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MORAL DISTRESS IN NURSES: A DESCRIPTION OF THE RISKS FOR PROFESSIONALS[1]

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ABSTRACT

Objective: to describe the profile of nurses and the occurrence and frequency of risk factors regarding moral distress.

Method: a quantitative, descriptive, cross-sectional study, with 268 nurses working in hospitals and primary health care units in the *Rio Grande do Sul* (Brazil), between the months of March and July, 2016. Data collection was performed using the online Google Docs tool. A moral distress risk scale and a set of variables were used to characterize the participants and their context.

Results: the sample mainly consisted of young women who worked between 36 and 40 hours a week, with an average monthly income between five and sevem wages and about 10 years of nursing experience. The risk of moral distress was considered moderate, with a considerable percentage of professionals showing an intention to abandon their current job.

Conclusion: moral distress is a reality experienced by the nurses under study, and the identification of risk factors is one of the tools used to create coping strategies.

DESCRIPTORS: Nursing. Ethics, nursing. Professional practice. Worker's health. Moral damage.

SOFRIMENTO MORAL EM ENFERMEIROS: DESCRIÇÃO DO RISCO PARA PROFISSIONAIS

RESUMO

Objetivo: descrever o perfil de enfermeiros e a frequência de ocorrência de fatores de risco de sofrimento moral.

Método: estudo quantitativo, descritivo e transversal, realizado com 268 enfermeiros assistenciais atuantes no Rio Grande do Sul (Brasil), em de instituições hospitalares e unidades de saúde de atenção primária, durante os meses de março e julho de 2016. A coleta de dados foi *online*, através da ferramenta *GoogleDocs*. Foram utilizadas uma escala de risco de sofrimento moral e um conjunto de variáveis para caracterização do participante e do seu contexto de trabalho.

Resultados: a amostra foi constituída, sobretudo, por mulheres, jovens, que mantinham um vínculo empregatício, trabalhavam entre 36h e 40h por semana, com renda mensal média entre cinco e sete salários mínimos e cerca de dez anos de experiência na enfermagem. O risco de sofrimento moral foi considerado moderado, com um considerável percentual de profissionais demonstrando intenção de abandonar o emprego atual.

Conclusão: o sofrimento moral é uma realidade vivenciada pelos enfermeiros investigados, sendo a identificação dos fatores de risco uma das ferramentas no processo de construção de estratégias de enfrentamento.

DESCRITORES: Enfermagem. Ética em enfermagem. Prática profissional. Saúde do trabalhador. Dano moral.

SOFRIMIENTO MORAL EN ENFERMEROS: DESCRIPCIÓN DEL RIESGO PARA LOS PROFESIONALES

RESUMEN

Objetivo: describir el perfil de enfermeros y la frecuencia de ocurrencia de factores de riesgo de sufrimiento moral.

Método: estudio cuantitativo, descriptivo y transversal, realizado con 268 enfermeros asistenciales actuantes en Rio Grande do Sul (Brasil), en instituciones hospitalarias y unidades de salud de atención primaria, durante los meses de marzo y julio de 2016. La recolección de datos fue online, a través de la herramienta *GoogleDocs*. Se utilizó una escala de riesgo de sufrimiento moral y un conjunto de variables para caracterización del participante y de su contexto de trabajo.

Resultados: la muestra fue constituida, sobre todo, por mujeres, jóvenes, que mantenían un vínculo laboral, trabajan entre las 36h y las 40h por semana, con ingresos mensuales promedio entre cinco y siete salarios mínimos y cerca de diez años de experiencia en la enfermería. El riesgo de sufrimiento moral fue considerado moderado, con un considerable porcentaje de profesionales demostrando intención de abandonar el empleo actual.

Conclusión: el sufrimiento moral es una realidad vivenciada por los enfermeros investigados, siendo la identificación de los factores de riesgo una de las herramientas en el proceso de construcción de estrategias de enfrentamiento.

DESCRIPTORES: Enfermería. Ética en enfermería. Práctica profesional. Salud del trabajador. Daño moral.

INTRODUCTION

Work aspects specific to nursing, especially those related to the moral commitment of the nurse, when conflicting with working conditions, may contribute to a greater risk of events that generate moral psychological problems for these professionals, such as moral distress.[1] In the nursing profession, moral distress was described for the first time in 1984 as distress resulting from the difficulty in carrying out an action considered morally appropriate due to restrictions or obstacles, particularly institutional in nature.[2]

Moral distress is considered a psychological, emotional and physiological distress, that nurses can experience when, limited by circumstances, participate in actions perceived to be incorrect, either by participating or refusing to participate.[3]

It's usually associated with barriers that are experienced in the context of nursing work or activities. These barriers are mainly connected to issues related to end-of-life care, limited resources, work overload, personal/professional conflicts, and lack of autonomy. The most common manifestations of moral distress may be physical sickness, dissatisfaction, frustration, establishment of an impersonal relationship, and distancing themselves from patients.[4] It is common to see organizational consequences, such as increased staff turnover, absenteeism and requests for dismissal, as well as potential interference with patient outcomes and quality of care. [5]

Research on the subject has been performed around the world, especially in the North American health context. However, the approach to moral distress from the perspective of risk factors is less frequent. This type of design aims to consider the subjective nature of morality and thus contribute to an increase in sensitivity and comprehensibility in investigations related to the phenomenon.[6]

Although it is not as discussed as work burnout, moral distress is a phenomenon that should not be neglected. According to a study carried out by the Brazilian Federal Nursing Council, approximately 73.3% of nurses in the *Rio Grande do Sul (Brazil)* report experiencing a high level of work-related burnout.[7] It is important that researchers, managers and coordinators recognize that moral distress may be affecting workers and should not hesitate to question the sources of this distress, which may be a key strategy for coping with the problem.[1] The purpose of this study was to describe the profile of nurses and the frequency of the occurrence of risk factors associated with moral distress .

METHOD

This is a quantitative, descriptive cross-sectional study performed with nurses from hospital institutions and primary health care units in the State of *Rio Grande do Sul*. Data were collected between March and July 2016.

There were approximately 22,377 active professional nurses enrolled in the Regional Nursing Council of *Rio Grande do Sul* (COREN-RS) by the first half of 2016.* All nurses working in hospitals or in primary health care units were included in the study and those who practiced exclusively in the areas of teaching and research were excluded. The sample size calculation considered approximately five to ten participants per variable[8] of the data collection instrument.[9] The final sample of this study included 268 nurses.

The recruitment strategy involved an online data collection, the instrument was sent via GoogleDocs format. The research was published on the COREN-RS website, on social media networks, by e-mail, by direct contact with nurses and by using the 'snowball' sampling technique.

The Moral Distress Risk Scale (MDS)[9] was used in the data collection. It is composed of 30 items, evaluated by a 4-point Likert scale, where 1=never, 2=rarely, 3=frequently and 4=always, to verify the frequency of the occurrence of risk factors of moral distress in nursing care practices. The results of the mean responses are categorized as 1=no risk, 2=low risk, 2.5=moderate risk, 3=high risk and 4=severe risk.

The scale was theoretically constructed based on the analysis of 38 studies from scientific nursing literature studies, [6] and was submitted to psychometric tests in order to search for validity evidence.[9] The MDS considers moral distress as what one feels when one "knows the right thing to do, but institutional constraints make it almost impossible to pursue the right course of action." [2:6] It is based on two theories that address the psychological responses of nurses and their work environment,[10] considering the different elements of the moral distress process.[11]

The variables for describing the profile of the nurses - participants as respondents of the present study - include sociodemographic variables, education, professional activity, workplace and moral distress experiences. Concerning the sociodemographic variables, participants were asked to state their gender and age. The education variables included the options of specialization, masters and doctorate degree. In order to describe the professional activity, the participants were asked to list how many employment positions they had, what their weekly working hours were, whether they worked overtime, and if they were paid for such overtime, and what was their average monthly income, considering that the minimum wage to R$ 788.00.

The professional activity variables also included the length of their professional experience in total and the amount of time in the current employment. Regarding the workplace, the participants were questioned as to whether their work relationship was in a hospital or in a primary health care unit.

In questions related to the experience of moral distress, participants were asked how often the moral distress risk factors from the scale could effectively provoke moral distress (never/rarely/frequently/always) and what feelings they experienced as a result. They were also asked if they were currently experiencing moral distress, if they had experienced moral distress previously, if they felt free to speak about moral distress with their boss and colleagues and if they would leave their current workplace due to moral distress; those who answered affirmatively, were asked about what type of employment they would seek (similar service / other type of service / work not related to nursing).

Data was exported from the GoogleDocs tool into version 21.0 of the Statistical Package for Social Sciences - SPSS. The descriptive analysis of the data was performed with the help of the statistician from the Nursing School of the *Universidade de São Paulo* (Brazil). The results are presented in simple percentage frequency tables, with the continuous variables being described by the mean, standard deviation, minimum and maximum; the categorical variables were described by the sample (n) and by the relative frequency. Non-respondents were not included in the results.[12]

The Research Ethics Committee of the Nursing School of the *Universidade de São Paulo* (Opinion No. 1,180,518, CAAE 45957915.4.0000.5392) approved the project. An informed consent form was presented to the professionals, with the purpose of informing the participants about the content of the investigation, guaranteeing their freedom to participate in the study as well as their right to withdraw from the research at any time.

RESULTS

A total of 268 nurses participated in the study, 89.2% (n=239) were women, ranging from 23 to 62 years of age with a mean age of 36. Among the participants, 75% (n=201) completed one or more specializations, 32% (n=87) had completed a master's degree and 7% (n=19) concluded a doctorate. The number of professionals who performed some of these postgraduate degrees specifically in the area of ethics was small, with n=5 (2.3%) in the specialization, n=4 (3%) in the master's degree in=2 (9.5%) in the doctorate. A total of 16.4% (n=44) of the nurses confirmed that they had participated in some type of ethics training in the last year, such as a congress, lectures or short courses.

Regarding the professional employment variables, the majority reported being linked to only one place of work (81%, n=213) and worked between 36 - 40 hours (74.8%, n=199) per week, but exceeded theses amount of hours frequently (60.4%, n=162).

Among the 162 nurses who work overtime, 71.6% (n=116) said that they are not paid for this overtime work. The average monthly income of these professionals is between R$3,940-5,516 - considering that the minimum wage is R $ 788.00 (31.3%, n=83). The average number of years of nursing experience was 10 years (± 8.15) and the average working time in the current job was 6.7 years (±6.3). Regarding the workplace, about 63% of the participants (n=171) said they worked in care practices in hospital institutions, while the other 36.2% (n=97) were nurses in primary health care units (Table 1).

Table 1 – Profile of nurses according to sociodemographic, education professional activity and workplace characteristics. Rio Grande do Sul, RS, Brazil, 2016. (n=268)

Characteristics	Categories	n (%)†	Media±*
Sex	Female	239 (89.2)	
	Male	29 (10,8)	
Age			36.6±8.6 (minimum 23–maximum 62)
Qualifications	Specialization	201 (75)	
	Masters	87 (32.5)	
	Doctorate	19 (7.1)	
Ethics training in the last year	Yes	44 (16.4)	
	No	224 (83.6)	
Employment links (non- respondents n=5)	1	213 (81)	
	2	47 (17.9)	
	3 or more	3 (1.1)	
Weekly working hours (non-respondents n=8)	Up to 35 hours	20 (7.5)	
	36 – 40 hours	199 (74.8)	
	More than 40 hours	41 (15.4)	
Exceeds the amount of contract hours	Yes	162 (60.4)	
	No	106 (39.6)	
If yes, are they paid for overtime work	Yes	46 (28.4)	
	No	116 (71.6)	
Monthly salary (non respondents n=3)	From R$788-R$2,364	19 (7.2)	
	More than R$2,364-R$3,940	66 (24.9)	
	More than R$3,940 – R$5,516	83 (31.3)	
	More than R$5,516-R$7,880	63 (23.8)	
	More than R$7,880	34 (12.8)	
Length of nursing experience			10.1±8.1 (minimum 1- maximum 40)
Time in current working position			6.7±8.1 (minimum 1- maximum 37)
Place of work	Hospital Institution	171 (63.8)	
	Primary Health Care Units	97 (36.2)	

*±: standard deviation; † non-respondents excluded

When questioned about how often risk factors could lead to moral distress, 59.6% (n=189) said 'rarely', while 31.1% (n=83) reported 'frequently / always'. According to the participants, experiencing this type of situation can lead to feelings of discomfort (69%, n=180), uselessness (66.7%, n=174), frustration (63.2%, n=165), anguish (59.8%, n=156), dissatisfaction (57.9%, n=151) and sadness (41.8%, n=109) (Table 2).

Table 2 – Situation related to the experience of risk factors in relation to the possibility of the occurrence of moral distress and resulting feelings. Rio Grande do Sul, RS, Brazil, 2016 (n=268)

Characteristics	n (%)
How often experiencing risk factors can lead to moral distress (non-respondents n=1)	
Never	25 (9.4)
Rarely	159 (59.6)
Often/Always	83 (31.1)
Experiencing this situation can cause feelings of	
Discomfort	180 (69)
Uselessness	174 (66.7)
Frustration	165 (63.2)
Anguish	156 (59.8)
Dissatisfaction	151 (57.9)
Sadness	109 (41.8)
Anger	82 (31.4)
Distress	81 (31)
Desperation	68 (26.1)
Pain	56 (21.5)
Exhaustion	56 (21.5)
Headaches	51 (19.5)
Malaise	49 (18.8)
Insomnia	36 (13.8)
Lack of appetite	6 (2.3)

The risk factors that presented the highest frequency means were: stress (3,11), problems related to the physical structure of the institution (3.00), physical/mental/emotional exhaustion (2.97), disorganization of the health system (2,96), lack of time due to excessive work hours (2.90), lack of financing/resources/equipment (2.84), health care commercialization (2.81), excessive number of patients assigned to each nurse (2.77), lack of nurses (2.75), professional devaluation (2.74), observing inappropriate family behavior (2.71), institutional norms that make caring difficult (2.60), inappropriate use of available resources (2.56), care delays (2.55), inability to challenge the decisions of other professionals (2,54) and hierarchical structure (2,50). The mean scores of the items varied between 3.11 and 1.88, with an average of 2.50 (± 0.73), indicating a moderate risk for moral distress (Table 3).

Table 3 – Risk factors for moral distress in nurses Rio Grande do Sul, RS, Brazil, 2016. (n=268)

Risk Factors	Never		Rarely		Often/ Always		Median Scores
	n	%	n	%	n	%	
Stress	3	1.1	35	13.1	230	85.8	3.11
Problems related to the physical structure of the institution	9	3.4	60	22.4	199	74.3	3.00
Physical / mental / emotional exhaustion	2	0.7	52	19.4	214	79.9	2.97
Disorganization of the health system	2	0.7	54	20.1	212	79.1	2.96
Lack of time due to excessive work hours	13	4.9	51	19.0	204	76.1	2.90
Lack of financing / resources / equipment	11	4.1	71	26.5	186	69.4	2.84
Health care Commodification	14	5.2	75	28.0	179	66.8	2.81
Excessive number of patients assigned to each nurse	20	7.5	72	26.9	176	65.7	2.77
Lack of nurses	18	6.7	80	29.9	170	63.4	2.75
Professional devaluation	19	7.1	67	25.0	182	67.9	2.74
Observing inappropriate family behavior	5	1.9	92	34.3	171	63.8	2.71
Institutional norms that make caring difficult	14	5.2	103	38.4	151	56.3	2.60
Inappropriate use of available resources	13	4.9	112	41.8	143	53.4	2.56
Care delays	13	4.9	114	42.5	141	52.6	2.55

Inability to challenge the decisions of other professionals profissionais	14	5.2	117	43.7	137	51.1	2.54
Hierarchical structure that determines the impotence and subordination of the nurse to the doctor	39	14.6	91	34.0	138	51.5	2.50
Patient unable to pay for treatment	60	22.4	54	20.1	154	57.5	2.49
Conflicts between patients, family and professionals	11	4.1	138	51.5	119	44.4	2.44
Excluded from decision making	27	10.1	112	41.8	129	48.1	2.44
Work dissatisfaction	25	9.3	126	47.0	117	43.7	2.40
Lack of autonomy at work	33	12.3	139	51.9	96	35.8	2.28
Unpreparedness to deal with death	34	12.7	142	53.0	92	34.3	2.26
Linguistic and cultural obstacles	32	11.9	167	62.3	69	25.7	2.16
Excessive use of high technology in the prolongation of life	66	24.6	106	39.6	96	35.8	2.16
Disrespect to the patient's will	40	14.9	169	63.1	59	22.0	2.09
Fear of not being accepted by the team	46	17.2	162	60.4	60	22.4	2.06
Being questioned about information that is confidential	51	19.0	158	59.0	59	22.0	2.05
Fear of losing the job	77	28.7	126	47.0	65	24.3	2.03
False hopes for patients and families	60	22.4	167	62.3	41	15.3	1.94
Fear of reporting errors	87	32.5	137	51.1	44	16.4	1.88
Total Median							2.50

When questioned if they considered themselves to be experiencing moral distress at that moment, 32.7% (n=87) said yes. Approximately 73.6% (n=195) reported having experienced moral distress at another point in their professional lives, with 23.8% (n=63) only experiencing it once and 49.8% (n=132) more than once. In relation to feeling free to talk about moral distress, about 43% (n=114) said they rarely talked about the topic with their manager, but talking about moral distress with colleagues was more frequent (44.5%; n=118). In this study, 36.9% (n=99) of the nurses said that if they could, they would leave their current workplace due to moral distress. Among these, 37.5% (n=36) would seek employment in another type of service, 35.4% (n=34) would seek employment in a similar service and 21.9% (n=21) would seek work unrelated to nursing. The percentage of nurses who had already left a workplace due to moral distress was 33.1% (n=88) (Table 4).

Table 4 - Moral distress variables. Rio Grande do Sul, RS, Brazil, 2016. (n=268)

Moral Distress	Categories	n (%)
Would say they are experiencing moral distress at present (non- respondents n=2)	Yes	87 (32.7)
	No	179 (67.3)
Has experienced moral distress before (non-respondents n=3)	Never	70 (26.4)
	Once	63 (23.8)
	More than once	132 (49.8)
Would feel free to talk to the manager about moral distress (non-respondents n=3)	Never	33 (12.5)
	Rarely	114 (43)
	Frequently	58 (21.9)
	Always	60 (22.6)
Would feel free to talk to their colleagues about moral distress (non-respondents n=3)	Never	9 (3.4)
	Rarely	79 (29.8)
	Frequently	118 (44.5)
	Always	59 (22.3)
Would leave their place of work due to moral distress	Yes	99 (36.9)
	No	169 (63.1)
If yes, what type of work would you look for (non-respondents n=8)	Similar work	34 (35.4)
	Another type of work	36 (37.5)
	Work unrelated to nursing	21 (21.9)
Terminated employment due to moral distress (non-respondents n=2)	Yes	88 (33.1)
	No	178 (66.9)

DISCUSSION

Considering the purpose of the study was to describe the profile of the participants and the frequency of the occurrence of risk factors for moral distress, a study with a sample of nursing assistants in *Rio Grande do Sul*, showed that the majority of these participants were women, had completed specializations in nursing, maintained employment, worked between 36-40 hours a week, performed overtime frequently, and had an average monthly income of between five and seven minimum wages . It was observed that the distribution of nurses between the hospital and primary care areas was consistent, with alleged high percentages of moral distress during their professional lives, and a considerable percentage of professionals intending to leave their current work position. There was a moderate average regarding the experience of risk factors for moral distress.

Moral distress has gained interest in the field of nursing ethics in recent years, which, according to the literature, is related to the increasing challenges of professional practice regarding rapid technological development and global financial tension, associated with its consequences for the organizations.[13] In this context, studies aiming to identify and confront the challenges that guide the nursing practice can represent a considerable effort during the search for job quality and satisfaction in professional practice.[14]

Considering the characterization of nursing and its work contexts, ranging from the local characteristics to the global political context, the high percentage of women is crucial to the understanding of moral distress, not only in the sample of this study, but in nursing as a whole, as it questions greater predisposition to the experience of moral distress because it is a predominantly female profession.[7] In the literature, the link between moral distress and gender is not clear, with studies showing higher percentages of moral distress in women,[15] others in men,[16] while most studies do not show significant differences between the two.[17-18]

Historically, nurses were expected to accept the authority of physicians and as a result they did not participate in the decision-making process in patient treatment at a time when medicine was mostly performed by men and nursing by women. This power structure associated with gender remains in the current social imaginary, even with a higher number of women doctors and male nurses.[19] In fact, in a study carried out with male nurses in Brazil, 65.8% of the respondents reported already suffered gender discrimination in their work environment.[7]

The relationship between age and moral distress is also unclear in the literature.[20] A study of nurses in New Zealand highlighted higher rates of moral distress in younger nurses, which could be related to these professionals receiving more ethical training when compared to the older nurses. According to this study, the advances in the ethical education of the new generations of nurses can help in the greater recognition of the degree of moral distress in their practices.[17] A study with male Chinese nurses highlighted higher rates of moral distress among older nurses, mainly related to the appropriation of knowledge and experience, which could be a differential element when faced with care considered incorrect.[21]

Regarding the variables of professional activity, working conditions have been pointed out in the literature as factors strongly related to moral distress in nursing,[1] mainly due to the high workload of these professionals.[14] In this study, despite the low number of nurses with more than one employment position, the percentage of professionals who frequently perform overtime is high. This type of work overload can create a mismatch in patient care, hindering the adequate execution of professional activities, and increasing the risk of moral distress.[14] The nurses' response to such working conditions may be found in the manifestation of dissatisfaction and professional burnout.[7]

Regarding the context of the nurses' performance, the literature describes differences in the experience of moral distress between hospital services and primary health care units, with the highest levels of moral distress described by nurses from hospital institutions. The reason for this difference between services is mainly anchored in aspects related to the shortage of time and the quality of work relations, which are more pronounced in the hospital context.[22] Another aspect would be the distribution of professionals between public and private institutions, as nurses working in private institutions in the *Rio Grande do Sul* tend to work longer hours and earn less, when compared to nurses in public institutions, which may be directly related to the professional´s amount of experiences related to the risk factors for moral distress.

The moderate risk level for moral distress found in this study is similar to that of other studies,[23-24] although these studies were performed exclusively in hospital settings. The risk factors with the highest frequency averages were mainly related to organizational and management difficulties, high workloads and low professional autonomy.

This preoccupation with organizational and managerial difficulties was also described by other studies carried out in similar scenarios in developing countries, where financial and social difficulties lead to reflection on working conditions.[25] In this context, the literature draws attention to the importance of including political, social, and economic aspects in research related moral distress.[26]

The high workload is mainly associated with the lack of personnel and the possibility of compromising care, which can lead to professional burnout and professional alienation, both because it deprives the professional of giving attention and listening to their patient and it deprives the nurses of time to reflect on their own distress.[25] The lack of personnel can be observed in studies conducted both in Brazil,[27] and abroad.[28]

The perception of low professional autonomy may be related to the fact that nurses often have more responsibility than authority in their work context. The nurse performs the activities but almost never considered in the decision-making process. This problem may be even more serious in contexts where the rules are set by the manager, without their participation, with bureaucratic hierarchical structures and the institution´s inflexible attitudes.[29]

The number of participants who reported to be experiencing moral distress or have experienced this phenomenon at another time of professional life, is significant. According to the literature, a nurse who has experienced moral distress has a greater risk of experiencing it again, because there is a relationship between the experience of repeated experiences of moral distress and the intensity of the phenomenon. This effect is due to the moral residues that remain with the health professional and accumulate after each occurrence of moral distress.[30]

The results also show that nurses tend to have greater freedom to talk about moral distress with colleagues than with managerial staff. This type of result shows that institutions must attend to the difficult ethical issues that arise on a daily basis, and must be interested and open so that the professional can express their uncertainties and difficulties without fear of retaliation.[1] The fear of being considered weak, unable to cope with the problems arising from work and to tolerate the pressure inherent to the role of nurse can condition the professional to maintain silence, causing distress to be a natural part of the work routine.[1]

The number of participants who, if they could, would leave their workplace due to moral distress was relevant. The literature demonstrates that this association is significant when a study with an analysis model adjusted for age, gender, ethnicity, and specialty area in adult and pediatric nursing care, showed that each unitary increase in the frequency of moral distress can double the chances of the nurses intention to terminate their employment.[16]

It is also important to think about those professionals who, despite their intention to leave, remain in their positions due to contextual factors, such as the shortage of other employment.[23] In order to investigate such sensitive issues such as moral distress , actions must be developed that can improve not only the retention of nurses, but also satisfaction in nursing work.[15]

This is a descriptive study, which did not intend to demonstrate associations between the variables, in a sample of professionals from a state in the southern region of Brazil. The ability to determine causal inferences and to extrapolate results to other populations is therefore limited. However, in general, it is possible to perceive that many national and international studies corroborate the findings, and collaborate in the foundation of cohesive information on the theme of moral distress.

CONCLUSION

Research that addresses issues related to employee health can contribute to improved job satisfaction, prevent absenteeism, and prolonged sick leave. Identifying the risk factors for moral distress that concern nurses the most, in the different contexts of professional performance, can help both prevention and the construction of coping strategies and contribute to the maintenance and improvement of nursing care quality .

Management plays an important role in the process of identifying these risk factors and in the discussion of moral distress with nursing staff as well as preventing the acceptance or naturalization of such distress. When the professional feels that they can express their anguish and raise ethical issues freely, moral distress can be approached in a collaborative way.

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