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Concept analysis of moral disengagement among nurses in the intensive care unit: A hybrid model

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ABSTRACT

Background & Aim: Moral disengagement may result in unethical behavior, compromising patient safety in Intensive Care Units. This study aims to provide a clear and culturally grounded definition of moral disengagement among Iranian ICU nurses.
Methods & Materials: This research employed a hybrid concept analysis model based on Schwartz-Barcott and Kim's approach in three phases: 1) Theoretical phase: A comprehensive literature review was conducted using relevant keywords in Iranian and international databases. Sixteen relevant peer-reviewed articles were selected and analyzed using conventional content analysis based on Graneheim and Lundman's method. 2) Fieldwork phase: In-depth semi-structured interviews were conducted with 20 ICU nurses selected via purposive sampling. Data were coded and analyzed using qualitative content analysis to extract themes. 3) Final analysis phase: The data from the previous phases were integrated to develop a refined and context-based definition.
Results: In the theoretical phase, key attributes included moral justification, cognitive reconstruction, detachment from ethical standards, and absence of moral emotions. Fieldwork analysis yielded 301 codes categorized into three main themes and seven subthemes, emphasizing illegitimate legitimization through commitment avoidance, self-justification, and cognitive reconstruction, as well as assurance of job and psychological security, and feelings of individual and organizational satisfaction. The findings from these phases contributed to the final definition.
Conclusion: Moral disengagement among ICU nurses is defined as: "The employment of protective mechanisms of justification, pleasant cognitive reconstruction of the event, and commitment avoidance to legitimize unethical activities aimed at preserving job security, psychological safety, and individual and organizational satisfaction." This definition offers a practical foundation for future research and ethical interventions in critical care.

Introduction

Despite repeated calls for nurses to adhere to predetermined professional ethics, challenges, dilemmas, and complicated situations in the workplace sometimes make it difficult for them to follow these principles (1). Moral disengagement has been proposed as an explanation for why individuals engage in unethical behavior at work (2). The process of moral disengagement explains why and how morally upright individuals sometimes engage in unethical behaviors without feeling guilt or self-blame (3). This phenomenon has been explored across various disciplines, including psychology (4), social sciences (5), education (6), athletics (7), and healthcare (1, 8). Although many studies have highlighted the need for more in-depth research on moral disengagement among healthcare workers and organizations involved in patient care (1, 3, 9), only limited attention has been given to examining this concept within the nursing profession (3). Furthermore, moral disengagement and its influencing factors can be affected by differences in professional contexts and cultural backgrounds (10).

In the nursing profession, which inherently relies more on ethical principles than many other fields, nurses may sometimes experience moral disengagement due to various factors, including the desire to avoid further waste of their resources and a tendency to rationalize their own ethically biased behavior

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(1, 11). In this regard, the Intensive Care Unit (ICU) is considered one of the most critical and stressful wards in the hospital, where providing care exposes nurses to a clinical setting full of ethical issues (12). Complexities such as the challenges in obtaining informed consent, compliance with principles such as confidentiality, jeopardizing patient's rights, providing highly invasive medical procedures, the nature of decision-making for life-saving interventions coupled with high work pressure, lack of time for delivering high-quality critical care, limited accessible resources, and unsafe facilities can all present multiple ethical challenges experienced by ICU nurses (12, 13). These challenges emphasize the importance of addressing issues such as moral disengagement in these settings.

In various literature, distinctive attributes associated with moral disengagement have been proposed, including moral justification, dehumanization (14), cognitive reframing of behavior, shifting responsibility for behavior, downplaying harmful consequences (15), euphemistic labeling (16), and several others that are not specific to any particular profession. These features reflect diverse perspectives on how individuals morally disengage across different situations and stressful environments. Given the absence of a suitable empirical definition of the concept of "moral disengagement" among Iranian nurses working in ICUs, it is crucial to comprehend the diverse perspectives of these nurses and clarify this concept. Therefore, this study utilized a hybrid model of concept analysis to provide a more precise definition of "moral disengagement" in this population.

Methods

This concept analysis was conducted based on the hybrid model proposed by Schwartz-Barcott and Kim (17, 18). The model integrates both inductive and deductive approaches and aims to refine concepts, create more thorough definitions, and, in some cases, offer entirely new definitions (19). This model is appropriate for concepts that are multifaceted in their application by individuals and has been utilized in a significant number of studies (20).

Given that the concept of "moral disengagement" is closely related to the performance of healthcare professionals, including nurses, and considering the previous studies that have utilized this concept, the hybrid model is particularly applicable.

This model consists of three phases: (1) theoretical, (2) fieldwork, and (3) final analysis.

1) Theoretical Phase:

The literature search was conducted following the guidelines provided by the University of York for a systematic literature review (21). This guide covers developing a search strategy, determining inclusion and exclusion criteria, evaluating literature, and extracting and analyzing data.

1.1. Database search

The Web of Science, PubMed, and Scopus databases were searched without time constraints using related keywords such as "moral disengagement," "moral evasion," "moral shirk," "moral escape," "health," "care," "nurs*," and "medic*," as well as equivalent Persian keywords in the Iranian databases SID and Magiran.

1.2. Inclusion and exclusion criteria

The inclusion criteria for this study encompass sources that are (1) relevant to the study's objectives, (2) published in either Persian or English, (3) specifically related to the definitions, characteristics, facilitating and hindering factors, and consequences of the selected concept, and (4) published in peer-reviewed journals. Conversely, the exclusion criterion specifies that any studies for which the full text is not accessible will be omitted from the analysis.

1.3. Quality assessment of articles

The quality of qualitative articles was assessed using the Critical Appraisal Skills Programme (CASP) checklist, and quantitative articles were evaluated using the

Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) tool. These tools were used for the quality assessment of the articles included in the study, with a minimum required score of 70% to ensure their quality. According to previous studies (22, 23), authors considered this threshold a pragmatic guide to minimize the inclusion of studies with significant methodological deficiencies and to enhance the accuracy of quality control for the articles.

1.4. Review and selection process

The process of reviewing and selecting studies during the theoretical phase is depicted in Figure 1. Initially, duplicate articles were removed using EndNote software. Then, the articles' abstracts were reviewed. Finally, the full texts of the articles meeting the inclusion criteria were assessed using relevant tools.

A total of 863 studies were identified in the literature review, of which 654 were screened. After removing irrelevant studies, 16 articles were included and analyzed (Figure 1).

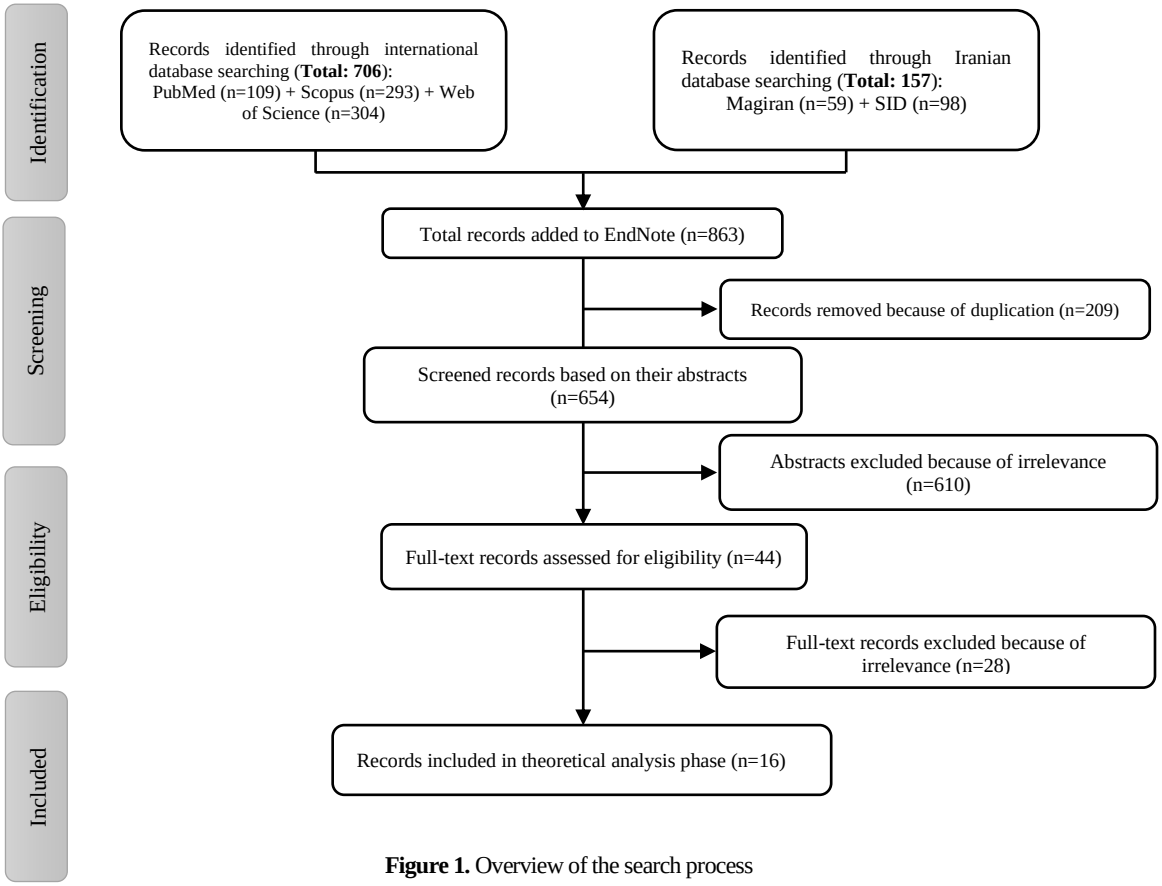

Figure 1. Overview of the search process

1.5. Data analysis

The text of literature was analyzed using a conventional content analysis approach, following the proposed stages outlined by Graneheim and Lundman (2004) (24). To ensure rigorous analysis, the following steps were undertaken:

1. **Familiarization with the text:** The full texts of the selected literature were read multiple times, line by line and paragraph by paragraph, to gain a deep understanding of the overall content and context.
2. **Identification of meaning units and condensation:** Segments of text relevant to the research question were selected as meaning units (words, sentences, or paragraphs containing aspects related to each other through their content and context). These meaning units were then condensed while preserving the core meaning.

3. **Coding:** Condensed meaning units were labeled with initial codes that described their essential content. Codes were data-driven and remained close to the original expressions.
4. **Categorization:** Similar codes were grouped into categories, reflecting shared patterns or topics within the data. These categories are more descriptive and remain close to the manifest content of the texts.
5. **Theme development:** Categories were compared and abstracted into themes, which reflect a latent content or underlying meaning across multiple categories. Themes are interpretive and express the thread of meaning running through the data.

Throughout this process, codes and categories were iteratively reviewed, revised, and merged where appropriate to ensure internal consistency. Special attention was paid to ensuring homogeneity within each category and heterogeneity between categories, as recommended by Graneheim and Lundman. This step-by-step analytical process enabled the identification of clear conceptual structures while preserving both descriptive accuracy and interpretive depth.

2) Fieldwork phase:

The steps taken during the fieldwork phase are as follows:

2.1. Participant selection and sampling strategy

Participants were selected using purposive sampling among nurses working in ICUs. The selection was made to ensure maximum variation in terms of gender, age, marital status, and educational background. Sampling continued until data saturation was achieved. Saturation was determined through an iterative process of data collection and preliminary thematic analysis, where no new themes or insights emerged after several interviews. The final sample included 20 ICU nurses, which aligns with qualitative research guidelines indicating that saturation typically occurs within this range (25-27).

2.2. Data collection

Data were collected through semi-structured, face-to-face interviews conducted in the ICU setting, at times chosen by the participants. Each interview began with general warm-up questions and transitioned to open-ended inquiries about the nurses' daily routines and experiences of moral disengagement in the ICUs. Each interview lasted approximately 45 to 60 minutes and was digitally recorded with consent. Recordings were transcribed verbatim immediately after each session. Data collection and preliminary analysis were conducted simultaneously.

2.3. Development and validation of interview questions

To ensure the consistency and reliability of the interview questions, an expert review of the interview guide was conducted by three specialists in qualitative research and nursing ethics, whose feedback helped refine the content and structure. Additionally, a pilot test was conducted with two ICU nurses (not included in the main study), leading to minor wording and flow adjustments. Memoing and reflexive journaling were used by the researcher throughout data collection to enhance consistency and reflectivity in the interviewing process.

2.4. Data analysis

Data analysis followed a conventional content analysis approach. Meaning units were extracted from participant statements, which were then condensed and assigned initial codes. Similar codes were grouped into categories based on thematic relevance. These categories were compared, merged, and abstracted to form subthemes and broader themes. In total, 301 initial codes emerged, which were subsequently refined into three main themes and seven subthemes. The analysis was conducted iteratively and reflexively, with continuous comparison and merging of codes to ensure clarity and conceptual depth.

2.5. Strategies for rigor and trustworthiness

To ensure data rigor, Lincoln and Guba's criteria (Credibility, Dependability, Transferability, and Confirmability) were utilized (28). The following strategies were also considered during this phase:

- Reflexivity: The researcher continuously evaluated their own perspectives throughout the research process, remaining aware of personal biases and preconceptions.
- Peer debriefing: Preliminary findings were shared with three experts in this field to receive independent feedback.
- Collaborative coding: Members of the research team jointly reviewed and coded the data, enhancing consistency.
- Member checking: Key themes were validated with a subset of participants to confirm the accuracy of the interpretation.

Ultimately, these strategies effectively contributed to reducing potential biases in the analysis process and strengthened the validity and overall credibility of the study's findings.

3) Final analysis phase:

In the final phase, the codes and themes obtained from the fieldwork phase were compared with those derived from the literature review phase in order to establish a definitive, context-based definition of "moral disengagement."

Ethical considerations

The necessary approvals for the study have been obtained from Tehran University of Medical Sciences (TUMS), and the study's code of ethics is IR.TUMS.FNM.REC.1402.123. The objectives of the study were clearly communicated to the participants, assuring them that their information would remain confidential. Participants were informed of their right to withdraw from the study at any time. Voice recordings were made only with their consent and were deleted after transcription. Following these assurances, informed written consent was obtained from each participant.

Results

The results obtained in the three phases of the study are as follows:

Theoretical phase

Finally, a total of 16 relevant studies of various types were analyzed, comprising two studies from the United States, two from Iran, two from Italy, two from the Netherlands, one from China, one from Turkey, and one from Malaysia. The country of origin for five studies could not be determined by their type and was marked as N/A. Among these studies, only one was conducted specifically with intensive care nurses, while eight focused on nurses, one on nursing students, one on physicians, one on medical students, and the remaining studies targeted a broader range of healthcare workers. Details of the literature included in this phase can be found in Table 1.

Based on the literature review, similar and identical definitions are presented in the documents related to healthcare professionals, while no distinct definition of moral disengagement specific to the nursing profession was identified. The general definition of moral disengagement aligns with Bandura's definition (1990). According to Bandura's social-cognitive theory, individuals have control over their thoughts and behaviors through self-regulatory processes, and a person's moral agency is governed by monitoring their actions in accordance with their ethical or professional ethics. "Moral disengagement" refers to the deactivation of this self-regulatory process, explaining how morally inclined individuals can engage in unethical behaviors without experiencing guilt, shame, regret, remorse, self-blame, or psychological distress (29). Individuals typically rely on internal ethical standards that guide their behavior, leading them to avoid deplorable behaviors inconsistent with their moral perspectives. However, a consistent and obligatory adherence to ethical standards cannot always be assumed, and moral disengagement can lead to the violation of personal moral standards through various mechanisms (1).

Table 1. Overview of the articles included in the literature review

Author(s)	Year	Country (language)	Type of study	Targeted population	Definition
R. Fida et al.	2016	Italy (English)	Longitudinal Study (Three-Wave Study)	Nursing Students	"Moral disengagement operates through eight mechanisms at four sites of the self-regulatory process that allow individuals to perceive transgressive and deviant conduct as morally acceptable and as an appropriate means to pursue their own goals" (6)
A. L. Antes et al.	2020	U.S (English)	Developing Instrument	Medical Students	"Moral disengagement is distancing oneself from ordinarily embraced ethical standards. Individuals can convince themselves that ethical standards do not apply through cognitive distortions, including victim blaming, assuming the worst, euphemistic labeling, and minimizing harms. Therefore, they can behave unethically and view it as acceptable." (37)
J. S. Christian and A. P. J. Ellis	2014	U.S (English)	Longitudinal Study	Nurses	"According to Bandura (1990), moral disengagement deactivates moral self-regulatory processes through the use of several interrelated cognitive mechanisms. In line with social cognitive theory (Bandura 1990, 1991), researchers have shown that moral disengagement predicts unethical decision-making and behavior." (16)
D. Copeland	2022	N/A (English)	Theoretical Pathways	Nurses	"Moral disengagement attempts to explain how ethical people can engage in unethical behavior without guilt. Social cognitive theory posits that people exert control over their thoughts and behaviors via self-regulatory processes; one's moral agency is governed by monitoring one's conduct and behaving in ways consistent with her/his moral standards or professional ethics. These self-regulatory processes can be selectively de-activated, a process referred to as moral disengagement." (29)
R. Fida et al.	2018	Italy (English)	Cross-Sectional Study	Nurses	"It means allowing individuals to morally disengage from their own actions and, as a result, legitimizing their aggressive and deviant behavior while keeping the same moral standards" (30)
J. Hyatt	2017	N/A (English)	Review	Healthcare Professionals	"Moral disengagement refers to a process that involves justifying one's unethical actions by altering one's moral perception of those actions. Simply, it " is a process that enables people to engage in negative behaviors, from small misdeeds to great atrocities, without believing that they are causing harm or doing wrong "(32)
Y. Ke and F. Li	2024	China (English)	Cross-Sectional Study	Emergency Nurses	"Moral disengagement is the cognitive tendency of individuals to rationalize unethical behavior to minimize the harm it causes. As a social cognitive process, moral disengagement causes individuals to rationalize their misbehavior at the level of thought and gradually deviate from their own moral codes and standards. Moral disengagement as a sociocognitive tendency can occur in all professions." (38)
L. Kuilman et al.	2018	Netherland (English)	Cross-Sectional Study	Nurse Practitioners and Physician Assistants	"People use mechanisms of moral disengagement to justify behavior that does not comply with their own standard of moral values and beliefs and thus avoid self-sanction. As such, moral disengagement is a manifestation of a lack of moral self-regulation." (8)
L. Kuilman et al.	2021	Netherland (English)	Cross-Sectional Study	Nurse Practitioners and Physician Assistants	"Moral disengagement defines the process of cognitive reframing of conduct as being morally acceptable without the necessity of changing one's moral standards. There are various ways to reframe immoral acts into moral ones." (15)
M. Mansor et al.	2023	Malaysia (English)	Cross-Sectional Study	Nurses	"Moral disengagement refers to a person's ability to justify immoral actions and avoid feeling remorse, guilt, regret, or shame. It allows people to behave in ways that deviate from moral standards without experiencing psychological discomfort." (39)
A. Mohammadpour et al.	2023	Iran (English)	Psychometric Study	Nurses	"Moral disengagement is a set of cognitive mechanisms through which a person violates his/her moral standards without losing his/her dignity." (40)
R. M. Sade	2012	N/A (English)	Letter	Physicians	"The term "moral disengagement" describes cognitive mechanisms that alleviate the cognitive dissonance that arises from conflicts between beliefs and actions, thus deactivating moral self-regulation and resulting in dishonest actions performed with apparent lack of guilt." (31)

Author(s)	Year	Country (language)	Type of study	Targeted population	Definition
B. Yildiz et al.	2022	Turkey (English)	Cross-Sectional Study	Nurses	"Moral disengagement helps explain why individuals may behave in immoral or unethical ways. Moral disengagement is a precursor to harmful tendencies to break the rules and justify unethical acts. It also accounts for why and how individuals justify their unethical behaviors." (41)
A Azimpour et al.	2022	N/A (Persian)	Narrative Review	Physicians and Nurses	Moral disengagement encompasses cognitive mechanisms that develop in an individual's mind when engaging in unethical actions or deciding against performing ethical ones, subsequently influencing the manifestation of unethical behaviors or the failure to engage in ethical conduct. (11)
L Jouybari et al.	2023	N/A (Persian)	Letter	Healthcare Providers	Moral disengagement is a process whereby an individual or group distances itself from general ethical standards or customary behavior. They become convinced that new unethical behaviors are often justifiable due to adverse conditions; this concept serves as a delimiter between personal ethical principles and actual behavior. (42)
Z Mohammadi Berengestaneki et al.	2023	Iran (Persian)	Cross-Sectional Study	ICU Nurses	Moral disengagement is considered a process in which an individual engages in negative behaviors, ranging from minor to significant misconduct, while remaining oblivious to the negative impact of their actions, which can lead to harm and errors. Thus, moral disengagement occurring within healthcare professions poses a serious threat to patient safety, organizational culture, and even the mental health of service providers. (43)

The theme of moral justification emerged with subthemes of "lack of guilt and remorse", and "acceptance of deviant behavior as appropriate" (Table 3). This finding indicates that moral disengagement involves allowing oneself to separate morality from one's actions, leading to the legitimization of aggressive and deviant behaviors by equating them with the observation of moral standards (30). In such cases, cognitive dissonance stemming from the conflict between beliefs and actions is diminished, resulting in the deactivation of moral self-regulation and leading to dishonest actions performed without feelings of guilt (31). In contrast to neutralization, which occurs when feelings of guilt or remorse are experienced, moral disengagement serves as a socio-cognitive mechanism for preemptively justifying future actions (9).

Through the analysis of these 16 sources in the theoretical phase, the attributes of moral disengagement were identified as follows: moral justification, cognitive reconstruction of events, detachment from ethical standards, and the absence of moral emotions such as guilt, shame, and remorse. These attributes reflect the core characteristics of moral disengagement, where individuals rationalize unethical actions and suppress moral self-regulation to align their behaviors with personal or situational justifications.

In addition, the theoretical data provided insight into the antecedents and consequences of the concept. Antecedents included factors such as exposure to morally distressing environments, organizational limitations, role ambiguity, and lack of ethical support systems. These conditions often predispose individuals to morally disengage. The consequences identified from the literature involved the normalization of unethical behavior, gradual erosion of personal and professional ethical values, and reduction of internal moral conflict or emotional burden. These findings laid the foundation for the subsequent fieldwork phase and contributed to the final analytical definition of moral disengagement specific to ICU nurses.

Model case: A nurse working in a high-pressure ICU environment frequently faces ethically challenging situations. Due to persistent resource limitations and emotional exhaustion, she begins justifying certain unethical actions, such as withholding medications from critically ill patients with poor prognoses in favor of those with better outcomes. She mentally reconstructs her actions as being in the best interest of the system and experiences no guilt or remorse. The

antecedents include work overload, ethical ambiguity, and organizational constraints; the attributes demonstrated are moral justification, avoidance of moral responsibility, and pleasant cognitive reframing; and the consequences include normalization of unethical behavior and emotional detachment.

Opposite case: A nurse in a similar ICU setting is also exposed to morally stressful conditions but chooses to adhere strictly to professional ethical guidelines. Despite facing difficult decisions and institutional pressures, she seeks ethical consultation when in doubt and remains emotionally affected when care is compromised. In this case, there are no indicators of moral disengagement. The nurse maintains moral agency, experiences guilt when standards are threatened, and does not rationalize or normalize unethical actions. Thus, neither the attributes, antecedents, nor consequences of moral disengagement are present.

Fieldwork phase

The results of the fieldwork phase are derived from interviews conducted with 20 participants who were nurses working in ICUs. The average age of the participants was 40.9 (19.85) years, and additional demographic characteristics are provided in Table 2.

Table 2. Characteristics of participants in the fieldwork phase

Characteristics		N (%)
Sex	Male	9 (45%)
	Female	11 (55%)
Education level	B.SC.	10 (50%)
	M.Sc.	7 (35%)
	Ph.D.	3 (15%)
Marital status	Single	4 (20%)
	Married	16 (80%)
Years of working in the ICU (years)	Less than 5	4 (20%)
	5 - 10	9 (45%)
	More than 10	7 (35%)

Based on the analysis of interview data collected during the fieldwork phase, several key features of the concept of moral disengagement among ICU nurses were identified. These features, categorized under three main themes and their corresponding subthemes, reflect the real-life expressions of moral disengagement in clinical settings. Table 3 provides a structured overview of these themes for better conceptual clarity. The findings related to the concept of moral disengagement, derived from interviews conducted during the fieldwork phase (Supplementary 1), are as follows:

In the theme of illegitimate legitimization, which includes subthemes such as "commitment avoidance", "self-justification", and "pleasant cognitive reconstruction of the event", participants in the study explained that they attempt to infuse their unethical actions with an appearance of morality through justifications they construct in their minds. When a participant engages in an unethical act, they attempt to recall various dimensions of their actions and seek to legitimize them internally. By presenting logical reasons from their own perspective, they try to justify their behavior, believing that through this justification, they can provide a moral cover for commitments they have neglected. Consequently, this process helps them alleviate any unpleasant feelings they might experience.

Table 3. Features of the concept of moral disengagement in ICU nurses based on theoretical and fieldwork phase results

Phase of study	Main theme	Subthemes	Description
Theoretical phase	**Moral justification**	– Lack of guilt and remorse – Acceptance of deviant behavior as appropriate	Rationalizing unethical behaviors by convincing oneself that such behaviors are acceptable or justified in a given context, leading to a diminished sense of guilt and an increased acceptance of deviant behaviors as normal or necessary.
Fieldwork phase	**Illegitimate legitimization**	– Commitment avoidance – Self-justification – Pleasant cognitive reconstruction of the event	Justifying unethical actions to reduce internal conflict and legitimize the neglect of responsibilities.
	Assurance of security	– Job security – Psychological safety	Engaging in unethical actions to avoid punishment or mental distress and to maintain stability.
	Feelings of satisfaction	– Individual contentment – Organizational contentment	Gaining personal and institutional satisfaction through perceived beneficial but unethical acts.

In this context, Participant 9, who has ten years of experience working in the ICU, expressed:

"You see, for a patient who has metastasized and is in pain, you administer high doses of morphine to help alleviate their suffering. The higher the dose, the less pain the patient feels. When a patient is in such agony that they are continuously screaming, it disrupts the comfort of other patients. You do this to help them."

Participant 12, with five years of experience in the ICU, commented:

"During my shifts, I put the ward phone on hold or silenced the ringer. There's no reason to keep answering calls from family members while you are caring for a critically ill patient; that would waste time that should be dedicated to patient care."

Participant 3, who holds a Ph.D. in nursing and has eight years of experience in the ICU, stated:

"At 3:00 a.m., my patient was dying. He had been hospitalized in our ward for 29 days; it was really just imposing costs on his elderly father. Every day, I saw his father waiting outside, and it broke my heart. I reduced the light and set the FiO2 on the ventilator to 21%. I didn't pursue further invasive and costly interventions for him and instead dedicated more time to the patient in the adjacent bed, who was discharged three days later."

The next theme that emerged in this study is assurance of security, which includes subthemes of "job security" and "psychological security". In this context, participants indicated that when they engage in actions that contradict legal and ethical standards—while firmly believing these actions are justified and necessary—they do so to maintain a reassuring work environment and to prevent potential repercussions. Essentially, individuals try to label their unethical behaviors with a moral justification, thus shielding themselves from consequences that might include verbal or written warnings, financial penalties, or reassignment. Furthermore, participants showed that by attributing a moral label to their unethical actions, they create a psychological safe haven for themselves, alleviating feelings of guilt, remorse, fear of punishment, judgment, and ruminative thoughts. Over time, they have learned that convincing themselves of the righteousness of their actions ensures their psychological and job security.

In this regard, Participant 19, who has twelve years of experience in the ICU, expressed:

"*In our country, ethical topics are a double-edged sword. While you may be performing an ethical act, it can be perceived as unethical by your colleagues, and you might receive a warning from the nursing office. Therefore, you are compelled to keep certain actions that you believe will benefit the patient between yourself and your conscience to avoid punishment."*

Participant 7, with over ten years of ICU experience, shared:

"Sometimes, I choose not to document certain actions exactly as they occurred, especially when I believe that being too transparent might backfire. For example, if a medication was delayed due to a system error or staff shortage, I may write it in a way that avoids blame. I know this isn't fully ethical, but I do it to protect myself from unnecessary warnings or disciplinary measures. It gives me peace of mind and allows me to continue working without stress."

Participant 13, with three years of experience in the ICU, articulated:

"*There is a tendency toward both excess and deficiency in our country. For example, why would I perform gastric gavage for a patient with a GCS of 3? Why should I devote my time to a patient who will ultimately end up in the morgue? Instead, I would prefer to focus my attention on a younger patient who I believe has the potential to recover. If I were to tell this to my supervisor, I would quickly receive a reprimand. So, there is no reason to broadcast this everywhere."*

"We are under sanctions, as you know. We lack medications and facilities, and if our equipment malfunctions or encounters issues, no replacements are available. I wish they could understand this, so we wouldn't be expected to commit the actions that would lead to nursing errors. In fact, some of these tasks and forms of care are simply not feasible at this time."

In another theme, participants in the study expressed feelings of satisfaction through the subthemes of "individual contentment" and "organizational contentment". They indicated that when they perform actions that benefit either the patient or the organization, it generates a sense of personal gratification while simultaneously ensuring organizational approval. Individuals who rationalize their actions are often aware of their ethical codes and their own unethical practices; however, they believe that through moral justification, they maintain organizational satisfaction. Since the organization does not suffer harm as a result, this not only leads to organizational approval but also fosters a sense of self-worth in the individual.

In this regard, Participant 11 remarked:

"At one point, there was a shortage of intravenous Imipenem antibiotic. The family of a critically ill patient suffering from sepsis, who had significant connections, managed to procure a large quantity of this medication for their patient. If another family had attempted to obtain this drug, they would have faced not only difficulties in finding it but also the necessity of paying a substantial amount. After some time, the physician changed the prescription for this patient, and I saw no reason to inform the family about this. Instead, I decided to keep the remaining supply of the medication for other patients who needed it. When the physician found this out, he praised my decision a lot. I genuinely believed that I had acted wisely. If I had informed the family, they might have taken back the medication to sell it, which would have complicated matters."

Participant 8 further elaborated:

"I always report my patients' Four Score at least 4 to 5 points lower. It is uncertain what might happen in the ICU afterward. Families often come demanding answers; if their loved one passes away, they threaten to file complaints, which can damage the reputation of the ward, the doctor, and the hospital. There is no reason for the family to know about their patient's improvement until the patient is discharged from the ICU. This reflects prudent predictions; I like my cleverness."

Also, based on the findings of the study, the antecedents identified through the interviews with ICU nurses include factors such as exposure to morally distressing environments, work overload, role ambiguity, and lack of ethical support. These conditions predispose individuals to engage in moral disengagement as a coping mechanism.

As for the consequences, the findings reveal that moral disengagement leads to the normalization of unethical behaviors, erosion of personal and professional ethical standards, and diminished emotional distress regarding unethical actions. These consequences reflect the long-term effects of moral disengagement on both individual behavior and organizational culture in healthcare settings.

Final analysis phase:

In this phase, the final definition of "moral disengagement" among ICU nurses was derived by integrating findings from both the theoretical and fieldwork phases. The theoretical phase involved a comprehensive literature review to identify the attributes, antecedents, and consequences of moral disengagement, establishing a solid conceptual foundation primarily based on Bandura's social-cognitive theory. According to this theory, individuals use defensive mechanisms such as moral justification to disengage from their moral standards, thereby justifying unethical behavior without experiencing guilt or ethical distress. In the fieldwork phase, interviews with ICU nurses provided valuable insights into moral disengagement. Mechanisms such as commitment avoidance, self-justification, and pleasant cognitive reconstruction of events were identified, allowing ICU nurses to legitimize unethical actions. These findings also highlight that these behaviors can be aimed at preserving job security, psychological safety, and individual and organizational satisfaction. The final conclusion drawn from the findings of this study is that moral disengagement involves the use of protective mechanisms such as moral justification and legitimization through commitment avoidance, self-justification, and pleasant cognitive reconstruction of events to rationalize unethical actions, accept them as appropriate, and reduce emotional distress, all while striving to preserve job security, psychological safety, and individual and organizational satisfaction.

Furthermore, the final antecedents, attributes, and consequences of this concept can be described as follows:

The identified antecedents include exposure to morally distressing environments, work overload, organizational limitations, role ambiguity, and a lack of ethical support, all of which predispose nurses to engage in moral disengagement as a coping mechanism. The attributes of moral disengagement, noted in both phases, include commitment avoidance, moral self-justification, and pleasant cognitive reconstruction of unethical events. Finally, the study revealed several consequences of moral disengagement, including the normalization of unethical behaviors, erosion of personal and professional ethical standards, and diminished internal moral conflict and emotional distress about engaging in unethical practices. These consequences highlight the long-term effects of moral disengagement on both individual and organizational levels within healthcare environments.

Discussion

This study aimed to explore the concept of moral disengagement among ICU nurses. The final definition of moral disengagement, derived by integrating findings from both the theoretical and fieldwork phases, is as follows: "The employment of protective mechanisms of justification, pleasant cognitive reconstruction of the event, and commitment avoidance to legitimize unethical activities aimed at preserving job security, psychological safety, and individual and organizational satisfaction."

In this study, we developed a definition of moral disengagement specific to ICU nurses, integrating both Bandura's original framework and the unique challenges faced in the ICU setting. While Bandura's theory of moral disengagement provides a broad understanding of how individuals can disengage from their ethical standards, our definition specifically addresses how these mechanisms manifest within the highly demanding environment of ICU nursing. This distinction allows us to further refine the concept, making it more applicable to healthcare settings.

Bandura's (1990) model of moral disengagement outlines eight core mechanisms that enable individuals to justify unethical behaviors. These mechanisms include moral justification, euphemistic labeling, displacement of responsibility, and dehumanization, among others. According to Bandura, these cognitive strategies enable individuals to engage in harmful behaviors

without experiencing guilt or remorse. While these mechanisms certainly apply to ICU nurses, our study has identified additional context-specific mechanisms that better reflect the emotional, professional, and organizational pressures ICU nurses face.

The results of this study align with Bandura's social-cognitive theory, which highlights the cognitive mechanisms through which individuals justify unethical behavior. In line with the literature, moral justification emerged as a central theme in our study, serving as a key protective mechanism for nurses to rationalize unethical behavior. This finding supports previous research that emphasizes the importance of moral justification in moral disengagement (32, 33).

One notable contribution of this study is its emphasis on the concept of protective mechanisms, such as cognitive restructuring and avoidance of commitment, which go beyond Bandura's eight mechanisms of moral disengagement. These mechanisms were identified as significant in explaining how ICU nurses justify their actions in response to organizational and emotional pressures. These strategies enable nurses to justify their actions, even when they deviate from ethical norms, by framing their behaviors as necessary to preserve personal safety, job stability, and organizational satisfaction. The nurses in our study highlighted job insecurity, emotional exhaustion, and organizational dissatisfaction as factors contributing to moral disengagement. This demonstrates that moral disengagement is not only an individual phenomenon but is also strongly influenced by external organizational factors.

The important aspect that distinguishes our definition is the emphasis on organizational and contextual factors that influence moral disengagement in ICU nurses. While Bandura's framework largely focuses on individual-level cognitive distortions, our study highlights how organizational culture, job insecurity, limited resources, and emotional exhaustion contribute to the emergence of moral disengagement in the ICU setting. These external pressures are crucial in understanding how ICU nurses navigate ethical challenges and justify behaviors that may otherwise be considered unethical.

The findings of this study emphasize the role of psychological safety and organizational satisfaction as crucial elements that influence nurses' decisions to engage in morally disengaged behavior. Nurses who perceive their work environment as unsupportive or inequitable are more likely to engage in behaviors that undermine ethical standards. This finding adds to the growing body of literature on the impact of organizational culture and ethical climate on professional behavior (34).

The study also found that ICU nurses often perceive their actions, which may be considered unethical, as morally justifiable due to contextual factors such as heavy workloads, resource shortages, and difficult patient situations. This aligns with previous research suggesting that moral disengagement can occur as a coping strategy when nurses face resource constraints and emotional exhaustion (35, 36). In particular, when ICU nurses feel unsupported by their organizations or face excessive workloads and insufficient resources, they are more likely to disengage from their moral standards. The work environment plays a critical role in shaping how nurses perceive their actions and whether they can justify them. By integrating these organizational and contextual elements into the definition of moral disengagement, we offer a more comprehensive understanding of the phenomenon.

Ultimately, while our definition aligns with Bandura's original framework in recognizing the cognitive mechanisms that underpin moral disengagement, we have expanded and refined the concept to reflect the unique challenges and dynamics of the ICU nursing profession. This adaptation enhances the applicability of the theory in healthcare settings, offering a clearer picture of how ICU nurses navigate ethical dilemmas and highlighting the importance of addressing the organizational and environmental factors that contribute to moral disengagement.

Limitations

Discussing unethical incidents may lead interviewees to withhold complete

information during the interviews. However, the researchers made efforts to establish rapport and emphasized confidentiality in order to build trust with the participants. Moreover, while this concept analysis offers new insights and a more comprehensive view of moral disengagement among Iranian nurses in ICUs, we acknowledge that the single-country focus presents limitations concerning the generalizability of the findings. The cultural, social, and healthcare system differences between countries may influence nurses' experiences and perceptions of moral disengagement.

Recommendations

Due to the fact that the concept of moral disengagement has been defined, it is recommended that further studies be conducted using diverse methodologies. Additionally, research should be designed and implemented to develop and evaluate interventions and strategies that can enhance nurses' moral engagement.

Also, future qualitative research may aim to explore moral disengagement in nursing across diverse geographical and cultural settings to enrich the understanding of this phenomenon globally.

Conclusion

In this concept analysis, utilizing the hybrid model approach, the phenomenon of moral disengagement among Iranian nurses working in ICUs has been thoroughly explored by examining its various dimensions and underlying dynamics. The findings underscore the complex and multifaceted nature of moral disengagement, particularly within the high-pressure context of ICUs, where ethical challenges are frequent and intense.

Four central themes were identified in this study: 1) moral justification, 2) illegitimate legitimization, 3) assurance of security, and 4) feelings of satisfaction (Table 3). These themes shed light on the cognitive and emotional mechanisms that enable nurses to rationalize ethically questionable behaviors, often as a response to environmental stressors and organizational constraints. Moral disengagement, as revealed through this analysis, not only poses ethical risks but also has the potential to compromise patient safety and the integrity of professional care.

By offering a clear and operational definition of moral disengagement specific to ICU nurses, this study contributes valuable insights for researchers, educators, and policymakers. It enhances the recognition and understanding of this phenomenon and provides a strong foundation for the development of targeted interventions and policies aimed at preventing its occurrence and promoting ethical practice in critical care settings.

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Conflict of interest

There are no pertinent financial or non-financial interests to report.

Supplementary 1. Themes and subthemes that appeared in the fieldwork phase of the study

Themes	Subthemes	Quotation
Illegitimate legitimization	Commitment avoidance	"Sometimes when we have long-term patients who are not improving, I prefer to skip the invasive treatments that might require more commitment and just focus on the basics. That way, I can save my time and energy for other patients." (Participant 11)
	Self-justification	"When a patient is restless and won't allow us to attend to other patients, we may administer a stronger sedative. We convince ourselves that this will help the patient calm down and enable us to care for the other patients more effectively." (Participant 16)
	Pleasant cognitive reconstruction of the event	"Once, instead of dedicating my whole time to a patient with no chance of survival, I chose to spend more time caring for another patient who needed it more. I thought to myself that this decision was more just. At least one other person now has a better chance of recovery." (Participant 18)
Assurance of security	Job security	"I once witnessed a colleague giving a patient the wrong medication. I hesitated to speak up, thinking, 'If I address this, it might harm my relationship with the team and put my job at risk'." (Participant 20)
	Psychological security	"When I am unable to reach all of my patients, I remind myself that I am only one person and cannot perform miracles. This mindset helps alleviate some of the pressure I feel." (Participant 18)
Feelings of satisfaction	Individual contentment	"If I see a patient suffering greatly and decide not to provide any more suffering and invasive care, I tell myself I'm helping them suffer less. This mindset helps alleviate some of my own discomfort." (Participant 13)
	Organizational contentment	"When I have to write reports in a way that they really shouldn't be, just to make everything look neat, I tell myself: This is necessary to maintain organizational order. I'm not doing this to make mistakes, but to prevent problems for myself and the team." (Participant 8)

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