

Research Article

# Moral Distress, Power Asymmetry, and Communication Breakdown in Critical Care: A Critical Ethnography of Nurse–Family Interactions at Yaounde Central Hospital, Cameroon

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## Abstract

This research aimed at studying nurse-family communication in the Internal Medicine Unit of Yaounde Central Hospital in Cameroon and how these encounters are affected by healthcare providers' power dynamics, communication breakages, and moral distress. A critical ethnography for this research obtained data through semi-structured interviews and other forms of communication with nurses, as well as those involved with patients in the department including families/caregivers. Thematic data analysis was conducted based on the power and practice relations framework. Three major and interrelated themes were identified. 1) Fragmented Communication Pathways: Small and sporadic communication channels for exchanging information between health workers and the patient's family members; 2) Unequal Power Relations in Communication: A situation where the doctor's supremacy tends to dominate both nurses and family members, resulting in the disenfranchisement of these two groups; 3) Perpetual Moral Distress: Continuously being in a state of ethical discomfort which is, for the most part, due to the inadequacies of the healthcare system. According to the investigation, insufficient communication, unbalanced power relations, and moral distress are different yet interconnected phenomena in this situation. Hospital authorities should tackle these problems through system-wide changes, setting up structured communication pathways and fostering an environment that promotes communication. Through this research, moral distress as a concept is advanced by redefining it as the interaction pattern of behaviors in intricate relationships within the healthcare system where power disparities and communication failures as the underlying condition are particularly context-specific for resource-constrained Critical Care settings. It aims to influence policy and nursing practice through identifying the necessity for fair decision-making, communicative framework development concerning case situations, and welfare that is provided by structures such as ethical competence that enhances nurse advocacy/care partner roles in patient- and family-centered care.

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## Keywords

Moral Distress, Power Asymmetry, Nurse–family Interactions, Communication Breakdown, Critical Ethnography, Internal Medicine Units

## 1. Introduction

The internal medicine unit (IMU) of the Yaounde Central Hospital is one of the important units of the hospital which focuses on the treatment of medical conditions affecting adults such as heart problems, diabetes, infections, and multisystem disorders. This unit is widely regarded worldwide as highly complex clinical setting where communication is a major factor in determining patient outcomes, family experiences, and ethical decision-making. In these environments, patients who are critically ill are often unable to communicate; thus, health care providers and family members become the ones who interpret clinical data and negotiate decisions surrounding care [1]. However, communication in IMUs tends to be irregular and is influenced by several factors including; organizational pressures, shortages of staff, and hierarchical structures that regulate the flow of information [2].

Communication in IMUs goes far beyond just transferring information; it is profoundly relational and ethical, since it is through communication that families come to understand a patient's prognosis, decisions are openly explained, and trust is either built or broken [3]. Research indicates that families of IMU patients not only experience confusion but also emotional upheaval as they have to cope with receiving inconsistent information and the absence of a systematic communication method [4].

In nursing practice, communication barriers are one of the main reasons nurses experience moral distress, a situation when nurses know the right thing to do, ethically speaking, but are prevented from doing it by institutional or hierarchical pressures. Moral distress has been extensively discussed in the literature in relation to IMU settings and has been found to contribute to emotional fatigue, burnout, and lower work satisfaction [5]. In resource-limited settings like Cameroon, these difficulties are made worse by the very few staff, poor facilities and the lack of formal communication rules. Cultural habits that support decision-making based on authority only very much restrict communication between doctors and patients/families to collaboration [6].

Though the international literature on communication in IMUs and moral distress is increasing, there is still a lack of context-specific qualitative research in African IMUs that looks at the intersection of these two phenomena. The study presented here focuses on this issue by carrying out an intensive critical ethnographic study of nurse-family interactions in the IMU of Yaounde Central Hospital.

## 2. Problem Statement

Whilst it is generally accepted that communication is an essential element of high-quality internal medicine care, in many resource-constrained environments, its implementation is still fragmented, uncoordinated, and poorly structured [7, 8]. One of the main complaints raised by family caregivers is that they receive contradictory information about patient conditions which not only causes confusion and anxiety but also leads to mistrust of the care process [9]. In contrast, IMU nurses have a primary communicative role with families but are not given formal decision-making powers. The resulting mismatch between responsibility and authority creates a situation where ethical concerns arise, and the nurses are emotionally burdened [10].

Recent studies conducted by Howard Silverman and Kim H. indicates that some of the significant causes of moral distress among nurses include structural constraints such as the lack of cooperation between nurses and doctors, absence of ethical environment, and insufficient organizational assistance. Some of the consequences of the above include powerlessness, ethical dilemma, emotional exhaustion, and staff turnover intentions, among others [11, 12].

Empirical evidence drawn from two studies carried out in Cameroon shows that breakdowns in communication, power differences, and organizational distress are not fully investigated yet but are related phenomena within the healthcare industry in Cameroon. The first study, undertaken by Esther L. Wanko Keutchafo and Jane Kerr, examines how older patients in Cameroon interpret the non-verbal communication of nurses. It highlights the critical influence of poor communication skills on patients' perception of the service. The researchers noted that, in Cameroonian healthcare institutions, there is a lack of effective communication practices for which there is little evidence [13]. The second study done qualitatively among nurses working in public health facilities in Cameroon demonstrates that stress factors like inadequate pay, organizational constraints, emotional burnout, and poor working environment affect nurses' morale and professional practice adversely. The findings point to the negative impact of organizational and structural limitations on professional nursing practice and nurses' psychological well-being [14].

From the above discussion, it can be seen that even though empirical evidence on the phenomenon of nurses' distress in IMUs in Cameroon is scanty, existing evidence shows that there are several factors contributing to nurses' experiences of stress and their practice. Consequently, one may conclude that

the problems under investigation will not be resolved without a proper understanding of the situation and may end up focusing on the symptoms rather than the roots of the problems [4].

### 3. Methodology

#### 3.1. Study Design

We conducted a descriptive and exploratory study using a critical ethnographic method focused on communication among nurses and family members in the IMUs. The study focused on how power relations, communication breakdowns, and moral injury among healthcare workers shape communication practices within the unit. Thus, not only can critical ethnography inform researchers about social interactions in clinical settings and the contexts of cultures or subcultures that influence health, but also provide insights into how communication and decision-making may be influenced by structures of inequality, dominance, and marginalization. Ironically, this method enabled the authors to disclose that it is institutional hierarchies and resource limitations that condition these normal routines and experiences in the IMU.

#### 3.2. Study Setting

The study took place at the Internal Medicine Unit of Central Hospital of Yaounde which is one of the largest teaching hospitals in Yaounde, Cameroon. This hospital provides specialized care for adult patients with both acute and chronic conditions. The unit was characterized by high patient acuity, limited resources, and complex interprofessional interactions, conditions under which challenges related to communication, ethics, and power dynamics commonly emerge. This setting was particularly suitable for the study because it enabled an exploration of the interrelationship between communication practices and structural constraints within clinical care.

#### 3.3. Study Population and Sampling

The study included both registered nurses working in the IMU and family members who served as the primary caregivers for patients in the IMUs. These two populations were selected because they play central roles in communication and decision-making regarding patient nursing care. Participants were selected for the study based on purposive sampling and were chosen because they were deemed to possess useful and diverse experiences of interactions by the researchers.

#### 3.4. Inclusion Criteria

Inclusion criteria required that nurses possess a minimum of six months of experience with the unit, indicating clarity to track communication patterns and ethical issues in the setting. Also included were family caregivers over the age of 18, since they had been exposed to the care environment long enough

to provide meaningful feedback (at least 48 hours following admission of their loved ones). Data collection continued until theoretical saturation was obtained, that is, no additional themes or ideas were derived from the data. In total, there were 14 nurses and 12 family caregivers in our study, providing ample perspectives from both groups.

#### 3.5. Data Collection

The research used interviews, observations, and field notes, thus contributing to an effective methodology for collecting data. The triangulation of methodologies improved the validity of results obtained from the study.

##### 3.5.1. Interviews

We also performed one-on-one, semi-structured interviews with nurses and family caregivers about a range of topics: communication experiences; the perception that either families-or health care professionals have power over each other; and finally ethical challenges or moral distress. The semi-structured design of the interview guide helped participants share with us in their words, while also providing a guarantee that key constructs were addressed. Interviews, either in English or French, were audio recorded with participants' consent and transcribed verbatim.

##### 3.5.2. Observation

In addition to the interviews, non-participant observation of healthcare-provider-family member interactions were conducted in real time within the unit. Observations focused on communication patterns, decision-making and displays of authority or hierarchy within the unit. These observations provided contextual insights that complemented the qualitative data obtained from the interviews.

##### 3.5.3. Field Notes

Field notes were recorded throughout data collection to capture non-verbal expressions, contextual information and reflexive commentary from the researcher. These notes formed an essential secondary data source and facilitated a richer interpretation of the findings observed.

#### 3.6. Data Analysis

Data were thematically analyzed using a practice-based power relations framework. The first step of the analysis involved repeated reading of the data to familiarize myself with the interview transcripts. Then an inductive coding was used to identify meaningful units of data, and these were later organized into categories and themes.

The analysis was an iterative process consisting of constant comparison across interviews, observations and fieldnotes for coherence and depth. In this process, three major interrelated themes were uncovered: scattered communication pathways,

imbalanced power dynamics in communication and an inevitable cycle of moral distress. These themes were also analyzed through a critical lens, providing insights on how communication breakdown and power imbalance compromise ethical and psychosocial challenges in the IMU.

### 3.7. Ethical Considerations

Ethical approval was obtained from the respective institutional review bodies for the study. All participants received a detailed description of the study and consented to take part. Personal identifiers were removed and all transcripts and reports used pseudonyms so that confidentiality and anonymity were strictly maintained.

Since IMU encounters can be associated with trauma, the emotional state of participants was also closely scrutinized. Interviews were conducted in a calm manner, and the participants were advised of their right to withdraw from the study at any time without penalty. Qualitative research governing

ethical standards were adhered to, including complete confidentiality as data was stored safely and can only be viewed by the research team.

## 4. Results

### 4.1. Demographic Characteristics of Participants

Twenty-six participants from the IMUs of Yaounde Central Hospital's participated in this study. The participants included both nurses working in the IMU (14) and family members (12) who were directly involved with the care of their loved ones' rehabilitation/communication during their stay in the hospital. The demographics of the sample provided a balance between years of clinical experience and diversity of relationships among the family caregivers, leading to a diverse context for the study of communication in the IMU.

*Table 1. Demographic Characteristics of Participants (n = 26).*

Variable	Category	Frequency (n)	Percentage (%)
Participant Type	Nurses	14	53.8
	Family caregivers	12	46.2
Gender	Female	15	57.7
	Male	11	42.3
Nursing Experience	1–5 years	5	35.7
	6–10 years	6	42.9
	>10 years	3	21.4
Caregiver Relationships	Spouse	5	41.7
	Parent	4	33.3
	Sibling/Other	3	25.0

The demographic profile indicates that the majority of nurses had mid-level experience. This is key to understanding how communication behavior develops based on exposure to hierarchical structures, such as nursing and other staff, through institutional routinization processes. Similarly, the majority of family caregiving was done by spouses or parents, demonstrating a commitment to making decisions with a significant emotional investment.

### 4.2. Frequency of Emergent Themes

Analysis found three main themes emerging multiple times from interviews, observations, and field notes. These themes were intertwined, not separate, representing the complicated relationship and institutional complexities of the IMU.

**Table 2.** Frequency of Emergent Themes.

Theme	Description	Frequency Across Data Sources (n=26)	Proportion (%)
Communication Breakdown	Fragmented, inconsistent, and unstructured communication between staff and families	24	92.3
Power Asymmetry	Hierarchical dominance of physicians and limited autonomy of nurses and families	22	84.6
Moral Distress	Emotional and ethical suffering experienced by nurses due to systemic constraints	21	80.8

The overlaps and similarities among these three themes demonstrate that these occurrences are not unique and instead illustrate systemic conditions that impact patient care in Yaounde's Intensive Care Unit.

### 4.3. Thematic Findings

#### 4.3.1. Communication Breakdown - The Reality of a Systemic ICU

Communication in the Intensive Care Unit was consistently described as being disjointed, inconsistent and reliant on the availability of individual staff members as opposed to any structured institutional guidelines. Due to conflicting messages among health care professionals, family members were frequently left uncertain about the condition of their loved one. One family member was openly frustrated by this discrepancy:

*"In the morning, I am informed that the patient is stable, yet by the evening, another staff member reports that the patient is in critical condition. Such inconsistencies make it difficult to know which information to trust"*

The inconsistency wasn't just about information. Families said it made them more anxious and they lost trust in the care process. Observers found that communication was mostly reactive. Staff only spoke when families asked for updates, not through scheduled information sharing. Nurses admitted this. They blamed workload and staffing limits.

*"We are often overwhelmed. Sometimes you have to choose between giving care and explaining things to families."*

It shows that the communication breakdown isn't just one person's failure. This is a result of organizational pressure and limited resources.

#### 4.3.2. Power Asymmetry and Hierarchical Control of Communication

Power relations in the IMU were strongly hierarchical. Physicians were the ones in charge of clinical decisions and of who got information. Though nurses were at the bedside all the time, they were set up as intermediaries, not decision-makers. As one nurse put it plainly: "We are closest to the patient, but we are not the ones who decide anything." Family caregivers see the same hierarchy when they deal with the system.

Many said they felt left out of the real decision-making.

*"We are only contacted when something needs to be signed. Before that, no one consults us or seeks our input."*

It shows a communication model that mostly sends information downward instead of sharing it. This setup reinforces institutional authority and keeps shared understanding and participation limited.

#### 4.3.3. Moral Distress as a Continuous Ethical and Emotional Burden

Moral distress was persistent for all IMU nurses. It was not seen as a temporary discomfort but a steady emotional and ethical burden. It came from facing the same situations again and again where they knew what to do but couldn't act because of institutional limits. One nurse said this about the conflict.

*"You may know the most appropriate decision for the patient, but you cannot advocate for it because it is not your decision."*

And that squeeze built up over time. Nurses said they carried it home.

*"Even when you go home, you are still thinking about the patients you could not help the way you wanted."*

Family caregivers felt distress too. Mostly from not knowing and from uneven communication.

*"The worst part is not knowing what is happening. Your mind creates its own stories."*

When communication breaks down and power is uneven, it doesn't just make things inefficient. It hits nurses and families with real psychological and ethical harm.

### 4.4. Integrated Interpretation of Findings

The findings show that communication breakdown and power asymmetry are tied to moral distress. They're not separate, but depend on each other. Communication failures make hierarchy stronger because transparency drops, and power differences stop nurses from changing how people communicate. All of it leads to ongoing moral distress for healthcare providers. In the IMU of Yaounde Central Hospital, these dynamics look normal in daily practice. They seem embedded in the institutional culture, not just rare incidents.

## 5. Discussion

### 5.1. Communication Breakdown as a Structural and Organizational Phenomenon

This study shows that communication breakdown in the IMU of Yaounde Central Hospital isn't just about individuals, but structural and tied to how the health system works. The inconsistencies point to no standard protocols and a fragmented flow of information. Staff end up relying on individual initiative instead of institutional coordination [15, 16]. Recent IMU research shows similar patterns. Communication failures often come from heavy workloads and a lack of structured ways to talk with families, not from individual negligence [2]. In critical care, this matters a lot, as families rely on healthcare providers to explain rapidly changing conditions. If information is inconsistent or delayed, families feel uncertain, thereby reducing trust and increasing emotional distress [17]. Recent studies show that structured communication systems improve family satisfaction and reduce anxiety in IMUs, thus showing why institutional communication protocols matter [4].

At Yaounde Central Hospital's IMU, there are no formal communication systems. Communication is treated as an informal clinical task instead of part of care, making messages vary and pushes decisions onto individual discretion which is dangerous in a high-stakes environment like intensive care.

### 5.2. Power Asymmetry and the Reinforcement of Hierarchical Clinical Culture

The study shows IMU communication is shaped by strict hierarchies as doctors are the sole decision-makers with nurses and family caregivers being their subordinates. This makes shared decision-making rare, making communication unidirectional instead of being conversational [18]. Recent papers say these hierarchies are still common in many low- and middle-income healthcare systems. Physician authority sits at the center of clinical governance. This keeps teams from working across disciplines and limits nurses' autonomy [5]. In this study nurses said their role was mostly to communicate, not to decide, as nurses often mediate between doctors and families but have no real power to influence decisions leading to professional frustration and inequality in interprofessional collaboration [19]. Family caregivers also reported being left out of actual decision-making, which is of greater concern for patient and family centered care in intensive care. Evidence shows that when families aren't engaged in IMU decisions, it leads to mistrust and dissatisfaction with care [9].

### 5.3. Moral Distress as a Systemic and Relational Outcome

Moral distress came up in this study as something that IMU nurses live with. It shows up as a persistent, deeply embodied

experience. Due to institutional constraints, nurses are not able to act on their ethical judgment. The literature now sees moral distress as systemic and relational, rooted in organizational structures and ethical environments and not just a personal psychological problem [20, 21]. Recent critical care nursing studies show a strong link between moral distress and repeated exposure to ethically challenging situations where nurses lack the authority to intervene even though they recognize patient needs. This is connected to burnout, emotional exhaustion and reduced quality of care [10, 22].

In the IMU at Yaounde Central Hospital, moral distress grew from poor communication and strict hierarchies. Nurses kept saying they felt an ethical tug between their duty and the hospital's rules. They knew what good care looked like and they couldn't do it. The stress piled up, remained unresolved, carried on and became a moral residue over time [12, 23]. Recent evidence shows that when moral distress goes unresolved, it can seriously hurt workforce retention and professional engagement, especially in high-intensity places like IMUs [6, 12].

### 5.4. Interrelationship Between Communication, Power, and Ethics

One point from this study is that there is a communication breakdown and power asymmetry, with moral distress tied in. When communication breaks down, transparency falls, and hierarchies tighten, with nurses having less agency and growing moral distress. This often causes nurses to pull back emotionally or engage less in communication activities [24]. This pattern fits theories that see healthcare as a complex adaptive system. Structural setups shape relationships, and emotions loop back into both. Recent work suggests that improving IMU outcomes means tackling communication and power along with ethical issues, treating them as linked, not separate [4].

### 5.5. Contextual Influences in Resource-Constrained Settings

The IMU at Yaounde Central Hospital works under tight resources, few staff, and poor infrastructure. It makes communication harder, pushing decisions up the chain. Efficiency gets priority over talking with families. Similar studies have shown that limited resources shape how teams communicate in IMUs. They often force providers to perform clinical tasks first and skip structured family conversations [25].

In that setting, ethical care is hard to maintain. Limited time and weaker chances to build relationships. So moral distress and communication breakdowns become systemic.

## 6. Conclusion

This study shows that in the IMU of Yaounde Central Hospital communication keeps breaking down, power is uneven

and nurses face moral distress. Communication patterns are not separate but are deeply connected to structural conditions of care tied to broader systemic and organizational limits that shape everyday clinical practice. Addressing these challenges would require institutional reforms, improved communication systems, a more equitable distribution of power, and stronger ethical support for nurses.

## Abbreviations

IMUs Internal Medicine Units

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## Author Contributions

**Mispar Guinyonga Wankam:** Conceptualization, Data curation, Investigation, Methodology, Project administration, Visualization, Writing – original draft

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## Data Availability Statement

The data supporting the outcome of this research work has been reported in this manuscript.

## Conflicts of Interest

There was no outside funding for this project, and the authors have no conflicts of interest relative to this publication.

## References

- [1] Secunda KE, Kruser JM. Patient-Centered and Family-Centered Care in the Intensive Care Unit. *Clin Chest Med* 2022; 43: 539. <https://doi.org/10.1016/J.CCM.2022.05.008>
- [2] Tadros EM, Al-Akash HY, Ababneh A, Kawafha M, Al-Kouri OA, Al-Ghabeesh SH, et al. Voices from the intensive care unit: A qualitative study on communication between family members and nurses. *Applied Nursing Research* 2025; 85: 151991. <https://doi.org/10.1016/J.APNR.2025.151991>
- [3] Ozgultekin A, Yilmaz Altuntas E, Birtan D. Interpersonal Communication in Intensive Care Units: A Qualitative Study on Family Members' Experiences in a Turkish Public Hospital. *Healthcare (Switzerland)* 2025; 13: 3100. <https://doi.org/10.3390/HEALTHCARE13233100/S1>
- [4] Saifan AR, Tadros EM, Rawas H, Al-Akash HY, Alsulami GS, Almagherbeh WT, et al. Cultural and systematic barriers to communication between nurses and family members in the ICU. *BMC Nurs* 2025; 24. <https://doi.org/10.1186/S12912-025-03417-X>
- [5] Qu K-Y, Zhu D-J, Yang P-F, Huo H-J, Liu H-J, Min Z, et al. Moral distress of intensive care unit nurses: a systematic review and meta-analysis. *BMC Nurs* 2026; 25: 108. <https://doi.org/10.1186/S12912-025-04274-4>
- [6] Yin J, Zhao L, Zhang N, Xia H. Understanding the interplay of compassion fatigue and moral resilience on moral distress in ICU nurses: a cross-sectional study. *Front Public Health* 2024; 12: 1402532. <https://doi.org/10.3389/FPUBH.2024.1402532/TEXT>
- [7] Al-Shamaly HS. Patterns of communicating care and caring in the intensive care unit. *Nurs Open* 2021; 9: 277. <https://doi.org/10.1002/NOP2.1061>
- [8] Bonaconsa C, Charani E, Van den Bergh D, Joubert I, Mendelson M. Exploring the influence of communication and team dynamics relating to infection care on intensive care unit patient discussions: Insights from sociograms and team reflexivity. *J Crit Care* 2025; 89: 155127. <https://doi.org/10.1016/J.JCRC.2025.155127>
- [9] Blok AC, Valley TS, Weston LE, Miller J, Lipman K, Krein SL. Factors affecting psychological distress in family caregivers of critically ill patients: a qualitative study. *Am J Crit Care*. 2023;32(1):21-30. <https://doi.org/10.4037/ajcc2023593>
- [10] Vincent H, Jones DJ, Engebretson J. Moral distress perspectives among interprofessional intensive care unit team members. *Nurs Ethics*. 2020 Sep;27(6):1450-1460. <https://doi.org/10.1177/0969733020916747>
- [11] Kim H, Kim H, Oh Y. Impact of ethical climate, moral distress, and moral sensitivity on turnover intention among haemodialysis nurses: a cross-sectional study. *BMC Nursing* 2023 22: 1 2023; 22: 55. <https://doi.org/10.1186/S12912-023-01212-0>

- [12] Silverman HJ, Wilson T, Tisherman SA, Kheirbek RE, Mukherjee T, Tabatabai A, et al. Ethical decision-making climate, moral distress, and intention to leave among ICU professionals in a tertiary academic hospital center. *BMC Med Ethics*. 2022; 23(1): 45:1–15. <https://doi.org/10.1186/S12910-022-00775-Y>
- [13] Wanko Keutchafo EL, Kerr J. Older Adults' Interpretation of Nurses' Nonverbal Communication in Cameroon: A Grounded Theory Inquiry. *Inquiry (United States)* 2022; 59. <https://doi.org/10.1177/00469580211056194>
- [14] Chance EA, Théophile P. The ripple effect: irregular salary payments, job satisfaction, and patient safety among nurses in Cameroon. *Discov Glob Soc*. 2026;4(1): 5: 1–20. <https://doi.org/10.1007/S44282-025-00284-4>
- [15] Atinga RA, Gmaligan MN, Ayawine A, Yambah JK. "It's the patient that suffers from poor communication": Analyzing communication gaps and associated consequences in handover events from nurses' experiences. *SSM - Qualitative Research in Health* 2024; 6. <https://doi.org/10.1016/J.SSMQR.2024.100482>
- [16] Mispa W. Communication dynamics between healthcare providers and family caregivers in intensive care units: Implications for clinical decision-making, care ethics, and the quality of nursing practice at Yaounde central hospital. ~ 1 ~ *International Journal of Midwifery and Nursing Practice* 2026; 9. <https://doi.org/10.33545/26630427.2026.v9.i2a.232>
- [17] de León Oliva B, Rodríguez Gómez JÁ, Rodríguez Novo N. Difficulties in Communicating Between Nurses and Relatives of Patients Admitted to Intensive Care Units: A Scoping Review. *Nurs Crit Care* 2025; 30: e70148. <https://doi.org/10.1111/NICC.70148>
- [18] Wubben N, Van Den Boogaard M, Van Der Hoeven JG, Zegers M. Shared decision-making in the ICU from the perspective of physicians, nurses and patients: A qualitative interview study. *BMJ Open* 2021; 11. <https://doi.org/10.1136/BMJOPEN-2021-050134>
- [19] Laari L, Duma SE. Health advocacy role performance of nurses in underserved populations: A grounded theory study. *Nurs Open* 2023; 10: 6527. <https://doi.org/10.1002/NOP2.1907>
- [20] Rosa D, Bonetti L, Villa G, Allieri S, Baldrighi R, Elisei RF, et al. Moral Distress of Intensive Care Nurses: A Phenomenological Qualitative Study Two Years after the First Wave of the COVID-19 Pandemic. *Int J Environ Res Public Health* 2022; 19: 15057. <https://doi.org/10.3390/IJERPH192215057>
- [21] Jang SG, Min A, Kim S. Experience of Pediatric Patient Death, Moral Distress, and Turnover Intention among Pediatric Nurses at a Tertiary Hospital in South Korea: A Cross-Sectional Study. *J Palliat Med* 2022; 25: 1215–21. <https://doi.org/10.1089/JPM.2021.0394>
- [22] Boulton O, Farquharson B. Does moral distress in emergency department nurses contribute to intentions to leave their post, specialisation, or profession: A systematic review. *Int J Nurs Stud Adv* 2023; 6: 100164. <https://doi.org/10.1016/J.IJNSA.2023.100164>
- [23] Andersson M, Nordin A, Engström Å. Critical care nurses' perception of moral distress in intensive care during the COVID-19 pandemic – A pilot study. *Intensive Crit Care Nurs* 2022; 72. <https://doi.org/10.1016/J.ICCN.2022.103279>
- [24] Dehghani A, Sobhanian M, Jahromi MF. The effect of communication skills training on nurses' moral distress: A randomized controlled trial. *Electronic Journal of General Medicine* 2022; 2022: 2516–3507. <https://doi.org/10.29333/ejgm/12313>
- [25] Jin J, Son YJ, Tate JA, Choi JY. Challenges and Learning Needs of Nurse-Patients' Family Communication: Focus Group Interviews with Intensive Care Unit Nurses in South Korea. *Eval Health Prof* 2022; 45: 411. <https://doi.org/10.1177/01632787221076911>