

Ethical Dilemmas among Healthcare Professionals in the Emergency Center of Tikur Anbessa Specialized Hospital, Addis Ababa, Ethiopia: A Mixed-Methods Study

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ABSTRACT

Background: Ethical dilemmas are intrinsic to emergency care, arising from tensions among respect for patient autonomy, resource allocation, confidentiality, and end-of-life decision-making. Data on the prevalence and nature of such dilemmas from emergency departments in low- and middle-income countries, including Ethiopia, remain scarce. This study aimed to determine the prevalence, nature, and determinants of ethical dilemmas among healthcare professionals in the Emergency Center of Tikur Anbessa Specialized Hospital (TASH).

Methods: An institution-based, cross-sectional, mixed-methods study was conducted in the Adult Emergency Center of TASH from 1 to 30 August 2025. Ninety Emergency and Critical Care Medicine (ECCM) residents and emergency nurses, selected by stratified random sampling, completed a structured, pretested questionnaire; 12 additional participants took part in two profession-specific focus group discussions. Quantitative data were summarized descriptively and analyzed by multivariable logistic regression; qualitative data were analyzed thematically and triangulated with the quantitative findings. Statistical significance was set at $p < 0.05$.

Results: Ethical dilemmas were common: 75.6% of participants reported resource-allocation dilemmas, 70.0% confidentiality/communication dilemmas, and 62.2% end-of-life dilemmas, driven mainly by shortages of ventilators, intensive care beds, oxygen, and essential medicines, compounded by culturally influenced expectations around communication and consent. Longer clinical experience was independently associated with lower odds of autonomy-related dilemmas (AOR 0.10; 95% CI 0.01-0.52; $p = 0.011$), whereas higher job satisfaction was associated with higher odds of resource-allocation dilemmas (AOR 5.4; 95% CI 1.2-23; $p = 0.02$). Sex, professional role, and prior ethics training were not significantly associated with dilemma occurrence. Qualitative accounts converged on themes of moral distress, emotional exhaustion, and decisional paralysis in the absence of institutional guidance.

Conclusions: Ethical dilemmas are frequent among healthcare professionals in this emergency center and appear predominantly structural. Strengthening resource availability, codifying institutional guidelines (including do-not-resuscitate policy), and embedding practical, case-based ethics training may reduce moral distress and support more consistent ethical decision-making.

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1. Introduction

Emergency departments are high-acuity, time-compressed environments in which clinicians must frequently make consequential decisions under clinical uncertainty and incomplete information. This operational reality generates a steady stream of ethical tension, as staff attempt to reconcile respect for patient autonomy with the competing imperatives of beneficence, non-maleficence, and distributive justice.^[1,2] The dilemmas that arise are rarely abstract: they concern whether to disclose a poor prognosis, how to preserve confidentiality when family members are present and emotionally invested, and how scarce life-sustaining resources should be allocated among patients with comparable need.^[3,4] Ethical practice in this setting therefore depends not only on clinical competence but on moral judgment, empathic communication, and the capacity to support patients and families through emotionally difficult decisions.^[5]

These challenges are magnified in resource-constrained health systems, where shortages of beds, ventilators, monitoring equipment, and essential medicines force clinicians into de facto rationing decisions that would rarely arise in better-resourced settings.^[6,7] Repeated exposure to such situations, particularly when clinicians recognize the ethically preferable course of action but are structurally prevented from pursuing it, is a recognized precursor of moral distress.^[8,9] Left unaddressed, moral distress is associated with emotional exhaustion, burnout, reduced empathic capacity, and attrition from clinical practice, compounding

strain on already fragile health systems.^[10] High-income health systems have partly mitigated these harms through institutional ethics committees, published guidelines, and clinical ethics consultation services; such infrastructure remains largely unavailable in many low- and middle-income countries (LMICs), leaving frontline staff to navigate ethically complex situations without structured support.^[11]

Evidence from Europe indicates that ethical difficulties, particularly around end-of-life care and disagreement with patients or families, are a near-universal feature of clinical practice, even where institutional ethics support exists.^[12] In sub-Saharan Africa, the absence of comparable infrastructure appears to intensify these difficulties: studies from South Africa and Ghana describe nurses and junior doctors encountering ethical dilemmas and professional role ambiguity with little formal preparation or institutional recourse.^[6,7] At the same time, research conducted during the COVID-19 pandemic showed how acute resource scarcity can fundamentally alter the character of professional obligation, compelling providers to make rationing decisions rarely required in well-resourced systems.^[13] Prevailing sociocultural and religious norms, under which family members often expect a central role in decisions about patient care, add a further layer of complexity distinctive to many African clinical contexts.^[8]

Within Ethiopia specifically, the ethical dimensions of emergency care remain poorly characterized. Available reports suggest that

resource shortages, overcrowding, and limited formal ethics education converge to intensify the ethical burden on residents and nurses, who provide most frontline emergency care, often without clear institutional guidance on triage, resuscitation, or end-of-life decisions. [10,11,14,15] Existing curricula have been criticized as overly theoretical and poorly aligned with the practical realities of high-acuity clinical environments, leaving many clinicians without confidence in their capacity to navigate ethically complex encounters. This gap constrains the development of evidence-informed institutional policy, targeted ethics curricula, and staff-support interventions.

The Emergency Department of Tikur Anbessa Specialized Hospital (TASH), Ethiopia's largest public referral and teaching hospital, manages a high volume of critically ill patients under conditions of intermittent resource scarcity, making it a relevant setting to examine this question. Accordingly, this study aimed to (i) determine the prevalence and principal categories of ethical dilemmas encountered by healthcare professionals in the TASH Emergency Center; (ii) identify sociodemographic, professional, and institutional factors associated with the major dilemma categories (autonomy, resource allocation, confidentiality, and end-of-life decision-making); and (iii) characterize, through the perspectives of residents and nurses themselves, the emotional and professional consequences of these dilemmas and how they are navigated in day-to-day practice.

2. Method

Study design, setting, and period

An institution-based, cross-sectional study employing a convergent mixed-methods design was conducted, in which quantitative and qualitative data were collected and analyzed

independently and integrated at the interpretive stage, allowing estimation of prevalence and correlates alongside an in-depth account of lived experience. The study was carried out in the Adult Emergency Center of TASH, Addis Ababa, Ethiopia's largest public teaching and referral hospital. Established in 1950, with its Faculty of Medicine formally recognized in 1963 and postgraduate training initiated in 1979, TASH's Department of Emergency and Critical Care Medicine (ECCM) was founded in 2010 in partnership with Addis Ababa University and international collaborators. The Emergency Center provides continuous, 24-hour tertiary emergency services staffed by ECCM consultants, ECCM residents, nurses, interns, and other detaching residents. Data were collected between 1 and 30 August 2025.

Study population and eligibility

The source population comprised all ECCM residents and nurses working in the Adult Emergency Center. Eligible participants had worked actively in the unit for at least six months and were present during the data-collection period. ECCM consultants and senior staff, residents from other departments on rotation, medical interns and nursing students, and staff on leave were excluded.

Sample size and sampling procedure

The quantitative sample size was calculated using the single-population-proportion formula ($Z_{\alpha/2} = 1.96$; assumed prevalence $P = 0.5$ in the absence of local estimates; margin of error $d = 0.05$), yielding an initial estimate of 384. Because the total eligible source population was small ($N = 100$; 45 ECCM residents, 55 nurses), the finite-population correction was applied, reducing the required sample to 80; a 10% allowance for non-response yielded a final target of 88, and 90 participants were ultimately recruited by

stratified random sampling proportional to professional cadre. For the qualitative component, 12 participants (6 residents, 6 nurses) were purposively sampled to ensure diversity by sex and years of experience and allocated to two profession-specific focus groups.

Data collection

Quantitative data were collected electronically via KOBO Toolbox using a structured, self-administered questionnaire adapted from previously used instruments assessing moral distress and ethical dilemmas in emergency care [16,17], modified for local context and organized into four sections: sociodemographic characteristics; frequency and type of ethical dilemma; institutional and resource-related factors; and professional factors. The instrument was piloted with 5% of the target sample to assess clarity and validity, and internal consistency was supported by a Cronbach's alpha of 0.75.

Qualitative data were collected through two semi-structured focus group discussions (one with residents, one with nurses; six participants each, a size informed by anticipated thematic saturation), using a guide adapted from published studies of healthcare workers' ethical experiences. [4,17] Discussions, conducted in English and Amharic in a private setting, lasted 60-90 minutes, were audio-recorded with participant consent, and were supplemented by field notes documenting non-verbal cues and group dynamics.

Data quality assurance

Completeness and internal consistency of quantitative data were checked daily during collection. Qualitative rigor was addressed through methodological triangulation, peer

debriefing, purposive sampling to support transferability, iterative re-analysis to support dependability, and maintenance of an audit trail with verbatim quotations to support confirmability. Data collection continued until thematic saturation was reached.

Data analysis

Quantitative data were exported from KOBO Toolbox, cleaned in Microsoft Excel, and analyzed in SPSS version 27. Descriptive statistics characterized participants and estimated the prevalence of ethical dilemmas; dilemmas reported as occurring daily or weekly were classified as "frequent." Variables associated with each dilemma domain at $p < 0.25$ in bivariate analysis were entered into four separate multivariable logistic regression models corresponding to resource allocation, confidentiality/communication, end-of-life decision-making, and autonomy. Multicollinearity was assessed using variance inflation factors (range 1.03-1.30) and tolerance statistics (range 0.85-0.93), indicating no material collinearity; model fit was assessed with the Hosmer-Lemeshow test ($p = 0.70-0.87$ across models). Pseudo- R^2 values ranged from 0.078-0.086 for the resource-allocation and end-of-life models to 0.34-0.36 for the confidentiality/communication and autonomy models. Associations are reported as adjusted odds ratios (AOR) with 95% confidence intervals; statistical significance was set at $p < 0.05$.

Qualitative data were analyzed using thematic content analysis combining inductive and deductive coding. Focus group recordings were transcribed verbatim and translated into English; an initial coding framework derived from the study objectives was iteratively refined during analysis, and codes were grouped into themes reflecting recurrent patterns in participants'

ethical experience. Reflexivity regarding the investigating team's own emergency medicine background was maintained throughout coding to mitigate interpretive bias. Quantitative and qualitative findings were triangulated at the interpretive stage, and results were reviewed by academic supervisors to enhance credibility.

Ethical considerations

The study protocol was approved by the Department of Emergency Medicine Research Ethics Review Committee. Written informed consent was obtained from all quantitative survey participants; verbal consent, including separate consent for audio-recording, was obtained from focus group participants. Confidentiality was maintained through de-identification with participant codes, and

recordings and datasets were stored securely with access restricted to the research team. Participants were informed of their right to withdraw at any time without consequence.

3. Result

Participant characteristics

Ninety healthcare professionals completed the quantitative survey (53.3% nurses, 46.7% ECCM residents), complemented by 12 focus group participants drawn in equal numbers from each cadre. Most survey respondents were male (63.3%) and aged 30-40 years (52.2%); most were single (70.0%). Among residents, the R3 level was most represented (41.5%); among nurses, 67.8% had 2-5 years of emergency department experience (Table 1).

Table 1. Sociodemographic and professional characteristics of healthcare professionals in the TASH Emergency Center (N=90).

Sex	Male	57	63.3
	Female	33	36.7
Age (years)	<30	40	44.4
	30-40	47	52.2
	>40	3	3.3
Profession	ECCM resident	42	46.7
	Nurse	48	53.3
Residency level (ECCM)	R1	11	28.3
	R2	15	30.2
	R3	16	41.5
Nurses' ED experience (years)	1-2	19	21.1
	2-5	61	67.8
	>5	10	11.1
Marital status	Single	63	70.0
	Married	24	26.7
	Divorced	2	2.2
	Widowed	1	1.1
Prior ethics training	Yes	24	26.7
	No	66	73.3
Satisfied with profession	Yes	63	70.0
	No	27	30.0

Percentages for residency level and nurses' ED experience are calculated within each subgroup (residents, n=42; nurses, n=48).

Prevalence and nature of ethical dilemmas

Ethical dilemmas were reported by a majority of participants across all domains assessed. When

“daily” and “weekly” responses were combined, resource-allocation dilemmas were most prevalent: 75.6% (n=68) of participants reported that inadequate resources had forced a difficult clinical decision, most often reflecting shortages of ventilators, oxygen, monitoring equipment, and intensive care beds (Table 2). Confidentiality- and communication-related

dilemmas were reported by 70.0% (n=63) of participants, principally arising when family members were present during clinical discussions or requested information on the patient's behalf; end-of-life dilemmas, particularly around resuscitation of patients perceived to be dying, were reported by 62.2% (n=56).

Table 2. Frequency of specific ethical dilemmas reported by healthcare professionals in the TASH Emergency Center (N=90).

Lack of resources forced a difficult decision	56.7	18.9	6.7	17.8
Confidentiality compromised by others present	51.1	18.9	17.8	12.2
Difficulty maintaining confidentiality due to family presence	43.3	25.6	15.6	15.5
Challenges disclosing information to the patient	44.4	28.9	7.8	18.9
Several patients require the same equipment	44.4	27.8	15.6	12.1
Challenges disclosing information to the family	41.1	24.4	13.3	21.1
Patient unable to communicate their wishes	38.9	38.9	5.6	16.6
Resuscitating a terminally ill patient	37.8	24.4	14.4	23.3

Qualitative accounts illustrated the clinical texture behind these figures. Participants described the distress of allocating a single available ventilator among several patients with comparable need, and of managing critically ill patients in lower-acuity triage areas because monitored beds were unavailable. Communication dilemmas frequently centered on tension between disclosing information directly to patients and deferring, per family expectation, to relatives as the primary recipients of clinical information; one participant described weighing a husband's request for confidentiality against his wife's deteriorating health, illustrating how competing duties of confidentiality and beneficence can come into direct conflict in this setting. End-of-life dilemmas commonly involved performing resuscitation regarded by the treating team as

non-beneficial, in the absence of an institutional do-not-resuscitate (DNR) policy and amid concern about family disagreement.

Decision-making, personal cost, and institutional context

When facing an ethical dilemma, most participants (76.7%) reported consulting colleagues rather than deciding independently (13.3%) or referring formally to a department head (32.2%); 18.9% reported feeling powerless to act. For decisions concerning unconscious or terminally ill patients, joint decision-making with family was the most common approach (67.8% and 62.2%, respectively), reflecting the centrality of family involvement in this context. Notably, 76.7% of participants reported having personally paid for a patient's treatment from their own funds, most commonly to save a life (40.5%) or

because they could not tolerate the patient's suffering (24.4%). This finding shows how frontline staff personally absorb structural resource gaps.

Institutional support for ethical decision-making was inconsistent (Table 3). While triage protocols were reported by most respondents

(76.7%), awareness of DNR guidelines (22.2%) and of guidelines for disclosure of medical error (14.4%) was low, and the large majority (83.3%) reported inadequate physical resources (beds, equipment, medicines) to deliver recommended care. Several participants were unaware of the existence or accessibility of the hospital's ethics committee.

Table 3. Availability of institutional guidelines and resources as reported by healthcare professionals at TASH Emergency Center (N=90).

Triage protocols for patient priority	76.7	13.3	10.0
Treatment guidelines for patient care	61.1	22.2	16.7
First-come, first-served resource distribution	56.7	33.3	10.0
ICU admission guidelines	55.6	24.4	18.9
Pain management guidelines	54.4	28.9	16.7
Operating room priority guidelines	35.6	28.9	35.8
Sufficiently qualified health workers	41.1	53.3	5.6
Routine disclosure of treatment costs	38.9	45.6	15.6
DNR (do-not-resuscitate) guidelines	22.2	47.8	30.0
Guidelines for disclosure of medical error	14.4	60.0	24.0
Adequate resources (beds/equipment/medicines)	13.3	83.3	3.3

Factors associated with ethical dilemmas

In multivariable logistic regression, longer clinical experience (≥ 5 years) was independently associated with substantially lower odds of autonomy-related dilemmas relative to less experienced staff (AOR 0.10; 95% CI 0.01-0.52; $p=0.011$) (Table 4). Higher job satisfaction was independently associated with higher odds of resource-allocation dilemmas (AOR 5.4; 95% CI 1.2-23; $p=0.02$). Sex, professional cadre, and prior ethics training were not significantly associated with either outcome after

adjustment. Model fit was adequate across all four domain-specific models (Hosmer-Lemeshow $p=0.70-0.87$), and variance explained was higher for the autonomy and confidentiality/communication models (pseudo- $R^2=0.34-0.36$) than for the resource-allocation and end-of-life models (pseudo- $R^2=0.078-0.086$), consistent with the qualitative observation that structurally driven dilemmas were less closely tied to individual-level characteristics than were dilemmas with a stronger interpersonal or experiential dimension.

Table 4. Factors associated with autonomy-related (Panel A) and resource-allocation (Panel B) ethical dilemmas, multivariable logistic regression, TASH Emergency Center (N=90).

Panel A. Autonomy/consent-related dilemma

Profession	Nurse	2.5 (0.4-14)	0.29
Years of experience (<5 vs >5)	>5 years	0.10 (0.01-0.52)	0.011*
Prior ethics training	Yes	0.6 (0.08-3.8)	0.57
Sex	Male	2.5 (0.5-12)	0.25
Job satisfaction	Yes	6.6 (0.8-55)	0.07

Panel B. Resource-allocation dilemma

Profession	Nurse	1.6 (0.5-5.3)	0.40
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Years of experience (<5 vs >5)	>5 years	0.7 (0.14-3.6)	0.69
Prior ethics training	Yes	2.3 (0.6-8.0)	0.20
Sex	Male	1.1 (0.3-3.3)	0.80
Job satisfaction	Yes	5.4 (1.2-23)	0.02*

AOR: adjusted odds ratio; CI: confidence interval. * $p < 0.05$.

Emotional and professional impact

Across both quantitative and qualitative data, participants described substantial emotional burden. Although only 18.9% endorsed “feeling powerless” as a general coping style, qualitative accounts described recurrent moral distress, emotional exhaustion, and what participants termed “moral residue” following ethically fraught encounters, particularly around futile resuscitation and rationing decisions. Several participants described a process of emotional desensitization over time, and others described a defensive orientation toward self-protection from perceived legal risk, which some framed as being in tension with patient-centered practice.

4. Discussion

This mixed-methods study found that ethical dilemmas are frequent, multidimensional, and predominantly structural in origin among healthcare professionals working in the Emergency Center of TASH. Consistent with evidence from other low- and middle-income emergency care settings, dilemmas most commonly stemmed from resource scarcity, followed by communication/confidentiality conflicts and end-of-life decision-making.^[12,18]

Resource-allocation dilemmas, reported by more than three-quarters of participants, mirror findings from Kenya and South Africa, where clinicians in similarly resource-constrained emergency and critical care settings routinely confront de facto rationing decisions.^[19,20] The qualitative accounts in this study, describing the emotional toll of allocating a single ventilator among multiple patients, suggest that these are

not abstract policy questions but recurrent, high-stakes clinical realities for frontline staff.

Confidentiality and communication dilemmas, affecting 70% of participants, appear closely tied to the sociocultural context of Ethiopian emergency care, in which family involvement in clinical communication is both expected and, at times, in direct tension with a patient's individual right to confidentiality and autonomous decision-making. This pattern is consistent with prior descriptions of family-centered decision-making norms complicating individual patient autonomy in African clinical settings,^[21] and suggests that ethics guidance developed in individualist, high-income contexts may require substantial local adaptation rather than direct adoption.

The prevalence of end-of-life dilemmas (62.2%) and the qualitative theme of performing resuscitation regarded as non-beneficial echo findings from other sub-Saharan African settings, where the absence of a formalized DNR policy leaves clinicians to negotiate emotionally and ethically difficult decisions on an ad hoc basis.^[22] Only 22.2% of participants in this study reported awareness of an institutional DNR guideline, suggesting that policy gaps, rather than clinician uncertainty about the underlying ethical principles, may be the more tractable target for intervention.

The independent association between greater clinical experience and lower odds of autonomy-related dilemmas is consistent with the broader literature on the maturation of ethical reasoning and communication skills through sustained clinical exposure.^[23] Qualitatively, participants

attributed this pattern to growing comfort with family communication and increasing confidence navigating ethically ambiguous situations, rather than to any reduction in the underlying frequency of ethically complex encounters.

The finding that higher job satisfaction was associated with greater odds of reporting resource-allocation dilemmas warrants cautious interpretation. Rather than implying that satisfaction causes dilemmas, this pattern is more plausibly explained by the moral-distress framework, in which clinicians most invested in providing guideline-concordant care may be more attuned to, and more troubled by, the gap between recommended and actually deliverable care.^[24] This interpretation is supported by the qualitative data, in which participants most committed to patient welfare described the greatest frustration when unable to deliver best-practice management.

The absence of a significant association between sex, professional role, or prior ethics training and dilemma occurrence, together with qualitative reports describing existing ethics training as largely theoretical and poorly aligned with clinical reality, is consistent with prior observations from other LMIC settings that formal training alone, without institutional infrastructure and case-based pedagogy, may be insufficient to meaningfully reduce the ethical burden experienced by frontline staff.^[25,26]

Reported institutional deficits, limited awareness of DNR and medical-error-disclosure guidelines, and the near-universal perception of inadequate physical resources align with the broader literature associating structural constraints, rather than individual moral failure, with the ethical dilemmas and moral distress experienced by emergency and critical care clinicians in resource-limited settings.^[27,28] The convergence

of quantitative and qualitative findings on moral distress, emotional exhaustion, and self-protective behavior in the face of perceived legal risk aligns with the global moral-injury literature describing the psychological toll of repeated exposure to ethically constrained clinical decision-making.^[29-31]

Taken together, these findings suggest that ethical dilemmas in this setting arise predominantly from systemic and institutional gaps, resource scarcity, absent or unclear guidelines, and communication structures poorly adapted to local sociocultural expectations, rather than from deficits in individual clinician judgment. Addressing these gaps directly, rather than relying solely on individual-level ethics education, is likely necessary to meaningfully reduce moral distress and support more consistent, ethically defensible decision-making in this and comparable settings.

Limitations

This study has several limitations. The cross-sectional design precludes causal inference regarding the associations identified. Self-reported data on dilemma frequency and personal financial contributions to patient care may be subject to recall and social-desirability bias. As a single-center study, findings may not generalize to other Ethiopian or regional emergency care settings with different resource profiles or staffing structures. Certain organizational and cultural factors that may influence ethical decision-making were not systematically captured by the study instruments. We also note, and recommend resolving prior to submission, the internal inconsistencies described above between certain narrative and tabulated sociodemographic figures (prior ethics training and, across the two regression models, the ethics-training subgroup

counts), which should be reconciled against the primary dataset.

5. Conclusion

Ethical dilemmas are common among healthcare professionals in the TASH Emergency Center and appear to arise predominantly from structural and institutional gaps rather than individual failings. More experienced staff reported fewer autonomy-related dilemmas, while more satisfied staff more often identified resource-allocation dilemmas, a pattern consistent with a moral-distress framework in which engaged clinicians are most attuned to gaps between recommended and deliverable care. Strengthening resource availability, codifying institutional guidelines for do-not-resuscitate decisions and medical-error disclosure, and reorienting ethics education toward practical, case-based training may reduce moral distress and support more ethically consistent emergency care in this and similar resource-constrained settings. Priorities for future work include multicenter replication with larger samples and longitudinal designs capable of examining the relationship between moral distress, staff retention, and patient-care quality over time.

Abbreviations

AOR, adjusted odds ratio;
CI, confidence interval;
DNR, do-not-resuscitate;
ECCM, Emergency and Critical Care Medicine;
ED, emergency department;
FGD, focus group discussion;
ICU, intensive care unit;
LMIC, low- and middle-income country;
TASH, Tikur Anbessa Specialized Hospital;
VIF, variance inflation factor.

Author Contributions

All authors contributed to the conception and design of the study. Data collection was coordinated by the corresponding author with support from the research team. All authors contributed to data analysis and interpretation, drafted and critically revised the manuscript for important intellectual content, and read and approved the final manuscript.

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Competing interests

The authors declare no conflict of interest.

Data Availability

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References

1. Iserson KV, Heine CE, Larkin GL, et al. Ethical dilemmas in emergency medicine. *Emerg Med Clin North Am.* 2008;26(3):409-32.
2. Heffernan DE, Heilig S. Ethical issues in emergency room care. *West J Med.* 1999;171(5):302-5.
3. General Medical Council. Treatment and care towards the end of life: good practice in decision making. London: GMC; 2020.
4. Downar J, et al. Ethics teaching in emergency medicine: the Canadian experience. *CJEM.* 2012;14(5):330-7.
5. Whitehead PB, Herbertson RK, Hamric AB, Epstein EG, Fisher JM. Moral distress among healthcare professionals: report of an institution-wide survey. *J Nurs Scholarsh.* 2015;47(2):117-25.

6. Bruce JC, et al. Ethical dilemmas and moral distress in emergency nursing: a South African perspective. *Curationis*. 2015;38(1):1-9.
7. Adams A, et al. Ethical decision-making in clinical practice in Ghana. *BMC Med Ethics*. 2016;17(1):61.
8. Tadele H, Habte D, Adane T. Ethical challenges in clinical practice in public hospitals of Ethiopia: a qualitative study among health professionals. *Ethiop J Health Dev*. 2016;30(1):50-6.
9. Al Ahwal MS, Al Zahrani AM, Alzahrani H, Kurdi A, Bajouh OS. Medical ethical dilemmas among physicians in Saudi Arabia: a cross-sectional survey. *J Family Community Med*. 2018;25(2):109-14.
10. Ali H, Yassin M, Hailu S. Challenges in the emergency healthcare system in Ethiopia: a review. *Ethiop J Health Dev*. 2020;34(4):203-10.
11. Demessie Y, Tadesse M, Fekadu A. Perceived ethical challenges among healthcare professionals in Addis Ababa: a cross-sectional study. *BMC Med Ethics*. 2022;23(1):15.
12. Hurst SA, Perrier A, Pegoraro R, Reiter-Theil S, Forde R, Slowther AM, et al. Ethical difficulties in clinical practice: experiences of European doctors. *J Med Ethics*. 2007;33(2):51-7.
13. Johnson M, et al. Institutional ethics support in emergency medicine: a qualitative study. *J Med Ethics*. 2022;48(3):195-202.
14. Yimer A, Belay A. Knowledge, attitudes and practices of ethics among medical residents in Addis Ababa. *Ethiop J Health Dev*. 2021;35(1):44-51.
15. Melaku T, Mohammed A, Abate A. Knowledge and attitudes of health professionals about medical ethics in Ethiopia. *Ethiop J Health Sci*. 2021;31(2):179-87.
16. Chala W. Ethical dilemmas and decision-making process in emergency departments: experience of physicians in public hospitals, Addis Ababa, Ethiopia [master's thesis]. Medtigo; 2023.
17. Miljeteig I, Defaye F, Desalegn D, Danis M. Clinical ethics dilemmas in a low-income setting - a national survey among physicians in Ethiopia. *BMC Med Ethics*. 2019;20(1):63.
18. Kabinga P, et al. Emergency medicine ethics in resource-limited settings. *Afr J Emerg Med*. 2020;10(3):150-6.
19. Benatar S, Fleischer T, Kuhn L. Resource allocation in LMIC emergency centers. *S Afr Med J*. 2018;108(6):452-8.
20. Brown S, et al. Ethical challenges in emergency medicine in LMICs. *BMC Emerg Med*. 2021;21(1):1-10.
21. Molyneux CS, et al. Communication and ethics in African hospitals. *Soc Sci Med*. 2012;75(5):877-84.
22. Dawson A, et al. End-of-life decision-making in African hospitals. *J Bioeth Inq*. 2020;17(1):45-56.
23. Campbell AV, et al. Medical ethics maturity and experience. *J Med Ethics*. 2016;42(3):187-94.
24. Epstein EG, Hamric AB. Moral distress, moral residue, and the crescendo effect. *J Clin Ethics*. 2009. [volume/issue/pages to be confirmed by the author against the original source before submission]
25. Oluoch P, et al. Ethical practice among emergency professionals in Kenya. *East Afr Med J*. 2020;97(10):1623-34.
26. Fisseha M, et al. Ethical dilemmas among Ethiopian clinicians: a cross-sectional study. *Ethiop J Health Sci*. 2021;31(4):623-32.
27. Downar J, et al. Guidelines for the withholding and withdrawal of life-sustaining treatment. *Intensive Care Med*. 2014;40(12):1818-31.
28. Rady MY, Verheijde JL. Do-not-resuscitate orders, futility, and end-of-life care in resource-limited settings. *J Med Ethics*. 2016;42(6):364-9.
29. Dean W, Talbot S, Dean A. Reframing clinician distress: moral injury. *BMJ*. 2019;364:l136.
30. Austin CL, Saylor R, Finley PJ. Moral distress in physicians and nurses. *AJOB Neurosci*. 2017;8(2):7-15.

31. Lamiani G, et al. Moral distress in emergency clinicians. *Emerg Med J.* 2017;34(4):240-5.