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Original Article

Moral distress in nursing personnel

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Objective: to analyze the frequency and intensity of moral distress experienced by nursing personnel in southern Brazil, covering elements of their professional practice. Method: a survey was undertaken in two hospitals in Rio Grande do Sul, Brazil, with 247 nurses. Data was collected by means of the adapted Moral Distress Scale. Results: the perception of situations that lead to moral distress is enhanced in nurses and in nursing staff working in institutions with greater openness to dialogue, which hold team meetings, with fewer working hours and a greater ratio of professionals to patients. Conclusion: understanding moral distress allows us to go beyond solving the problems of the workers themselves, enabling the development of an ethics of active individuals and wide opportunities, defined mainly by the relationship with oneself.

Descriptors: Nursing; Nursing Ethics; Burnout.

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Sofrimento moral em trabalhadores de enfermagem

Objetivo: analisar a frequência e a intensidade de sofrimento moral vivenciado por trabalhadores de enfermagem do Sul do Brasil, contemplando elementos do seu cotidiano profissional. Método: survey realizado em dois hospitais do Rio Grande do Sul, Brasil, com 247 profissionais de enfermagem. A coleta dos dados ocorreu mediante aplicação da adaptação do Moral Distress Scale. Resultados: a percepção de situações que conduzem ao sofrimento moral é intensificada em enfermeiros e em trabalhadores de enfermagem que atuam em instituições com maior abertura ao diálogo, realizam reuniões de equipe e têm menores jornadas de trabalho. Essa percepção também é intensificada quando se observa maior relação no número de profissionais por pacientes. Conclusão: compreender o sofrimento moral permite ir além da resolução dos problemas dos próprios trabalhadores, possibilitando a elaboração de uma ética de sujeitos ativos e de amplas possibilidades, definidas principalmente pelas relações consigo mesmos.

Descritores: Enfermagem; Ética de Enfermagem; Esgotamento Profissional.

Sufrimiento moral en trabajadores de enfermería

Objetivo: analizar la frecuencia e intensidad del sufrimiento moral vivido por los profesionales de enfermería del sur de Brasil, abarcando los elementos de su rutina profesional. Método: investigación survey en dos hospitales, con 247 profesionales de enfermería. Los datos fueron recolectados mediante aplicación de la adaptación del Moral Distress Scale. Resultados: la percepción de situaciones que conducen al sufrimiento moral es intensificada en enfermeros; en trabajadores de enfermería que actúan en instituciones con mayor apertura al dialogo, que realizan reuniones de equipo, con menos horas de trabajo y mayor relación del número de profesionales por paciente. Conclusión: entender el sufrimiento moral permite ir más allá de la resolución de los problemas de los propios trabajadores, lo que posibilita la elaboración de una ética de sujetos activos y de amplias posibilidades, definidas principalmente por la relación consigo mismo.

Descriptores: Enfermería; Ética en Enfermería, Agotamiento Profesional.

Introduction

The nurse's professional training is directed at the importance of ethical practice, and seeks to prepare the future workers to competently and daily face ethical and moral problems in the work environment; that is, situations of moral uncertainty, moral dilemmas, and moral distress[1].

It may be seen on a daily basis how much the experience of exhausting routines, stress, precariousness of nursing care, bureaucracy, lack of dialog and banalization of death, among others, accompanied by feelings of impotency in the face of apparent neglect in relation to the patients, influence the nurses' ways of being and doing[2-3], which can provoke in them feelings of discomfort and suffering, without these commonly being identified as moral distress (MD).

Considered to be an "inconsistency between the nurses' actions and convictions", or, further, as a painful feeling or psychological imbalance that results from recognizing an ethical action that cannot be adopted, the usual causes of MD's occurrence in the nursing teams are the low number of workers, associated with the high demand for care, the lack of time for carrying out the activities, and the exercising of power capable of inhibiting a moral, political, institutional or legal action[4].

From a Foucaultian perspective, these characteristics demonstrate that for an ethical action to be adopted, consistent with the nurses' perspectives, it is not only one act or the constant repetition of a behavior that guarantees its adoption. Their action is related to something more intense and profound, linked to a relationship with oneself, that is, with a personal

constitution of oneself as a living experience of a moral subject[5].

MD may be understood as pain or distress that can affect the mind, the body and interpersonal relations in the work setting, in response to a situation in which a person recognizes their moral responsibility in the face of moral conflicts and makes a moral judgement on the correct behavior, but is impotent to carry it out due to constraints or opposing forces, and recognizes their moral participation as inadequate[6].

Although suffering may be experienced by those who work in health care, principally linked to the high work demands and to the constant requirement for productivity and privatization and mercantilization of health and its spaces, MD refers to the phenomenon of suffering associated with the ethical dimension of care in health practices. When nurses and other health care professionals face limitations on their capacity for ethical practice, they feel forced to compromise their personal values and norms, and may experience MD[7].

On reflecting on MD and the problems of the profession, one is dealing with something larger than an analysis of how power relations are constructed and deconstructed in nursing and health: one is moving towards how nursing professionals become subjects, and how they construct themselves as ethical beings[8], perceiving MD and confronting – or not – the moral problems related with it.

In the first studies of MD, predominantly with qualitative approaches, professionals were interviewed, individually or in small groups[9]. Differently to this, an instrument called the Moral Distress Scale (MDS) [4] has been applied in quantitative studies, in distinct contexts[10-14]. Its questions focus on dilemmas, ethical problems, therapeutic futility and insecure work conditions, among others, and it is possible to identify the experience of diverse behaviors related to MD in different cultures.

The MDS´s transcultural adaptation to Portuguese was accomplished in a study with Brazilian nurses[2], in which four constructs related to the perception of MD were identified and validated: *negation of the role of the nurse as the patient´s advocate*; *lack of competency in the work team*; *disrespect of the patient´s autonomy*; and *therapeutic obstinacy*. On the termination of the present study, it was possible to confirm that the instrument appeared not to have adequately explored MD referent to moral problems that are related principally to organizational problems previously identified in nurses' day-to-day activities – such as lack of health professionals, precariousness of material resources, and the lack of professional autonomy[15]. Further, considering that in Brazil nursing is carried out by three different categories, it was questioned how the nursing workers – and not just the nurses – experienced MD.

Thus, justifying the need to better explore MD in nursing workers, considering previously-detected peculiarities of their organizational routines, this study aimed to analyze the frequency and intensity of moral distress experienced by nursing workers in the South of Brazil, covering elements of their professional routines.

Method

This is quantitative, exploratory-descriptive research, a survey, and with a cross-sectional design. The research subjects were nurses, nursing technicians and auxiliary nurses in two hospitals located in the South of Brazil – one public (H1), of 185 beds and 295 nursing workers – and one philanthropic (H2), of 658 beds and 387 nursing workers. The hospitals were intentionally chosen to serve as a field for other research previously undertaken by the authors, in related areas, extending the knowledge which made this study possible.

In H1, the nursing professionals had gained their positions through passing *concursos**, with job security and a working week of 30 hours, guaranteed after extended strikes and demands from the nursing teams. In H2, the nursing professionals have contracts governed by the Consolidation of Labor Laws (CLT) and have a weekly workload of 36 hours. In H1, the ratio is of 1.59 nursing workers per bed, while in H2 it is 0.58 workers per bed.

For data collection, the authors used an adaptation of the MDS[4] undertaken by the present research's authors and tested in a previous study[2], validated in Portuguese and with 21 questions[2], which included, for the reformulation of the instrument in the present research, an additional 18 questions resulting from the knowledge produced by studies which were either directed or carried out by the authors of the present research[2-3,15-16]. Data collection occurred between September 2010 and April 2011, through a self-administered three-page questionnaire. The first page had detailed instructions about MD and how to fill out the instrument, and questions about the subjects'

* Examinations for government positions. Translator's note.

characterization; the second and third pages had 39 questions operationalized in seven-point Likert scales, varying from (0) for 'never occurs or no frequency', to (6) for 'very intense suffering or very frequent'. These were related to specific situations which can provoke MD and which are faced in the profession's daily routine. There was also a 40th question, also operationalized on a seven-point Likert scale, but which was more generic: *in a general way, the situations experienced at work provoke MD in me.*

The questionnaire was applied in two versions, one for the nurses and one for the nursing technicians and auxiliary nurses. The two versions differed only in the items referent to the subjects' characterization. Of the 39 questions proposed by the instrument, under a factorial analysis, 23 were validated in the present study, of which 10 were from the instrument previously validated in Portuguese[2] and 13 from the version proposed by the present study.

The instrument's 23 questions were validated in five constructs, termed, in this research, as: *lack of competency in the work team,* defined as an absence of skill or technical competency which each professional category should present in carrying out a task which is specific to their profession[11]; *negation of the nurse's role as the patient's advocate,* defined as the nurses' failure to use the potential to exercise the patients' rights[17]; *negation of the nurse's role as advocate for the terminally-ill patient*, defined as the nurses' failure to use the potential to exercise the patients' rights during the dying process[17]; *inadequate work conditions*, characterized as a lack of material/human conditions for carrying out nursing work[18]; and *disrespect for patient autonomy,* defined as disrespect for the patient's self-governance, privacy, individual choice and freedom of will[19].

Cronbach's alpha for the instrument was 0.95, varying between 0.79 and 0.91 in the five constructs identified. The total variance explained by the validated instrument was 68.99%. The measure of sampling adequacy (KMO) was 0.941.

The sample size was defined by a specific mathematical formula[20], which established that a minimum number of 245 subjects was necessary to ensure the study's statistical reliability. 350 questionnaires were handed out to the nursing workers in the two institutions, of which 291 were handed back – representing an 83.14% return rate. 44 were excluded, either because of incorrect filling out of the questions or because of a single response being given throughout the entire instrument (i.e. only 0 or only 6), or because the instrument was handed back blank. The final sample was, therefore, 247 questionnaires.

The data was subjected to three distinct analyses, using the statistical software SPSS (Statistical Package for Social Sciences) version 13.0: 1) descriptive statistics, through the use of averages and frequency distribution, to identify the intensity and frequency with which MD is experienced; 2) variance analyses between groups of respondents (different hospitals, departments, professional categories), according to the sample's characteristics, to check possible significant differences between the groups of subjects/respondents; 3) regression analysis, seeking to evaluate which constructs had the greater effects on the nursing professionals' perceptions of experience of DM. The project was judged and approved by the Research Ethics Committee, under Decision number 70/2010.

Results

The sample was comprised of 47 (19%) nurses, 31 (12.5%) auxiliary nurses and 169 (68.5%) nursing technicians, of whom 212 (86.0%) were female, respectively, 43 (17.5%) nurses, 26 (10.6%) auxiliary nurses and 143 (57.9%) nursing technicians; 67 (27.1%) of the nursing professionals were from H1 and 180 (72.9%) from H2. In relation to age, 129 (52.2%) nursing workers were aged over 30 years old, approaching maturity. The length of service in the profession was, on average, nearly six years (5.8), with a median of four years, which may be considered a reasonable length of professional activity. These professionals' average length of service in their hospital institution was four years, with a median of two years.

In relation to professional qualification, 72.3% of the 47 nurses had undertaken a post-graduate qualification: in H1, eleven nurses had M.As and seventeen were specialists; in H2, only six professionals had finished the specialization course. In relation to the two institutions' nursing technicians and auxiliary nurses, 70.5% had concluded only their initial training course. Questioned about openness of dialog, in H1, 68.6% of the subjects stated that their institution was open to dialog, whereas only 31.1% of H2's subjects recognized this characteristic in their institution.

The descriptive analysis (Table 1) allowed the identification of the nursing teams' perceptions concerning the MD experienced. Each of the five constructs identified in the research was operationalized

through a numeric value, which represented the arithmetical average of the 23 questions previously grouped by factor analysis. The averages of intensity of MD varied from (3.77) to (4.37) and the frequencies of occurrence of situations which lead to MD varied from (1.98) to (2.57).

Table 1 – Rates of intensity and frequency of moral distress experienced through the situations represented in the validated instrument's questions - Rio Grande, RS, Brazil, 2012

Factors and questions	n	Intensity	n	Fq
Lack of competency in the work team	247	4.36	247	2.57
q-18. Assist a physician who, in your opinion, is being incompetent in providing patient's care.	247	4.52	247	2.38
q-25. Work with nursing assistants who are not as competent as the patient's condition requires.	245	4.38	246	2.57
q-31. Work with physicians who are not competent enough to work	244	4.38	247	2.65
q-29. Work with nurses who do not have the competency to work.	247	4.36	246	2.57
q-33.Work with non-licensed employees who are not competent enough to work	245	4.36	246	2.58
q-32. Work with support services who do not have the competency to work.	245	4.21	245	2.68
Negation of the role of the nurse as the patient's advocate	247	4.19	247	2.37
q-10. Allow medical students to carry out painful procedures on patients simply to improve their skills.	247	4.39	247	2.36
q-17. Follow the physician's order of not telling the patient the truth when he/she asks for it.	245	4.30	244	2.34
q-16. Observe without taking action when nursing teams do not respect the patient's privacy.	246	4.13	244	2.45
q-11. Assist physicians who are practicing procedures on a patient after CPR has been unsuccessful.	246	3,96	246	2.34
Negation of the role of the nurse as advocate for the terminally-ill patient.	247	4,13	247	2.26
q-38. Avoid taking steps when you see that the terminally-ill patient is being abandoned by the health team	247	4,29	247	2.04
q-34. Avoid taking steps in situations of death of patients associated with professional negligence.	245	4.23	243	2.09
q-39. Avoid taking steps when you notice that a terminally-ill patient is being abandoned by the family.	247	4.17	247	2.33
q-37. Begin intensive procedures for saving a patient's life when the terminally-ill patient has already made clear their desire to die.	246	4.03	246	2.35
q-36. Work with professionals who do not clarify to the patient his/her state of health and illness.	245	3.99	247	2.48
Inadequate work conditions	247	4,08	247	2.54
q-08. Not have available the equipment necessary for emergency assistance of a patient.	247	4.30	247	2.49
q-14. Need to prioritize which patients shall receive care due to insufficiency of human resources.	244	4.19	245	2.51
q-06. Not having the necessary materials for providing care to the patients.	241	3.96	241	2.71
q-15. Need to delegate nursing care to patients' relatives due to insufficient human resources.	242	3.91	245	2.46
Disrespect for patient autonomy	247	3.77	247	1.98
q-21. Follow the physician's order not to discuss with the patient his or her resuscitation in the event of a cardiac arrest.	247	3.82	246	1.93
q-23. Follow the physician's order not to talk about death with a dying patient who asks you about dying.	246	3.81	245	1.97
q-22. Obey a doctor's request not to discuss with a patient's family the resuscitation of the patient in the event of a cardiac arrest, when the patient cannot choose for him- or herself.	247	3.79	245	1.86
q-04. Provide assistance to a doctor who is carrying out a procedure on a patient without the consent of the patient or a member of his or her family.	247	3.66	247	2.17

Some important correlations were identified from the variance analyses undertaken (Table2), with significance rates at the level of 5%. Firstly, using the T test and seeking significant differences between the groups of data, it was ascertained that the more an institution is open to dialog, the greater the openness to dialog on the part of the management and the nursing teams, and the greater the workers' perception of MD in four constructs, with the construct *disrespect for patient autonomy* not included.

Furthermore, the researchers obtained correlations at the level of 5% with *post-hoc* analyses in the Duncan's test (Table 2), making it possible to identify homogenous groups with each of the variables. In relation to the type of unit where staff worked, it was noticed that the mixed and private units formed a distinct bloc, showing that MD is perceived with greater intensity by those working in UHS units, correlated with question q-40 in all five constructs. Further, in the correlation between *professional categories* and the construct *negation of*

the role of the nurse as advocate for the terminally-ill patient, nursing technicians and auxiliary nurses constitute an isolated group, presenting lower averages for perception of MD, when compared to the nurses.

Table 2 – Comparison of the perception of MD, according to types of unit, hospital, carrying out of meetings and professional category - Rio Grande, RS, Brazil, 2012

Alpha = 0.5	q-40		Lack of competency in work team		Disrespect for patient autonomy		Inadequate work conditions		Negation of the role of the nurse as advocate for the terminally-ill patient		Negation of the role of the nurse as patient advocate	
Type of unit												
Private (17)	3.55		3.93		3.38		3.37		3.45		3.85	
Mixed (128)	3.71		4.01		3.56		3.84		3.76		3.96	
UHS (122)		4.22		4.87		4.09		4.52		4.71		4.53
Hospital												
H2 (180)	-	-	4.10		3.65		3.81		3.89		4.01	
H1 (47)				5.05		4.08		4.13		4.60		4.68
Carries out meetings												
No (150)	-	-	4.21		-	-	-	-	3.98		-	-
Yes (97)				4.60						4.38		
Professional category												
Auxiliary nurse (31)									4.21			
Nursing technician (169)	-	-	-	-	-	-	-	-	3.96		-	-
Nurse (47)										4.67		

Significance at the level of 5%

It also stood out that the perception of MD among nursing workers in H1 was higher than in those in H2, in all five constructs. Moreover, it was identified that there was a higher perception of MD in the constructs *lack of competency in the work team* and *negation of the role of the nurse as advocate for the terminally-ill patient* among professionals who stated that they held meetings with the work team.

In the evaluation of the effects of the five constructs in relation to the perception of MD, using the linear regression model, with question q-40 as a dependent variable, the results identified a significant relationship at the level of 5% in four constructs, with *negation of the role of the nurse as patient advocate* (Table 3) being excluded. The test obtained an adjusted coefficient of determination (R^2) value of 0.24, representing an explanatory value of 24% for MD based on the questionnaire used in this research.

Table 3 – Analysis of linear regression between the constructs - Rio Grande, RS, Brazil, 2012

Variable	B	P
Lack of competency in the work team	0.185	0.02*
Disrespect for patient autonomy	0.350	0.00*
Inadequate work conditions	0.225	0.00*
Negation of the role of the nurse as advocate for the terminally-ill patient	0.146	0.05*
Negation of the role of the nurse as patient advocate	0.106	0.76

* significance at the level of 5%

Discussion

Lack of competency in the work team was the construct that caused most MD in the workers, with question 18 standing out - "Provide assistance to a doctor who, in your opinion, is acting in an incompetent manner with a patient" (4.52), in addition to the other questions related to working with medical professionals (4.38), nurses (4.36), nursing technicians and auxiliary nurses (4.38), who do not present the competency necessary for the role or with student nurses or doctors (4.36).

The perception of MD in these cases appears to be strongly associated with these workers' need to exercise power, which can mean needing to face conflicts with other health professionals so as to avert risks to the patients, ensuring patient safety. These situations show that for nursing professionals, their actions should not be based only in following behaviors or rules, but in something more intense and profound, linked to a relationship with oneself, a personal constitution of oneself as a living experience of a moral subject[5].

In relation to the construct which had the greatest effect on the perception of MD, it was identified through the regression model that *disrespect for patient autonomy* obtained the highest average in the study, followed by the construct *inadequate work conditions.* Situations related to the constructs *disrespect for*

patient autonomy and *inadequate work conditions* may be experienced daily and routinely, without their moral aspect being recognized or emphasized by the workers, causing, in this way, an apparent normality which may be reflected in the quality of the care, which in addition to being a technical-scientific activity, is also a moral practice[21].

Continuing in relation to hospital H2, where the perception of MD was lower, various situations may be associated, among which one may cite, in addition to lower openness to institutional dialog, and as a result of management and health teams, job insecurity, a lower ratio of health professionals to beds, a greater number of hours worked per week, and lower qualification among the health professionals. These situations, however, being considered "historical factors related to the development of the profession"[22], seem to be fairly common in the daily routine of many nursing professionals, who, in the mortification of their desires and in personal renunciation[23], find a way of confronting their everyday problems, with implications as much for care of oneself as for care for others.

Thus, such forms of renunciation are related to how these workers exercise their liberty, submitting to states in which they may perceive few possibilities for change, with characteristics of mortification which may be reproduced while strategies for resistance are not yet constructed, from an ethical perspective.

In hospital H1, on the other hand, it stood out that *disrespect for patient autonomy* was where MD was perceived with the greatest intensity. In this matter, it is considered that as a result of their job security, a greater incentive to gain professional qualifications under a program of career progression and financial stimulus, a higher professional/patient ratio and fewer weekly hours, resulting from a political movement for collective demands, as well as through experiencing greater openness to dialog (that is, having their rights as citizens apparently more recognized and respected), this institution's workers may be more conscious about recognition of patients' rights as subjects - regarding knowledge of them, their bodies and health, and decisions concerning themselves, regarding previous consent for physically handling them and for their resuscitation (or not) in the event of a cardiac arrest.

This organization of work in H1, often obtained through different forms of confrontation and struggle waged in the micro-spaces where nursing works, demonstrates that one can be more free than it is thought that one can be[8]. Such advances apparently help the workers to exercise their rights and duties in a broader way, contributing to nursing becoming effective as a profession which advocates for the patients' rights[11].

The advocacy of patients' interests at the end of their lives, in situations where death is inevitable ,[3], of being cared for in the process of dying, of being informed of their condition, consulted about how they wish to experience this process, and respected in the different phases of the dying process which they manifest, shows a direct relationship with morality, and constitutes a fundamental nursing activity; it can create MD when the nursing professional cannot perform this role in a way that satisfies her ideals[15].

When mentioning nursing professionals, it should be highlighted that differences exist in the composition of the team, whose workers present different professional training and even cultural differences, arising from distinct social contexts. In this study, the authors observed significant differences (at a level of 5%) in the perception of MD, according to professional category. That is, more intense perception of MD was observed in nursing professionals in the construct *negation of the role of the nurse as advocate for the terminally-ill patient.*

This increased perception may be associated with various factors, such as: professional training at degree level, based in curricular guidelines which direct the professional nurse to integral care; a professional qualification with completion of post-graduate courses; greater knowledge in relation to how patients live healthily, fall ill, and die, in relation to their rights to access information about the health-illness process experienced, and in relation to decisions concerning the best conduct in their care and treatment – elements which, apparently, contribute to the differences identified.

It was also determined that only 29.5% of the nursing technicians and auxiliary nurses invested in their professional training after the end of their initial training course. Thus, the perception of problems in the area of health and nursing in its moral aspect seems to be benefitted when professional qualification and competence are higher[2]. One strategy identified for nursing professionals to understand both the importance of acting collectively and how much their professional knowledge could alter the reality is education in nursing[24].

It was verified that workers who work in UHS units perceive MD more intensely than those working

in private or mixed units. This situation may be associated with the more complete exercising of the role of nursing in being the patient's advocate, principally when, in some Unified Health System* units, the assistance is intended for patients who are socially and economically disadvantaged, and who may receive fewer clarifications, if compared with patients in private units[25], and who often receive insufficient guidance about their rights, or even about their right to benefit from rights.

However, it was ascertained that in hospital H1, where the perception of MD was more intense in all the constructs, assistance is restricted to UHS patients, a situation which may have positively influenced the perception of MD in these units.

Another noteworthy situation is the relationship of the institution open to dialog between management and teams, in which communication and its positive potential in work, when effective and open, is emphasized. It was identified that an institution open to dialog is reflected in greater openness to dialog between management and teams, as the results indicated. Dialog seems to be relevant for perception of MD and, according to the findings of a study which applied the MDS among North American nurses, even for its confrontation[11].

The holding of meetings with the nursing teams demonstrated important results, as a greater perception of MD was verified in environments where meetings were carried out. Differently from a study carried out previously with Brazilian nurses[2] in which 70.2% of the nurses stated that they held team meetings, it was noted that meetings were held infrequently; nevertheless, comparing information (about holding meetings) with data related to the perception of MD – distinct in the two hospitals – it was ascertained that they had a significant relationship.

In institution H2, where perception of MD was lower, only 36.6% of the workers stated that they participated in meetings with their teams, while in institution H1, the number of subjects who stated that they participated in meetings rose to 46.3%, data which may also be associated with this institution's organizational characteristics. In this way, the nursing professionals' job security stands out - it may benefit the existence of greater spaces for dialog, communication and the expressing of feelings and perceptions, which may – possibly – happen in meetings.

Conclusion

Hospital environments with distinct organizations may be relevant to the differences identified relating to the perception of MD, as greater openness to dialog, freedom to act, ability and resources to act appropriately job security, as well as a higher ratio of nursing staff to patients and better salaries, among others, may contribute to a greater perception of, and confrontation of, situations which lead to MD.

In this approach, understanding MD allows one to go beyond confronting the workers' own moral problems, moving to configure in a broader and more reflexive way the situations of the institution itself and the health system – which may be imperceptibly impeding the nursing care and comprehensive health care – thus benefitting the elaboration of an ethics of active subjects and wide possibilities, defined mainly by relations with oneself.

When the professionals base their actions in values recognized as ethical in the area of health and nursing, they seem to be more protected in their decisions, which may benefit both them and the patients themselves. From this perspective, it seems to be an efficient alternative for nursing professionals to question themselves and to look with fresh eyes at daily facts, problematizing the everyday and the relationships instituted, seeking, in the small things of everyday life, ways to denaturalize practices which were previously established and commonly accepted.

One limitation of this study is that it was undertaken with a sample of nursing professionals from a region in the South of Rio Grande do Sul which, although representative, may not be similar to the multiple health contexts identified in Brazil, in which case, therefore, its results may not be generalizable.

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