The experience of moral distress in nursing: the nurses' perception*

VIVÊNCIA DO SOFRIMENTO MORAL NA ENFERMAGEM: PERCEPÇÃO DA ENFERMEIRA

EXPERIENCIA DEL SUFRIMIENTO MORAL EN ENFERMERÍA: PERCEPCIÓN DE LA ENFERMERA

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ABSTRACT

With the objective to understand the nurses' perception of moral distress, as well as its frequency and intensity, this study used a survey utilizing a six-point Likert scale, with 124 nurses working in hospitals in southern Brazil in 2008. Using a self-administered questionnaire and factorial analysis, four constructs were identified and validated. The final results were obtained through three different analyses: 1) descriptive statistical analysis; 2) analysis of variance; and 3) multiple regression. The construct that showed the highest intensity of perception regarding moral distress was the lack of competency in the work team (4.55), followed by the nurse's denial of their role as patient advocate (4.30), therapeutic obstinacy (3.60) and disrespecting the patient's autonomy (3.57). Regarding the perception of the frequency of moral distress, once again, the highlighted construct was the lack of competency within the work team (2.42), followed by therapeutic obstinacy (2.26), the nurse's denial of their role as patient advocate (1.71) and disrespecting the patient's autonomy (1.42).

DESCRIPTORS

Nursing
Ethics, nursing
Professional competence
Professional burnout
Stress psychological

RESUMO

Objetivando conhecer a percepção do sofrimento moral vivenciado, relacionando frequência e intensidade, realizou-se pesquisa Survey, utilizando escala Likert variando de 0 a 6 pontos, com 124 enfermeiras em hospitais do sul do Brasil, no ano de 2008. Mediante questionário autoaplicável e análise fatorial, foram identificados e validados quatro constructos. Os resultados finais foram obtidos através de três diferentes análises: 1) estatística descritiva; 2) análises de variância 3) regressão múltipla. O constructo que apresentou maior intensidade de percepção de vivência do sofrimento moral foi a falta de competência na equipe de trabalho (4,55), seguido pela negação do papel da enfermeira como advogada do paciente (4,30), obstinação terapêutica (3,60) e desrespeito à autonomia do paciente (3,57). Em relação à percepção da frequência do sofrimento moral, destacou-se, novamente, o constructo falta de competência na equipe de trabalho (2,42), seguido da obstinação terapêutica (2,26), negação do papel da enfermeira como advogada do paciente (1,71) e desrespeito à autonomia do paciente (1,42).

DESCRITORES

Enfermagem
Ética em enfermagem
Competência profissional
Esgotamento profissional
Estresse psicológico

RESUMEN

Objetivándose conocer la percepción del sufrimiento moral experimentado, relacionando frecuencia e intensidad, se efectuó investigación Survey, utilizando escala Likert variando de 0 a 6 puntos, con 124 enfermeras en hospitales del Sur de Brasil, en 2008. Se identificaron cuatro constructos mediante cuestionario autoaplicable y análisis factorial. Resultados obtenidos mediante tres análisis: 1) estadística descriptiva, 2) análisis de varianza, 3) regresión múltiple. El constructo con percepción de sufrimiento moral más intenso fue la falta de competencia del equipo de trabajo (4,55), siguiendo negación del papel de la enfermera como abogada del paciente (4,30), obstinación terapéutica (3,60) y falta de respeto a la autonomía del paciente (3,57). Respecto a percepción de frecuencia de sufrimiento moral, nuevamente predominó la falta de competencia del equipo de trabajo (2,42), siguiéndolo la obstinación terapéutica (2,26), negación del papel de la enfermera como abogada del paciente (1,71) e falta de respeto a la autonomía del paciente (1,42).

DESCRIPTORES

Enfermería
Ética en enfermería
Competencia profesional
Agotamiento profesional
Estrés psicológico

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INTRODUCTION

Moral distress (MD) was first described in the 1980s[1] and was expressed as suffering that arises from incoherence between one's actions and convictions. In other words, one knows what is the right thing to do but recognizes herself/himself as unable to pursue such an action either due to errors of judgment, personal failure, weakness of character, or even due to circumstances beyond personal control[2].

Specifically in nursing, moral distress is defined as a psychological imbalance caused by painful feelings that result when nurses cannot perform morally appropriate actions according to their conscience or knowledge[1]. It can be also defined as a response, when after an ethical conflict, personal action is impeded by individual, institutional or social barriers[3].

Anger and sorrow are the feelings most mentioned in the literature as biopsychosocial effects arising from moral distress. Introspection is also manifested by nursing workers receiving little or no support while coping with moral conflict[4]. Such feelings, which result in moral distress, can cause emotional responses in individuals, such as dissatisfaction with work, reluctance to work, or even abandoning one's profession[5].

Qualitative studies show that nursing workers can experience moral distress accruing from situations already considered to be part of their professional practice, such as a lack of informed consent on the part of patients before diagnostic and therapeutic procedures, prolonging life without a concern with its quality, questionable professional practices, fragmented decisions, and the unequal distribution of resources, especially those destined for nursing[6].

Qualitative studies show that nursing workers can experience moral distress accruing from situations already considered to be part of their professional practice

The Moral Distress Scale (MDS)[7] was used to deepen knowledge concerning the experiences of nurses with moral distress in the Brazilian context. The instrument was validated for Portuguese after its author's consent.

OBJECTIVE

To analyze the perception of nurses concerning moral distress in relation to its frequency and intensity.

METHOD

This is a survey[8] and its participants included nurses from four hospitals located in the South of Brazil: one public, two philanthropic and one private hospital. Data were collected from May to September 2008 by a team of eight professionals previously trained in data collection. Each nurse received in their workplace a self-applied form along with instructions on how to fill it out and information on moral distress. One part of the instrument addressed the participants' profile (hospital facility, years working in the facility, years since graduation, academic degree, age and others), which was followed by 38 statements addressing dilemmas potentially experienced in professional practice, in addition to a final question concerning their perception of the experience of moral distress in their workplaces. A due date to collect the completed form was established after it was delivered and the researchers would return five times, at most, to collect the completed forms.

Data collection was simultaneously conducted in all the studied hospitals. The forms were delivered in sealed manila envelopes along with two copies of free and informed consent forms to be signed. Clarification concerning the study, moral distress and how to complete in the instrument was provided at the time the envelope was delivered to each participant. Each data collector became responsible for a number of units and to distribute and collect the highest possible number of forms.

A total of 193 envelopes containing the forms were delivered to the nurses in the hospitals and 164 were returned. Forty of these were excluded: 12 due to a dichotomous scale that presented values 0 or 6, and another 28 forms that were returned blank. The remaining 124 were considered valid and represented 60.4% of the target population. The researcher responsible for the study in the Nursing and Health Studies and Research Group at the Federal University of Rio Grande do Sul (FURG) was responsible for keeping the forms. Two previously trained individuals tabulated the data.

Study background – An instrument already recognized and validated in other contexts[7] was validated and applied to the Brazilian context to investigate moral distress. The instrument, originally written in English, has a seven-point Likert scale, ranging from 0 – never occurred or no frequency to 6 – very intense suffering or very frequent suffering.

Back translation was performed in order to obtain a version as close as possible to the original version and reduce the risk of potential bias. One group of experts in the English language translated the original version to Portuguese and the Portuguese version was back translated by another group of translators. The new English version was then compared to the original one to check for potential differences and verify its equivalence.

Instrument validation – The instrument was validated in three different respects: a) *face validation*: in which we verified whether the instruments had the proper form and a vocabulary appropriate to what it was intended to

measure. Two professors at FURG, College of Nursing performed this process; b) *Content validation*: in which we verified whether the items of the instrument translated and adapted to Portuguese represented the content we intended to evaluate. This process was conducted through the application and analysis of 30 pretests among Master's students attending the graduate program in Nursing, FURG, which confirmed the items were sufficiently clear and easy to understand; c) *Construct validation*: in which we delimit the characteristics of the constructs of interest to the study, testing the internal consistency of each item (that is, the reliability of scales), their consistency under different statements (convergent validity) and the difference in relation to the other items of different constructs (discriminant validity), in order to make a connection between the theory and the construct (conceptual level) and the evaluated items (operational level). In other words, the conceptual level permitted specifying the nature of the studied construct and the operational level dealt with the list of statements (items or questions) that allowed measuring the constructs. This last validation was performed with the aid of statistical tests, while the first two were subjective, though essential in order to ensure the applicability and precision of the instrument.

After the forms were applied in the selected sample, two statistical tests were performed to ensure the validity of the construct: factorial analysis and Cronbach's alpha. Factorial analysis consists of a multivariate technique that is applied to identify factors in a set of measurements. Cronbach's alpha in turn tests the reliability of the instrument verifying whether different characteristics of each group, measures via the instrument's statements, or of indicators arranged within the instrument, were consistent.

Data analysis – The results concerning the studied sample were obtained through three different analyses: 1) descriptive statistics through averages and distribution frequency of constructs and their indicators, to identify the intensity and frequency these individuals experience moral distress; 2) variance analysis (ANOVA) among the different groups of respondents according to the sample's characteristics, to verify potentially significant differences among the group of respondents (hospital, age, years since graduation, years working in the hospital, among others); and 3) multiple regression analysis, seeking to evaluate which factors had a greater effect on moral distress, from the perspective of nurses.

The Statistical Package for Social Sciences (SPSS) version 13.0 was used to analyze the data, facilitating the process of organizing the data in tables, which permitted a better visualization and interpretation of results.

The study complied with ethical principles in all stages and was approved by the Ethics Research Committee (protocol No. 012/2008 – Minutes 65/2008).

RESULTS

Table 1 presents the demographic data of the studied sample. In regard to the participants' characteristics, it is important to note that 48.4% of the nurses were older than 30 years of age, approaching maturity. Of these, 37.9% had a specialization and 10.5% had a Master's degree, the highest academic degree achieved, showing a concern for professional qualification. Time in the profession was nine years on average (8.6), which is considered a reasonable and already very meaningful period of professional practice. The average time working in the hospital facility was approximately five years (4.94 years).

Table 1- Characteristics of the study's participants - 2011

Characteristics	N	%
Bachelor's degree	64	51.6
Specialization	47	37.9
Master's degree	13	10.5
Age		
21-30	64	51.6
31-40	31	25.0
41-50	24	19.4
51+	5	4.0
Time working in the profession (years)	(M = 8.60)	
Time working in the facility (years)	(M = 4.94)	
Type of hospital		
Public	37	29.8
Philanthropic	63	50.8
Private	24	19.4

The factorial analysis allowed grouping the statements concerning the perception of moral distress experienced in the profession, representing different facets perceived by the studied nurses. To maintain conceptual coherence, 21 out of the initial 38 statements were grouped into four dimensions and 17 were excluded due to low factorial load (below 0.50), high factorial load (above 0.40) in more than one factor, lack of conceptual coherence observed in relation to the bloc, or the formation of isolated blocs. The four proposed dimensions explain 66.71% of the variations of the original statements, which represents a good degree of data synthesis, facilitating handling and interpretation. Table 2 presents the factorial loads of each construct according to the formation of the factors, which correspond to the four dimensions discussed in the results.

The reliability of the four dimensions identified was tested through Cronbach's alpha. Values between 0.60 and 0.80 are recommended for exploratory studies to ensure reliability of the scales used in the instrument. It is worth noting that the higher the alpha, which varies from 0 to 1, the higher the scale's reliability. The instrument obtained a Cronbach's alpha equal to 0.93, while the coefficients of the four dimensions were between 0.68 and 0.91, which confirms the reliability of the four identified

dimensions (Table 2). Hence, the four proposed constructs were defined as: *denial of the nurses' role as patient advocate*, which refers to the unutilized potential of nurses to claim the rights of patients[9]; *the staff's lack of competence*, related to a lack of skills or technical expertise, which the staff should have, to perform actions specific to each profession[10]; *disregards patient autonomy,* that is, disregarding a patients' self-government, freedom, privacy, individual choice, and free will[11]; *therapeutic obstinacy* refers to treatments that no longer benefit patients facing irreversible death and are considered to be futile, useless[12].

Table 2 – Exploratory Factorial Analysis (Varimax rotation) – 2011

Indicators	Bloc	F1	F2	F3	F4
Denial of the nurses' role as patient advocate					
s-09. Avoid taking action when verifies that a member of the nursing staff administered wrong medication and failed to report it	7.55	.566			
s-10. Let medical students perform painful procedures on patients solely to increase their skills	.833	.704			
s-11. Assist physicians who are practicing procedures on a patient after CPR has been unsuccessful	.782	.774			
s-13. Work with unsafe levels of nursing staffing	.813	.632			
s-16. Observe without intervening when the nursing staff do not respect a patient's privacy	.808	.709			
s-17. Carry out the physician's order of not telling patients the truth when they ask for it	.805	.684			
s-18. Assist a physician who in your opinion is providing incompetent care	.766	.677			
s-30. Comply with the request of the physician not to talk about death with a dying patient who asks about it	.761	.614			
Staff's lack of competence					
s-32. Work with nurses who do not have the competence required by the patient's condition	.865		.726		
s-33. Work with technicians/auxiliaries who do have the competence required by the patient's condition	.849		.735		
s-34. Work with medical or nursing students who do not have the competence required by the patient's condition	.815		.846		
s-35. Work with physicians who do not have the competence required by the patient's condition.	.858		.790		
s-36. Work with support services that do not have the competence required by the patient's condition	.796		.615		
s-38. Be required to care for patients and not feeling prepared to provide such care	.674		.581		
Disregards patient autonomy					
s-04. Assist the physician who performs a test or procedure without the patient's or family's informed consent	.739			.661	
s-07. Ignore situations in which patients were not given adequate information to ensure their informed consent	.744			.622	
s-25. Comply with the physician's request not to discuss with the patient his/her resuscitation in the event of cardiac arrest	.869			.832	
s-26. Comply with the physician's request not to discuss resuscitation of the patient in the event of cardiac arrest with the family, when the patient is devoid of discernment.	.877			.818	
Therapeutic obstinacy					
s-02. Follow the family's wishes for maintaining the patient's life even if it is not the best for him/her.	.793				.716
s-05. Initiate extensive life-saving actions when I think it will only prolong death	.793				.863
s-12. Carry out the physician's orders for unnecessary tests and treatments for terminally ill patients	.759				.545
Initial Eigenvalue		9.57	1.70	1.45	1.28
% explained variance – rotated (66.71%)		45.57	8.13	6.91	6.11
Cronbach's alpha (instrument 0.93)		0.91	0.89	0.82	0.68
KMO measure of sampling adequacy (KMO = 0.92)					
Bartlett's test: chi-square = 3,087.167					

The descriptive analysis revealed the perceptions of nurses in the face of moral distress. Each of the four constructs identified in the study (denial of the nurses' role as patient advocate, staff's lack of competence, disregard patient autonomy, and therapeutic obstinacy) was represented by a numerical value, which refers to the arithmetic average of the statements that composed each perception individually, previously grouped by factorial analysis. The averages of the constructs and their respective indicators are presented in Table 3.

Table 3 – Indexes of intensity and frequency of moral distress experienced through situations represented in the statements of the validated instrument – 2001

Factors	N	Intensity	Frequency
Staff's lack of competence	**124**	**(4.55)**	**(2.42)**
s-32 Work with nurses who do not have the competence required by the patient's condition	124	4.40	2.11
s-33 Work with nursing technicians/auxiliaries who do not have the competence required by the patient's condition	124	4.71	2.52
s-34 Work with medical or nursing students who do not have the competence required by the patient's condition	124	4.35	2.76
s-35 Work with physicians who do not have the competence required by the patient's condition	124	5.02	2.94
s-36 Work with support services that do not have the competence required by the patient's condition	124	4.70	3.07
s-38 Be required to care for patients and not feeling prepared to provide such care	124	4.14	1.13
Denial of the nurses' role as patient advocate	**124**	**(4.30)**	**(1.71)**
s-09 Avoid taking actions when verifies that a member of the nursing staff administered wrong medication and failed to report it	124	4.24	1.17
s-10 Let medical students perform painful procedures on patients solely to increase their skills	124	4.65	2.25
s-11 Assist physicians who are practicing procedures on a patient after CPR has been unsuccessful	124	3.65	1.41
s-13 Work with unsafe levels of nursing staffing	124	4.68	2.26
s-16 Observe without intervening when the nursing staff do not respect the patient's privacy	124	4.15	1.94
s-17 Carry out the physician's order of not telling patients truth when they ask for it	124	4.39	1.66
s-18 Assist a physician who in your opinion is providing incompetent care	124	4.74	2.29
s-30 Comply with the request of the physician not to talk about death with a dying patient who asks about it	124	3.92	0.86
Therapeutic obstinacy	**124**	**(3.60)**	**(2.26)**
s-02 Follow the family's wishes for maintaining the patient's life even if it is not the best for him/her.	124	2.94	1.87
s-05 Initiate extensive life-saving actions when I think it will only prolong death	124	3.73	2.74
s-12 Carry out the physician's orders for unnecessary tests and treatment for terminally ill patients	124	4.15	2.16
Disregards patient autonomy	**124**	**(3.57)**	**(1.42)**
s-04 Assist the physician who performs a test or procedure without the patient's or family's informed consent	124	2.94	1.80
s-07 Ignore situations in which patients were not given adequate information to ensure their informed consent	124	3.73	1.99
s-25 Comply with the physician's request not to discuss the patient resuscitation in case of cardiac arrest with him her	124	4.15	0.86
s-26 Comply with the physician's request not to discuss resuscitation of the patient in case of cardiac arrest with the family when the patient is devoid of discernment	124	2.94	1.04

Different analyses of variance were performed to verify the existence of potential differences in the perceptions of nurses concerning their experience with moral distress, considering the uniqueness of each individual, such as in regard to age, year of graduation, completion of graduate program, hospital where employed, time working in the hospital, unit of work, time working in the unit, type of unit, presence/lack of meetings with the nursing staff, frequency of meetings with the nursing staff, meetings in the unit of work, frequency of meetings in the unit of work.

In finding differences, we performed the Duncan test among subgroups to identify homogeneous groups in each of the variables, whose averages did not present significant statistical differences. Only one important correlation was found in the analyses of variance with a level of significance of 5%, that is, nurses working in Intensive Care Units (ICU) experience moral distress when facing *the staff's lack of competence*.

Table 4 presents the correlation of moral distress experienced by ICU workers with the four categories, as well as that of workers from the remaining units, to support the discussion.

Table 4 – Analysis of variance among the different units – 2011

	Unit	Average	*P*
Disregards patient autonomy	Remaining (101)	3.71	0.056
	UTI (23)	2.97	
Therapeutic obstinacy	Remaining (101)	3.59	0.830
	UTI (23)	3.66	
Staff's lack of competence	Remaining (101)	4.71	0.030
	UTI (23)	3.83	
Denial of nurses' role as patient advocate	Remaining (101)	4.41	0.081
	UTI (23)	3.80	

Table 4 shows that suffering manifested by the 23 professionals working in the ICU is less intense than that experienced by the remaining workers in the categories *disregards patient autonomy* (2.7 and 3.71 respectively); *staff's lack of competence* (3.83 and 4.71); and *lack of advocacy* (3.80 and 4.41).

The nurses working in the ICU obtained a higher average only in the category 'therapeutic obstinacy' (3.66) when compared to the average of professionals from the remaining units (3.59). Such an outcome is probably explained by the greater occurrence of therapeutic obstinacy observed in ICUs. Additionally, the competence required from professionals working in ICUs is extremely relevant, a fact demonstrated by the level of significance of 5% obtained in this study, given the constant risk of death to which patients are exposed, which may require urgent and immediate action.

The last test evaluated the effect of the four variables obtained in relation to moral distress. A multiple regression model was used. It involved the studied variables; statement s-39 was established as a dependent variable: *In general, situations experienced at work cause me moral distress*. The results indicate there is a significant relationship among the variables at a level of 5%. The adjusted coefficient of determination (R^2) obtained in the test was 40%. Table 5 shows moral distress in the four categories obtained in the four hospitals.

Table 5 – Analysis of variance among the constructs – 2011

	Constant	B	*P*
Staff's lack of competence		0.40	0.00
Disregards patient autonomy		0.33	0.00
Denial of the nurses' role as patient advocate		0.30	0.00
Therapeutic obstinacy		0.25	0.01

Table 5 shows once more that staff's competence stands out as related to moral distress. A great power is culturally attributed to physicians in the decision-making process and among such decisions are those related to the life and death of patients. Hence, much conflict may result, since nursing professionals perform most of the procedures.

DISCUSSION

The perception of the intensity of distress experienced by nurses ranged from 2.94 to 5.02, with an average of 4.06, while frequency varied from 0.86 to 3.07, with an average of 1.72. Such values are very similar to those identified in another study replicating the moral distress scale with 106 American nurses[13]. This study reports that the perception of intensity of moral distress ranged from 2.61 to 4.79, with an average of 3.64, and the frequency ranged from 0.08 to 3.05, with an average of 1.45. Even though the values in both studies are very close, a greater intensity and frequency of moral distress is observed in the Brazilian context.

Statement s-35 *working with physicians who do not have the competence required by the patient's condition* in the variable *staff's lack of competence* was the one that most caused perceived moral distress in the investigated nurses (5.02), as opposed to the study previously mentioned performed with American nurses, in which statement s-13 *Work with unsafe levels of nursing staffing* was the one that presented the highest average of perceived distress[13].

Moral distress among nurses in the Brazilian context is more associated with coping with situations directly related to the *modus operandi* of some physicians, which may be linked to the perception of an apparent disregard and indifference on the part of physicians, in relation to the complaints and manifestations of patients, delay in addressing the requests of nurses, absences and lack of commitment to integrality of care, incomplete medical prescriptions, prescriptions with errors and/or delays, which are part of the perception of medical neglect, as *an act of omission, lack of attention to and observation of professional duty* [14].

In regard to the identified correlation of the lower perception of moral distress among ICU nurses in relation to *staff's lack of competence*, this outcome may be related to characteristics specific to ICU staffs, usually endowed with great professional competence. The complexity of equipment and medication used in ICUs requires differentiated technical knowledge, in addition to professional expertise appropriate to everyday situations, which include risk of death, terminality, and ethical conflicts[12], which also seem to be associated with the high incidence of studies in ICUs addressing ethical issues[6].

The second statement in the variable *denial of the nurses' role as patient advocate* was identified as the perception with the greatest intensity of moral distress in the entire instrument, s-18: *Assist a physician who in your opinion is providing incompetent care* (4.74). There are other situations in this variable that deserve to be noted in relation to the medical staff, such as that evidenced in statement s-10 *Let medical students perform painful procedures on patients solely to increase their skills* (4.65); its average stood out as the sixth highest value.

It has been argued that nurses' moral distress primarily accrues from the fact that nursing work is performed in a social space of health care that puts workers very close to patients for long periods of time[15].

Issues related to the medical hegemony within the health staff can contribute to nurse distress, since acknowledging the power of physicians in the work environment may discourage them from implementing actions that resist this power, especially advocating in favor of patients' rights. Additionally, 11 (52.38) out of the 21 final statements in the validated instrument refer to the routine of these nurses in relation to the medical staff, showing the difficulties and suffering they experience regardless of the moral issues and professional values involved.

It is important to note that even though these statements compose the variable *denial of the nurses' role as patient advocate*, they are also related to the staff's competence and to the way physicians and future physicians act, which may require nurses to take action to defend patients. Reflecting on nurses' failure to exercise power raises potential ethical implications associated with the submission of nurses. In addition to questioning this apparent *lack of power*, it has been argued that nurses underestimate or do not acknowledge their power. On the other hand, when nurses and other nursing professionals refuse, during their professional practice, to resist the actions of others, they may be refusing delivery of the best possible care to their patients[16].

Health workers, especially nurses, constantly need to commit themselves to the care of patients, providing technical-scientific knowledge and becoming responsible for their decisions and actions. Therefore, difficulties in assuming such a responsibility may cause them moral distress since, in the role of patient advocate, nurses have the moral and professional responsibility to question, reflect, defend patients and, if necessary, report the practices of other professionals and/or future professionals that may negatively affect patient care.

As shown in this study in different statements, the interests of patients do not seem to be fully met, leading to moral problems that may cause moral distress to nurses, with a diversified perception of both its intensity and frequency. All these statements bring, at their core, respect for the rights of patients and their physical, emotional, social and moral integrity, often negatively affected by situations described in the instrument.

For advocacy in health, the presence of sound ethical values becomes hugely important, since this influence the decision-making process and individuals' personalities. Hence, *the very human action is a way of expressing values*[17], which can always suffer constraints, whether through institutional imposition or through its members, resulting in inconsistent practices from an ethical point of view.

Institutional constraints constitute an important and major component for the occurrence of moral distress and increased suffering since nurses may also experience educational deficiencies; their formal education may have been deficient in terms of ethical reasoning and confrontation of ethical dilemmas that require advocacy[18].

The categories *Therapeutic obstinacy* (3.6) and *Disregards patient autonomy* (3.57), with very similar values and with a lower average of suffering, also present statements with the lowest averages of intensity of perception of suffering. That is, the statements s-02 *Follow the family's wishes to maintain the patient's life even if it is not the best for him/her*, s-04 *Assist the physician who performs a test or procedure without the patient's or family's informed consent* and s-26 *Comply with the physician's request not to discuss resuscitation of the patient in the event of cardiac arrest with the family when the patient is devoid of discernment* present an average of 2.94.

These lower values may result from a culture still present in the health field, which seems not to recognize the patient, or his/her family members, when the patient is unable to manifest him/herself as subject, as *owner* of his/her own body and, therefore, the one who has the final decision of what will or will not be admitted in his/her treatment based on clarification and guidance provided by health workers. The autonomy of patients or the autonomy and will of family members, when patients are unable to exercise such autonomy, may not be acknowledged by professionals, which is associated with the fact that the consent of patients is not asked, an essential requirement to perform any procedure[19].

CONCLUSION

The study shows that nurses in the selected hospitals presented the highest perception of intensity of moral distress associated with the *staff's lack of competence* followed by *denial of the nurses' role as patient advocate*, while the greatest frequency of moral distress was also related to *staff's lack of competence* followed by *therapeutic obstinacy*.

The perception of moral distress experienced by nurses reinforces the need to question, reflect on, and discuss, constantly, with the staff, focusing on moral problems and moral distress faced by the different workers, especially considering its potential relation to the care provided to patients and respect for their rights.

When the professionals ground their actions on ethical values, they seem to be more certain in their resolutions, benefitting themselves and their patients. From this perspective, it seems to be an alternative to reinforce professional competence: better preparing future nurses for situations they will potentially face in their professional practice.

Among the limitations of this study, we note it was conducted with a small population of nurses working in four hospitals in two cities in the extreme South of Brazil and generalization of the results is not possible. Additionally, there are no previous Brazilian studies addressing the intensity and frequency with which moral distress is experienced among nurses. Hence, comparison of results with other regions in the country was not possible.

The study shows the need for further research addressing ethics, moral problems and, especially, moral distress in the nursing and health fields, to contribute to the transformation of the current context, through better coping with situations in the workplace that are acknowledged as acceptable by professionals despite being characterized as morally inappropriate.

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