlie, V. (2010). Dignity of older people in a nursing home: narratives of care providers. Nursing ethics, 17(3), 289-300.
16. Joolaee, S., Jalili, H., Rafiee, F., & Haggani, H. (2011). The relationship between nurses' perception of moral distress and ethical environment in Tehran University of Medical Sciences. Iranian Journal of Medical Ethics and History of Medicine, 4(4), 56-66.
17. Joolaee, S., Jalili, H. R., Rafii, F., Hajibabaee, F., & Haghani, H. (2012). Relationship between moral distress and job satisfaction among nurses of Tehran University of Medical Sciences Hospitals. Journal of hayat, 18(1), 42-51.
18. Mauk, K. L. (2010). Gerontological nursing: Competencies for care: Jones & Bartlett Publishers.
19. Mobley, M. J., Rady, M .Y., Verheijde, J. L., Patel, B., & Larson, J. S. (2007). The relationship between moral distress and perception of futile care in the critical care unit. Intensive and Critical care nursing, 23(5), 256-263.
20. Nikkhah Farkhani, Z., Rahimnia, F., Kazemi, M *& ,.*Shirazi, A. (2015). Modeling the ethical behavior of nurses using the theory of virtue ethics. Iranian Journal of Medical Ethics and History of Medicine, 7(6), 29-48.
21. Oh, Y., & Gastmans, C. (2015). Moral distress experienced by nurses: a quantitative literature review. Nursing ethics, 22(1), 15-31.
22. Ohnishi, K., Ohgushi, Y., Nakano, M., Fujii, H., Tanaka, H., Kitaoka, K., . . . Narita, Y. (2010). Moral distress experienced by psychiatric nurses in Japan. Nursing ethics, 17(6), 726-740.
23. Pauly, B., Varcoe, C., Storch, J., & Newton, L. (2009). Registered nurses' perceptions of moral distress and ethical climate. Nursing ethics, 16(5), 561-573.
24. Piers, R. D., Van den Eynde, M., Steeman, E., Vlerick, P., Benoit, D. D., & Van Den Noortgate, N. J. (2012). End-of-life care of the geriatric patient and nurses' moral distress. Journal of the American Medical Directors Association, 13(1), 80. e87-80. e13.
25. Rees, J., King, L., & Schmitz, K. (2009). Nurses' perceptions of ethical issues in the care of older people. Nursing ethics, 16(4), 436-452.
26. Russell, A. C. (2012). Moral distress in neuroscience nursing: An evolutionary concept analysis. Journal of Neuroscience Nursing, 44(1), 15-24.
27. Silén, M., Svantesson, M., Kjellström, S., Sidenvall, B., & Christensson ,L. (2011). Moral distress and ethical climate in a Swedish nursing context: perceptions and instrument usability. Journal of clinical nursing, 20(23-24), 3483-3493.
28. Smith, K. V., & Godfrey, N. S. (2002). Being a good nurse and doing the right thing: a qualitative study. Nursing ethics, 9(3), 301-312.
29. Ulrich, C., O'donnell, P., Taylor, C., Farrar, A., Danis, M., & Grady, C. (2007). Ethical climate, ethics stress, and the job satisfaction of nurses and social workers in the United States. Social science *&* medicine, 65(8), 1708-1719.
30. Van der Dam, S., Abma, T., Kardol, M., & Widdershoven, G. (2012). "Here's my dilemma". Moral case deliberation as a platform for discussing everyday ethics in elderly care. Health Care Analysis, 20(3), 250-267.
31. Vaziri, M. H., Merghati-Khoei, E., & Tabatabaei, S. (2015). Moral distress among Iranian nurses. Iranian journal of psychiatry, 10(1), 32. World Health Organization, 'aging well'must be a global priority. News release. (2017).