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OPEN PEER REVIEW

Ethical Challenges Experienced by Physicians and Nurses in Caring for Patients with COVID-19: A Qualitative Study

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About this report

This open peer review (OPR) report shows the public comments made on this article during peer review, by the reviewers, the associate editor and the editor-in-chief, for every revision round, together with the authors' replies. Comments appear only with the consent of the people who wrote them. Reviewers who chose to sign their report are named; the others are shown as "Referee". Comments are edited for language only, and confidential remarks to the editors are not included.

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1 Original submission

3 comments · 19 Aug 2022 – 21 Aug 2022

Referee 1 Reviewer

MINOR REVISION 19 Aug 2022

I appreciate the authors' efforts, especially in choosing a subject concerning these days' tragedy.
Comments:
- Given the methodology of the study, "qualitative study" and the country/city should be indicated in the title.
- As indicated in the demographic characteristics of the participants, all are physicians or nurses; then could "HealthCare professionals" be used in the title of the study?
- The country/city should also be mentioned in the objectives (aim) part of the abstract.
- It would be better to rephrase the results part of the abstract, rather than just indicate the categories.
- I didn't understand how the authors derived "especially nurses" (line 17 of introduction) from the 7th reference.
- I suggest that the authors define "ethical challenges" somewhere (e.g., in the Introduction), as this term is also challenging.
- Although the authors indicated that the key participants were 18 healthcare professionals, only physicians & nurses participated. Healthcare professionals also include others, such as laboratory technologists, radiology technologists, medical engineers, and so on.
- Although the authors paid attention to maximal variation, the workplace & specialty columns in table (1) do not show that.
- It could be informative if the wards in which the participants worked were also mentioned (e.g., ER, ICU, …).
- It would be good if the authors provided their approach and references for the measures used to achieve trustworthiness.
- Please indicate whether participants were eligible to withdraw from the study (in ethical considerations).
- If we accept (!) Graneheim and Lundman's literature review as an approach to conventional content analysis, would the authors explain why there is nothing about "meaning units" or "codes" and why they jump from "Quotation" or "statement" to subcategories?
- I didn't understand why there is a column in table 2 filled with the phrase "main categories".
- Could the authors clarify why the interpretation processes did not develop a "theme" or "main categories"?
- The 4th category, "Moral Distress", seems to be on the same semantic level as the concept of "ethical challenge"; therefore, it may not be an appropriate choice in line with the study goals.
- In the 1st subcategory of the 4th category, whose negative attitudes did you mean? (This should be clear.)
- The "Quotations" for the 3rd subcategory of the 4th category indicate an unethical climate rather than an uncertain one.
- Many statements in the discussion section just repeat the results section. They may need revision.
- In line 17 of discussion, the suggestion for addressing the 2nd category is "enhancing professional care", and the 1st category is "poor professional care"! This could be a fallacy.
- The conclusion ends with "especially the nurses." How does this follow from the current study?
regards

Associate Editor

MINOR REVISION 20 Aug 2022

dear Dr Akrami
Thank you for submitting the manuscript "Ethical Challenges Experienced by Healthcare Professionals in Caring for Patients with COVID-19" to Shiraz E-medical Journal. The reviewer has made the following

comments:
- Given the methodology of the study, “qualitative study” and the country/city should be indicated in the title.
- As indicated in the demographic characteristics of the participants, all are physicians or nurses; therefore, could “Health Care professionals” be used in the title of the study?
- The country/city should also be mentioned in the objectives (aim) part of the abstract.
- It would be better to rephrase the results part of the abstract, rather than just indicate the categories.
- I did not understand how the authors interpreted “especially nurses” (line 17 of the introduction) from the 7th reference.
- I suggest that somewhere (e.g., in the Introduction), the authors define “ethical challenges”, as this is also challenging.
- Although it is stated that the key participants were 18 healthcare professionals, only physicians & nurses participated. Healthcare professionals also include others, such as laboratory technologists, radiology technologists, medical engineers, and so on.
- Despite the authors’ attention to maximal variety, the table (1) columns for workplace & specialty do not show this.
- It would be informative if the wards in which the participants worked were also mentioned (e.g., ER, ICU, …).
- It would be good if the authors provided their approach and references for the measures for achieving trustworthiness.
- Please indicate whether participants were eligible to withdraw from the study (in ethical considerations).
- If we accept (!) Graneheim and Lundman’s literature review as an approach in conventional content analysis, would the authors explain why there is nothing about “meaning units” or “codes” and why the analysis jumps from “Quotation” or “statement” to subcategories?
- I did not understand why there is a column in table 2 that is filled with the phrase “main categories”.
- Could the authors clarify why the interpretation processes did not produce a “theme” or “main categories”?
- The 4th category, “Moral Distress”, seems to be on the same semantic level as the concept of “ethical challenge”; therefore, it may not be an appropriate choice in line with the study goals.
- In the 1st subcategory of the 4th category, whose negative attitudes did you mean? (This should be clear.)
- The “Quotations” for the 3rd subcategory of the 4th category indicate an unethical climate rather than an uncertain one.
- Many statements in the discussion part merely repeat the results section. These may need revision.
- In line 17 of the discussion, the suggestion for addressing the 2nd category is “enhancing professional care”, and the 1st category is “poor professional care”! This could be a fallacy.
- The conclusion part ends with “especially the nurses.” How does this follow from the current study?

Editor-in-Chief MINOR REVISION 21 Aug 2022

Minor Revision

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Revision 1

AUTHORS' RESPONSE TO REVIEWERS

Authors' reply to reviewers

The next pages contain the authors' point-by-point reply to the comments of this revision round, as submitted with the revised manuscript. It is published as the authors wrote it.

In the name of God

With greetings and respect, and with thanks for the comments of the respected reviewers, the following points are stated in response to the respected reviewers:

Title, abstract, and introduction:

Although nurses and physicians constitute the major part of frontline health professionals, the term nurses and physicians was used as recommended by the respected reviewer.

As recommended by the respected reviewer, "qualitative study" was added to the title, and the city and country of the study location have been given in the Methods section.

The abstract of the article was completed.

The term "ethical challenges" was briefly explained.

The explanations related to reference number 7 were corrected and its reference was replaced.

Methods:

The ward where the participants served was written in the table, and the method used regarding the rigor of the study was added. As explained in this section, presenting quotations is one of the methods of showing the rigor of the study and its objectivity. Also, stopping the interview with a participant if they were unwilling to continue was added to the ethical considerations section.

If we accept (!) Graneheim and Lundman's literature review as an approach in conventional content analysis, would the authors illustrate why there is nothing about "meaning units" or "codes" and jumping from "Quotation" or "statement" to sub-categories

Results:

The limitation on the number of words used in this section, as intended by the respected managers and experts of the journal, made selecting, keeping, and deleting words difficult. Ultimately, meaning units and open codes were chosen for trimming and modification, so as to introduce fewer structural and content problems into the body of the article. For example, one of the selection criteria was that "the researchers' intent could be conveyed indirectly but close to the intended meaning". Despite the explanations submitted, in accordance with the instruction of the respected reviewer, several meaning units and open codes, within the limit set by the

respected journal regarding the number of words, were submitted in the form of a table.

- Didn’t get why there is a column in table 2 which filled with the phrase “main categories”.- Thank you. We did not write “main categories”; we have written “main challenges”. It is not unusual or uncommon; nevertheless, we deleted this column.

- May the authors clarify why the interpretations processes did not develop “theme” or “main categories”.

- Thank you. Given the word limit of the article according to the opinion of the respected managers and experts of the journal, selecting, keeping, and deleting words, and consequently including some second-priority sections, became difficult. Therefore, examples were provided in the form of the table that has been submitted.

The 4th category “Moral Distress” seems to be on a same semantic level with concept - .of “ethical challenge”; then may not be an appropriate choice in line with study Goals

- Thank you. Moral distress is a theme or title from the set of subtitles under ethical challenges. "Ethical challenge" is a "general topic" that contains the label or title of a set of conflicts, dilemmas, and multi-way dilemmas facing an ethical action. Moral distress, in the best conditions, is a state that accompanies us in normal conditions, and its intensity and frequency increase in crisis conditions. Of course, this description is itself a good reason for the argument that professionals will be able to manage it by acquiring or improving some job-related, professional, and social skills.

- 1st sub-category of 4th category, whose negative attitudes did you mean? (Should be clear)

- Thank you. These negative attitudes arise from various actions and reactions, including the behavior of colleagues, patients, their families, our own families, etc.; however, all these inputs are analyzed and, through a process, create an inner dissatisfaction between what we should do and what we do or even will do. We applied the respected reviewer's critique regarding increasing the clarity of the main stakeholder in the text and substituted the phrase " poor evaluation ".

The “Quotations” for 3rd sub-category of 4th category, more indicate unethical climate - .rather than uncertain

- Thank you. Yes, we consider the reviewer's remark accurate and correct, and we believe our findings show that a set of structural, added, or induced

factors, which interpretively can be ethical or unethical, affect the behaviors of professionals by influencing their general climate. Obviously, it starts first by affecting the environment (whether physical, psychological, social, organizational, or . . .), and then, by internalizing the phenomenon, the joint effect of the environment and the person appears as "professional performance". Because of the crisis conditions and the unethical performance of some care providers, the term weakening of the ethical climate was used, the continuation of which will lead to the persistence of an unethical climate.

Discussion:

The Discussion section of the article was revised.

2 Revision 1

1 comment · 22 Oct 2022

Associate Editor

ACCEPT 22 Oct 2022

accept