International Medical Society
http://imedicalsociety.org

International Archives of Medicine
Section: Nursing
ISSN: 1755-7682

2016
Vol. 9 No. 83
doi: 10.3823/1954

Experiences of Moral Distress in Nurses' Daily Work

ORIGINAL

Flávia Regina Souza Ramos[1], Carolina da Silva Caram[2], Lívia Cozer Montenegro[3], Beatriz Santana Caçador[4], Edison Luiz Devos Barlem[5], Maria José Menezes Brito[6]

1 PhD in Philosophy. Professor at the Federal University of Santa Catarina Nursing School. Belo Horizonte, Minas Gerais, Brazil.
2 PhD student at the Federal University of Minas Gerais Nursing School. Belo Horizonte, Minas Gerais, Brazil.
3 PhD in Nursing. Professor at the Federal University of Minas Gerais Nursing School. Belo Horizonte, Minas Gerais, Brazil.
4 PhD student at the Federal University of Minas Gerais Nursing School. Belo Horizonte, Minas Gerais, Brazil. Professor at the Federal University of Viçosa. Viçosa, Minas Gerais, Brazil.
5 PhD in Nursing. Professor at the Federal University of Rio Grande do Sul, School of Nursing, Graduate Program. Rio Grande, RS, Brazil.
6 PhD in Administration. Department of Nursing applied. Professor at the Federal University of Minas Gerais Nursing School. Belo Horizonte, Minas Gerais, Brazil.

Contact information:

Carolina da Silva Caram.

caram.carol@gmail.com

Abstract

Background: Moral distress in the work of nurses has been an emerging ethical problem in the different levels of complexity in the Brazilian scenario. Objective: raise the situations perceived by nurses working in different health services across the country, as generators of moral distress.

Methods: This is a descriptive study of quantitative approach, of survey type. The study was developed with 771 nurses that working in health services of different levels of complexity in the Brazilian scenario. The data were collected in open instrument, they were asked to identify work situations triggering potential mental distress/suffering. Data were statistically analyzed using SPSS statistical software and later organized in tables at the 2010 version of Excel®.

Findings: In the survey, were cited 2304 situations of Moral Distress. The situations involve Working Conditions; Professional Relations; Professional Competence; Quality of Care; Access; Labor Organization and Conflict. Conclusions: it becomes important to reflect on the role of the nurse and the development of an ethical and autonomous practice in their daily tasks, given that moral distress deprived nurses from their roles.

Keywords
Nursing; Ethics; Working Conditions.

Introduction

Moral distress in health work has been an emerging ethical problem in the different scenarios that make up the health services network. Nurses, in addition to being a significant number of professionals in the health services, experience situations in their daily work that are potential triggering of moral distress, harming them individually, the profession and the health services [1].

The concept of moral distress emerged in nursing studies in the 80s, in the United States, and was described as a psychological imbalance experienced by individuals when faced with obstacles that prevent or hinder their intervention in reality and the adoption of attitudes and behaviors considered correct and in line with their moral judgment. Extensively studied in clinical scenarios of that country, it has also been research object in other countries, such as Brazil. Applications, amplitude, potentialities and limitations of these studies have already been discussed [2, 3]. Even considering the diversity of situations studied, researchers share the idea of the significant impacts that can affect the professional and the professional care, besides the importance of understanding its origin. The key point of moral distress is when the individual recognizes their responsibility, weaves their moral judgment, elects the conduct they deem appropriate to intervene in the situation, but does not find conditions to act as they judgment and values, understanding their moral participation as inadequate [4, 5, 6].

In the context of work, moral distress can withdraw from the individual their action potential, turning them into a passive person in different circumstances, strengthening coercive practices and existing domination states. This may be related to the problem of professional invisibility, a phenomenon that is studied in nursing when uncritical positioning and loss of leadership reduce the visibility of professional action, hampering their relationship with the team, causing pain and interfering with their autonomy [7].

The moral distress of nursing professionals in Brazil have showed that among the main causes, there is highlight for the lack of material and human resources, difficulties in interpersonal relationships at work, disrespect for patients' rights, death, low pay and exhaustive workload [8]. So, the sources of moral distress encompass aspects of the management and organization of services, such as poor working conditions, lack of resources and personnel, lack of institutional support, weaknesses in the humanization of care and interpersonal relations, disrespect to the rights of patients and their autonomy, wrongful death and others [5, 4].

Besides the aspects mentioned above, it is worth mentioning the fact that nurses deal every day with paradoxes and ambiguities relating to life and death, pain and pleasure, grounded in intense human relationships. Moreover, it is noteworthy that the group of actors in health area experiences the antagonistic condition of competing and cooperating, because on the one hand, the professionals are compelled to provide patient needs with quality, through humanized actions focused on the comprehensiveness of individuals. Furthermore, they are pressed to ensure results, implement innovations, expand access and reduce costs in order to meet the expectations of organizational managers [9].

Nurses experience contradictory situations that interfere in decision making, given the constant demands emerging from their professional practices. Studies in different levels of health care and in different scenarios of Minas Gerais have showed the existence of daily practices marked by the confrontation of adverse situations related to procedural, structural and managerial issues, which impairs the work dynamics and the quality of care [10, 11, 12]. Such situations have reverberated not only in objective issues, but also in the subjectivities of health workers, producing physical and emotional imbalances, causing them to experience moral distress and identity breakouts.

In this sense, it is essential that the work is structured and organized in order to allow professionals to recognize themselves in this dynamic and to act in accordance with their moral values. It is necessary to know the potential situations experienced by nurses in the daily work generating moral distress, given that, better understanding the work of nurses will help the institution to develop ways to prevent moral distress [1]. Thus, this study investiga-

tes potential triggering situations of moral distress in nurses' daily work.

The fact that studies on moral distress in the Brazilian Nursing are still scarce, especially in relation to the international context, motivated the development of a scale for measuring intensity and frequency of moral distress in this context. The original American instrument, Moral Distress Scale, of Corley, has been validated and subsequently adapted in Brazil in 2012 and 2014, respectively [13]. The first stage of the building process of this instrument was the completion of the survey presented here, which aimed to raise the situations perceived by nurses working in different health services across the country, as generators of moral distress.

Methods

This is a descriptive study of quantitative approach, of survey type. The survey research is understood as an empirical verification method that involves the collection and measurement of data that serve as a permanent source of information about opinions, actions or characteristics of a particular group of people listed as representatives of a population [14].

The population consisted of nurses working in health services of different levels of complexity in the Brazilian scenario, who attended the course on nursing care lines, in online education modality, offered by the Nursing Department at UFSC. Through an open instrument, they were asked to identify work situations triggering potential mental distress/suffering, after the conceptualization of it, also indicating the intensity and frequency of these situations. The collection procedure adopted was on site, during physical meetings in the Brazilian states where the specialization course mentioned was developed.

The sampling method was non-probabilistic by convenience, considering the presence and availability of participants at the place and time of the interview, that is, during the physical meeting held concurrently in all capitals (26 states and Federal District) of Brazil. Of the 1,050 nurses present, 771 signed the Informed Consent Form, after receiving invitation and information on the survey and answered the instrument.

Data were statistically analyzed using SPSS statistical software (Statistical Package for Social Sciences), version 13.0 and later organized in tables at the 2010 version of Excel®.

Results

The 771 nurses covered the Northeast (39.9%) North (21.4%), Southeast (17.2%), South (10.5%) and Midwest (10.2%) regions; 87% were female and 13% were male and the majority (44.6%) were aged between 31 and 40 years. Regarding the number of employments, 47.6% had one bond and 45.1% had two bonds, and most worked in hospital services (52.2%), followed by primary health care (27.9%). 131.9% worked in public and 11.6% in private institutions and 61.08% of professionals had been working in the service for 1 to 5 years and 40.87% for 5 to 10 years. With regard to professional qualifications, 75% of nurses had post-graduation and 8.4% had a master's degree.

Regarding potentially triggering situations of Moral Distress, the 771 subjects who participated in the survey cited 2304 situations. The situations were grouped into categories and codes, preserving the authenticity of which was answered by the research participants. The categories were grouped into 8 codes, named by researchers who explain common features of the same code. The codes are: Working Conditions (WC); Professional Relations (PR); Professional Competence (PC); Quality of Care (QC); Access (AC); Labor Organization (LO); Conflict (CO); Others (O), as shown in **Table 1**.

It is noticed that, of the 2304 situations mentioned by the respondents, 22.96% were related to working conditions, followed by situations of Pro-

Table 1. Frequency of Codes.

Codes	Quantity	%
Working Conditions	529	22.96
Professional Relations	524	22.74
Labor Organization	316	13.72
Professional Competence	293	12.72
Conflict	264	11.46
Others	186	8.07
Quality of Care	112	4.86
Access	80	3.47
Total	2304	100

Source: Developed for purposes of this study (2015).

fessional Relations (22.74%). Other situations that appear with considerable frequency were those related to Labor Organization (13.72%), Professional Competence (12.72%) and Conflict (11.46%). As regards the codes Access, Quality of Care and Others (situations that do not match the defined codes), these showed lower frequencies, being, respectively, 3.47%, 4.86% and 8.07%.

The codes were divided into categories, which describe different potential situations triggering of moral suffering **(Table 2)**.

Table 2. Demonstrative of codes and their corresponding categories.

Categories		Quantity	%
Working Conditions	WC		
Reduced materials	4	156	29.49
Precarious/inadequate structure	8	115	21.74
Reduced human resources	5	67	12.67
Overload	3	67	12.67
Lack of medication	7	35	6.61
Low pay	9	34	6.43
Unskilled human resources	6	23	4.35
Difference of salary	11	21	3.97
Unequal workload	2	18	3.40
Insalubrity	10	15	2.83
Excessive workload	1	12	2.26
Different employment bonds	12	10	1.90
Professional Relations	PR		
Abusive Relations from Managers	9	99	18.89
Disrespect/Lack of education among staff	6	92	17.56
Lack of integration and dialogue	5	88	16.79
Feeling wronged/broken	3	71	13.55
Disputes between the teams	10	55	10.50
Moral/Sexual Harassment	2	51	9.73
Abusive relationships with the doctor	4	26	4.96
Insubordination	8	21	4.00
Disrespect/lack of education from the boss	7	20	3.81
Bullying/depreciation	1	11	2.10
Labor Organization	LO		
Lack of support from managers/ Class entities	3	108	35.64
Lack of scientific and technical support	5	54	17.82
Reference and counter-reference	9	51	16.83
Relocation and arbitrary distribution	2	21	6.93
Ineffective communication	1	19	6.27
Individual demands	4	14	4.62
Inadequate routines for biosafety	7	9	2.97
Organizational culture	9	5	1.65
Contradictions in the exercise of management	8	4	1.32
Professional competence	PC		
Non-recognition (image, enhancement)	1	68	23.21
Lack of commitments to the service	6	66	22.53
Not being able to...	3	43	14.68
Performing the competence of others	2	41	13.99
Team negligence	9	19	6.48
Low autonomy	10	18	6.14
Function deviance	4	17	5.8
Medical malpractice	5	17	5.8
Nursing negligence	7	10	3.41
Lack of technical mastery	8	9	3.07

Categories		Quantity	%
Conflict	CO		
Professional X User	10	63	23.86
Hierarchy		41	15.53
Omission against the conflict/ Impotence	8	40	15.15
As for the medical management	1	28	10.60
As for one's own conduct	3	28	10.60
User demand x Service Demand	2	24	9.09
Professional x Family member	6	11	4.17
Discrimination of responsibility (focused guilt)	5	9	3.41
As for the conduct of another nurse	9	7	2.65
Institution x Teaching	7	6	2.27
Professor X Student	12	6	2.27
As for beliefs	11	4	1.52
Others	O		
Political interference/bribes	2	89	47.85
Lack of ethics	3	39	20.97
Violence	5	29	15.59
Symptoms/Feelings Moral Suffering	6	24	12.90
Transfer of funds	1	8	4.30
Lack of affinity with the service	4	8	4.30
Quality of Care	QC		
Inadequate care	1	85	78.70
Non-humanized care	2	22	20.37
Preventable deaths	3	2	1.85
Lack of communication	4	1	0.93
Underreporting/Under information	5	1	0.93
Access (AC)	AC		
Right to health	4	44	55.00
Lack of Medical Care	1	19	23.75
Ineffective host	2	13	16.25
Social vulnerability	5	3	3.75
Lack of access to birth	3	1	1.25

Source: Developed for purposes of this study (2015)

With regard to Working Conditions (code WC), professionals cited most frequently work with reduced materials (29.49%), poor/inadequate structure (21.74%), reduced human resources (12.7%) and overload (12.67%). In Professionals Relations (code PR), nurses indicated 18.9% situations in which there are abusive relationships from managers; 17.5% disrespect and lack of education among staff; 16.8% lack of integration and dialogue among professionals; 13.5% the sense of injustice/discrimination; 10.5% disputes between teams and 9.7% moral/sexual harassment. Regarding the Labor Organization (code LO), the situations that stood out were: the lack of support from managers or class entities (35.6%); lack of scientific and technical support (17.8%), reference and counter reference (16.8%). The Professional Competence (code PC) presented as the most frequent categories the non-recognition (image/enhancement) (23.2%); the lack of commitment to the service (22.5%); not feeling qualified (14.7%); performing the competence of others (14%). Within the Conflict (code CO), the categories related to the relationship Professional vs. User (23.9%); the hierarchy (15.5%); the failure to act against the conflict/impotence (15.2%); the conduct, of both doctors (10.6%) and their own (10.6%); and User demand versus service demand (09.09%). The code named as Others (O) refers to situations/categories that did not fit in the other codes. Most referred to: Political interference/bribes (47.85%); Lack of ethics (20.97%); Violence (15.59%); and Symptoms/Feelings Moral Suffering (12.9%). The Quality of Care (code QC) covers items such as inadequate care (78.7%) and non-humanized care (19.4%). Concerning the Access (code AC), the categories that stood out are the right to health (55%); the lack of medical care (23.8%); and ineffective host (16.3%).

Discussion

The Professional Relations stood out in health work, given that it is a collective work. The collective nature of health work requires complementary actions of different professionals, in which the technical and the ethical dimensions are included [15]. The technical dimension refers to activities, procedures and all the tools necessary to achieve the purpose of providing care. The ethic dimension is not only limited to interpersonal relationships among professionals, which is expected to be respectful as it is to be in human relations, but extends to the concern to recognize and consider the work of others, whether they are in the same area of activity or in other areas [15].

The work relationship built by a multidisciplinary team involves knowledge, techniques and interpersonal relations, and that assistance provided should take place in a shared manner and traded between professionals of different categories [16]. However, the authors point out that a team does not necessarily set up to carry out an effective teamwork, although the legitimacy of the other, the understanding of the practices and assignments of each professional involved are important.

Studies show that the team often creates realities that provide the experience of moral distress, given the prevalence of abusive hierarchical relationships, individualism, lack of integration of knowledge and lack of communication, which comes against the findings of this research [17, 8, 6]. In this way, the distance between the members of the multidisciplinary team is configured as technician, routine and fragmented work, which provides conflicts between professionals and moral distress experiences.

In the present study, the conflict has been characterized as potentially triggering of moral distress by 11.46%, setting up in interpersonal relationships, in the dispute between the teams and in the conduct of professionals. Health work is always relational and permeated by what is proper to the human being [18].

The conflict represented in interpersonal relations lies in the fact that the production of care is carried out by the meeting between professionals and patients. In this way, it is expected, in the construction of care, that there is mutual recognition and leadership in making health, based in the bond, accountability, experience and critical thinking [18, 19]. Ethical and moral issues, principles and values that are compared at any time, given that it is inherent to social interaction, permeate the conviviality and the care provided by these actors. This can create conflicts and are potential triggers of moral distress.

Corroborating the findings, that professionals, due to the care models, adopt, in practice, devices operating in the hegemonic market logic, focusing the actions in prescriptive acts with high consumption of inputs and procedures [18]. In this sense, the hegemonic and structural model, predominant in the health sector, provides professional relations of domination, leading them to refuse and to omit their values and principles oftentimes. This relationship causes in moral dilemmas, since it generates feelings that can remove from the individual their potential to act, becoming a passive person to the circumstances and to the pre-existing domination modes.

The Working Condition (WC) involves aspects related to the physical and human resources considered as important by professionals, so that they can develop the work with quality. In this study, nurses presented the working conditions they encounter in everyday life that they consider potential causes of moral distress.

The World Health Organization (WHO) explains that creating a healthy environment for the professional can work involves promoting means for the actions may occur, and provide adequate processes, in which workers can direct their actions [20]. In this sense, the participants of this study pointed obstacles regarding the availability of material, the poor/inadequate physical structure to provide care, in addition to the reduced staff, which impairs the

provision of patient care. Studies show that poor working conditions cause moral suffering, since these are linked to the need for improvisation in professional practice and for exercising an activity that is not consistent with what they believe is the right way [21, 22].

The pointed obstacles arise reflections concerning the "multiple realities" [23] of the work, involving what is prescribed and what is real. The prescribed work refers to what is planned and determined to the ideal work, whereas the real work is that performed by the professional, and may be different from that prescribed [23]. The idealization of health work recommends a location with the availability of instruments, standards and sufficient and qualified staff so that professionals are able to provide the care safely and with appropriate conditions. However, there is a gap between what is prescribed and ideal for work in the reality of health services.

Distancing causes feeling of impotence in the professionals, who are in the service reality, situations where they need to provide care to the user without the physical conditions and human resources that they consider important. Moreover, distancing also permeates issues involving Labor Organization (LO), which involves the lack of support from managers, and the class entity, the lack of technical and scientific support, inadequate routines regarding the biosafety and arbitrary decisions made by the manager.

Regarding the participation of managers in work organization, participants cited contradictions in the manager's role in maintaining a pleasant environment for safe operation. That organizations should be managed in an organized and participatory manner in order to provide the worker's well-being and currently healthcare organizations have presented predominance of malaise at work [24].

Malaise at work due to inconsistencies in management, especially since the health work involves ethical issues, conflicts and differences may constitute barriers to professional practice, setting in moral distress for nurses. Managers and the institution are responsible for the experience of conflicting feelings [25]. Therefore, it is important that management practices in health institutions focus the professional valuation and the activities assigned to the nurse so that they are favorable to their performance and so that they recognize them and have a favorable environment for professional practice consistent with their ethical principles.

Moreover, it was pointed out by nurses that overload, low pay and the high workload are potential situations triggering of moral suffering. The stress generated in nurses due to experiences of poor working conditions generates behavior of omission in the service, which reflects in the quality of care and ways of being of nurses [26,27, 28].

In this sense, nurses are faced with precarious work conditions and organization, leading them to make decisions oftentimes contrary to those prescribed for a good professional practice. In this sense, the nurse gets discouraged about work, creating postures and inappropriate behavior with respect to labor relations and mainly to patient care.

Data from this study show aspects that affect negatively the quality of care (QC) and represent situations present in the daily lives of services that potentially generate moral distress in nurses. Situations are related to inadequate care practices, preventable deaths, non-humanized care and lack of communication, which denounce ways of doing health dissonant with the humanizing perspective, weakening the quality of care.

In the midst of discussions about reconfiguration of health practices that emerged from the new health social policy in Brazil, the debate on humanization has occupied a prominent place. Given the challenge of ensuring integrity and effectiveness of the actions and universal access, humanization composes the reflections on organizing strategies of health practices and implementation of care practices [29]. The achievement in daily practices of the recommendations enrolled in the National Health System configuration dispenses necessary changes

in the models of management and organization of work in health in such a way that professionals assume leadership and enhance the establishment of humanized practices.

Humanization can be understood as a structural axis of a new conformation of the care production praxis in health. In this sense, humanization refers to a way of providing health care that is based on the appreciation of the quality of care in relation to the technical principles and respect to the patient's rights, their subjectivity and cultural background. Moreover, humanization refers to enhancement of health worker and, above all, dialogue and flatter relations within the health team. From the data of this research, one must consider that inconsistent practices with the premises of humanization generate in nurses feelings of anxiety that may culminate in moral distress.

Research participants refer to situations related to access to health services that are potentially generators of moral distress. The failure to guarantee the right to health provided for in the Constitution, the lack of medical care and the ineffective host generate in nurses processes of moral distress/suffering.

A major achievement of Brazil's democracy movement is the right to health, which is based on the 1988 Constitution, that legitimizes the SUS as social health policy. Health is understood as a right necessary for the exercise of other human rights. Thus, the realization of the right to health depends, at the same time, on achieving other inalienable human rights as freedom, feeding, home, job and education, among others related to a dignified life. There is, thus, a dialectical relationship between health and human rights to the extent that health is a condition for receiving a dignified life. The complexity of health production also relates to this dialectics because at the same time that health is a condition for the exercise of human rights, its production depends on the realization of these rights, which involve all social, political, economic, cultural and social setting of the country [30].

The analysis of the right to health limited to the perspective of access to health has as bias the recognition of only the administrative inefficiencies at the expense of analysis of extreme poverty that succumbs not only the right to health, but above all, the right to life. In this sense, the debate on the right to health pervades the issue of access and needs to address issues of social justice and living conditions [31].

Although the SUS is based on the principle of universality, the current reality is still configured in a modality of limited supply of services and often excluding. The organizational dynamics of demand still occurs through lines that begin at dawn. In this way, barriers and obstacles that put the user in humanly inconsistent conditions with the ideological recommendations underlying the SUS [30] permeate access to health care. The nurse, in this context, feels oftentimes unable to transform the reality in favor of their values, which causes them suffering.

Besides that, the data from this study indicate that access was also related to medical care. The issue of medical care lag to the overall Brazilian population has been the agenda of the current debates, especially to those who live in rural areas and hinterlands. Although the strategies adopted by the government to address the shortage of medical professionals in Brazil have been controversial, it is clear that the condition that generated the need to think such policies is concrete: the absence of medical care for large populations. The paradox inscribed in this debate is the constitutional guarantee of a right that does not find echo in everyday reality. Therefore, although universal health care is one of the Brazilian citizen rights, the current context is marked by difficulty in attracting doctors to work in primary health care [32].

Thus, the lack of medical professionals in the health team has been constituted as potential generator of moral distress in nursing, given that, with the complexity of the health concept, the teamwork

is a prerequisite for a resolute and comprehensive practice. In that way, the absence of doctors undermines the continuity of the care process and the demand falls on nurses, although it is not their assignment, generating anguish and moral distress in the nursing team.

So, moral distress is expressed when nurses have their moral judgment concerning the right of users to access to health services but recognize their inability to act in accordance with their ethical judgment, either by political, institutional or social embarrassment. Thus, "the perception of moral distress by nurses reinforces the need for constant inquiries, reflections and discussions in teams, focusing on the moral problems and moral distress faced by different workers, considering, especially, their possible relation to the care of patients and respect to their rights" [4].

The difficulty of the nurse to put into practice the work according to their moral judgment, regardless of the scenario in which they work and the reasons that leads to such condition, makes their professional competence is brought to debate. Considering that, in superficiality, moral distress is not seen as something that take away the subject from the protagonism of their doing, which oftentimes can be misunderstood as weakness in their competence. The nurse who experiences moral distress and that is the situation of invisibility for the loss of their role is susceptible to psychological distress, as Burnout, and, in more severe cases, the abandonment of the profession [8].

With regard to the category professional competence, data show that the potential situations triggering of moral suffering are related to the non-recognition of nursing and its social value, and to the low professional autonomy. Moreover, nurses also listed the lack of commitment to service, the lack of qualification for professional performance, the lack of technical mastery, as well as the deviance of function and the lack of professional competence of their peers can generate anguish and moral suffering in nursing. Factors such as medical malpractice and nursing negligence were also referenced.

The dimension of human work has the potential to participate in the construction of the subject [33]. The author argues that every activity can produce positive identification, once they produce something of themselves in the course of work or produce useful services to society. In this sense, "they give meaning to individual existence and organize collective life" [33]. Therefore, all work transcends the economic logic of productive power in exchange for wage.

Instead, they reach a symbolic dimension with respect to self-fulfillment and social recognition. Avila et al [7] discuss the complex plot involving the representations of nursing work. For the authors, the devaluation of nursing professionals is a reality that is directly related to the lack of knowledge about the importance of these professionals. This framework outlines the weakness in the social visibility of the profession before the health team and society.

The reduced social visibility of nursing, in turn, configures disproportional power relations within the team and impairs the exercise of professional autonomy, generating a perpetuating cycle of this poor visibility and social prestige. However, the proactivity of nurses also hampers the visibility of the profession [7], in relation to adopting inadequate postures, professional disqualification, lack of technical skills and knowledge, which reflects negatively on the professional image, causing suffering and distress. Therefore, in addition to scientific and technical expertise, the professional acting also participates in the social valuation of the category, bringing to debate the need to support the professional work on ethical issues [7].

The lack of visibility and recognition in nursing can generate identity crises, since "the fact that many fail and do not have access to the recognition they expected is one of the most worrying elements of a particularly painful identity crisis" [33].

It should also be pointed out that misrepresentations in professional nursing image also relates to the lack of understanding of their duties by the team and by the nursing professionals themselves [7]. Thus, it is not uncommon that nursing takes the professional competences of other team members and accepts with some passivity the function deviances in their professional practice. Performing practices that do not relate to nursing skills brings to the debate the construction of professional autonomy of the category. Autonomy is understood as the ability to govern themselves by their own means. It refers the Kantian perspective that advocates autonomy as the human capacity to drive in accordance with their own law. So, freedom is understood as the ability to act autonomously [34].

Regarding professional autonomy in nursing, the same authors have showed difficulties to achieve it due to professional devaluation, power relations, lack of knowledge, as well as lack of material and human resources. In this way, professional autonomy is still incipient in nursing and its consolidation depends on both aspects related to the subject and professional attitude and those related to the structure and working conditions of public and private services.

Conclusion

Participants of this study have experienced moral distress more frequently associated with working conditions, followed by professional relationships, labor organization, professional competence, conflict, quality of care and access.

The situations referred by nurses working in different scenarios of health services in Brazil show that it is important to think of new ways to make health and management of health services practices in order to reconfigure the collective work and promote favorable and suitable environments for good professional practice. Besides that, it becomes important to reflect on the role of the nurse and the development of an ethical and autonomous practice in their daily tasks, given that moral distress deprived nurses from their roles, taking them to the situation of invisibility, which influences the service provided and the attitude and ethical and critical behavior.

The study demonstrates the need for studies on the moral distress in nursing area regarding the identification of potential situations triggering of suffering in order to create means to transform reality and propose a healthy workplace for staff and quality for users.

Funding

CNPq; CAPES

Conflicting interests

Not conflict of interest

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