Ethics and moral distress expressions in intensive care nursing practice

Expressões da ética e do distresse moral na prática do enfermeiro intensivista

Expresiones de la ética y del distrés moral en la práctica del enfermero intensivista

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Abstract

Objective: To understand ethics and moral distress expressions in intensive care nursing practice.

Methods: This is a qualitative, descriptive, interpretive and analytical research, developed with 12 nurses working on the day shifts in a ICU of a teaching hospital in Minas Gerais. Data were collected through interviews, guided by a semi-structured script and submitted to content analysis.

Results: Two thematic categories emerged: *Ethics expressions: influences of values, virtues, relationships, and work organization*; *Moral distress in the context of ethics expressions*.

Conclusion: In intensive care nursing practice, ethics is mainly related to the practice of patient advocacy. However, gaps in relationships with the team and in work organization encourage conflict situations that generate moral distress.

Resumo

Objetivo: Compreender as expressões da ética e do distresse moral na prática do enfermeiro intensivista.

Métodos: Pesquisa qualitativa, descritiva, interpretativa e analítica, desenvolvida com 12 enfermeiros lotados nos plantões diurnos do CTI de um hospital de ensino de Minas Gerais. Os dados foram coletados por meio de entrevistas, guiadas por roteiro semiestruturado e submetidos à análise de conteúdo.

Resultados: Emergiram duas categorias temáticas: Expressões da ética: Influências dos valores, virtudes, relacionamentos e organização do trabalho; e, Distresse moral no contexto das expressões éticas.

Conclusão: Na prática do enfermeiro intensivista, a ética está relacionada, principalmente, ao exercício da advocacia do paciente. No entanto, lacunas existentes nos relacionamentos com a equipe e na organização do trabalho, fomentam situações de conflitos geradoras de distresse moral.

Resumen

Objetivo: Comprender las expresiones de la ética y del distrés moral en la práctica del enfermero intensivista.

Métodos: Investigación cualitativa, descriptiva, interpretativa y analítica, realizada con 12 enfermeros sobrecargados en las guardias diurnas de centros de terapia intensiva de un hospital universitario de Minas Gerais. Los datos fueron recopilados por medio de entrevista, con guion semiestructurado y sometidos al análisis de contenido.

Resultados: Surgieron dos categorías temáticas. *Expresiones de la ética: influencias de los valores, virtudes, relaciones y organización del trabajo,* y *Distrés moral en el contexto de las expresiones éticas.*

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Conclusión: En la práctica del enfermero intensivista, la ética está relacionada principalmente con el ejercicio de la defensa del paciente. Sin embargo, los vacíos existentes en las relaciones con el equipo y en la organización del trabajo fomentan situaciones de conflicto que generan distrés moral.

Introduction

Health practice encompasses ethical dimensions and is influenced by the complexity of work processes. In this perspective, the ethics expression permeates an exercise in reconstituting oneself by the subject,[1] which happens permanently throughout life, with special importance for the experiences lived at work.

In this socialization space, individuals relate with their peers and with the world, they subject the apprehended reality and give a new meaning to its concepts, which confers reconfiguration of itself[2] remodeling the ways of perceiving, being and acting in the world.[3]

Thus, through subjectivations and continuous reflection on oneself, the individual builds himself as an ethical subject, molding his way of being and performing moral work, mediated by values, principles and cultural aspects.[3] In this regard, ethics is expressed in individuals' actions and relationships with themselves and with the environment that surrounds them, and, taking the terms ethics and morals indistinctly, the ethics-moral experience productivity is considered "as continuous, endless and productive. in terms of subjectivity and identity".[4,5]

Considering that nurses' practice spaces are characterized by the meetings and relationships of this professional with their peers and patients, ethical and moral experiences are present in their daily work, resulting, for instance, from dissonances and conflicts, mainly related to qualified care.[5] Studies show that, among health professionals, nurses are those who experience ethical-moral problems with greater intensity,[5,6] and the moral problem can be defined by a fact or situation that mobilizes doubt in the individual regarding the appropriate mode of action, which requires positioning.[4]

When looking at the Intensive Care Unit (ICU), it is clear that this is a field of work for nurses, marked by the intensity of feelings and daily relationships that impact on professionals' practice,

highlighting ethical aspects that involve care and interpersonal relationships.[7] Among the factors that predispose nurses to experience ethics-moral conflicts at ICUs, the permanent contact with patients in need of critical care, the presence of imminent death, the shared experience with patients and family members of pain, anxiety, anguish before serious illness and the massive use of hard technologies for care stand out.[7-9]

In this way, in the daily routine of intensive care, several situations are configured as moral problems, which require positioning by nurses. It should be noticed, however, that the emergence of an ethical-moral problem at work requires professional sensitivity to perceive it, as well as demands resolutive action or deliberation, which is loaded with subjectivities, expressing concepts, cultures and values specific to nurses.[4-6]

Moral sensitivity is considered a cognitive state that precedes moral judgment,[10] and deliberation is a conduct that is guided by methods, dialogue and logical reasoning, which aims to solve the problem situation.[4] Nurses' deliberation takes place in the midst of an organizational environment that interferes with their concreteness,[7] culminating in situations in which deliberation, according to their moral judgment, is not possible, triggering the experience of moral distress at work.[4]

The experience of moral distress (or moral suffering, terms here understood as synonyms) in nurses' daily work is a moral experience and can generate deleterious marks on professionals, manifesting through feelings of anguish, helplessness, dissatisfaction; in repeated and more serious cases, it can lead to demotivation, apathy, leave from work and profession abandonment.[4,11] However, studies[4,12] consider that the experience of moral distress can be understood beyond an experience of suffering, consisting of a broad experience, source of resistance and coping in the daily work.

Several factors contribute to the moral distress being experienced in everyday life and perceived by

nurses in intensive care, including the development of their moral sensitivity, professionals' autonomy, workspace organization and physical structure, as well as the existing power relations.[5,7,10] These factors express the ethics in nurses' practice regarding the ways of organizing work and their daily relationships, reflecting moral experiences rich in meanings and subjectivity.

Casting eyes on ethics and moral distress is justified, considering that moral experiences are forms of ethical expression in nurses' practice and that they can still be traversed by moral distress, producing deleterious effects on professionals,[11] as well as understanding it is necessary to understand and reflect on ethics and moral distress expressions in nurses' practice so that their productive potential is addressed.[4,12] It is necessary to focus on the study of the ethics expression and moral distress in intensive care nursing practice.

Considering the problem posed, the present study sought to answer the following guiding question: How are ethics and moral distress expressed in intensive care nursing practice?

To this end, the present study aimed to understand ethics and moral distress expressions in intensive care nursing practice.

Methods

This is a qualitative, descriptive, interpretive and analytical research, carried out in an ICU of a University Hospital located in the state of Minas Gerais. The methods and results of this research are presented following the precepts defined by the Consolidated criteria for reporting qualitative research (COREQ).

The research setting was chosen intentionally and considered recent changes in its organizational context, which promoted new arrangements in nurses' work. For instance, the hospital management developed by EBSERH (Brazilian Company of Hospital Services - *Empresa Brasileira de Serviços Hospitalares*) stands out, which instituted the global care model as a nursing care model and tender as a way of admission to service.

The adoption of this care model led nurses to take on direct and comprehensive care for patients, being assisted by nursing technicians, developing care "at the bedside". Considering that studies indicate that nurses who work closer to patients tend to experience ethical situations more often[6] and even though the changes resulting from the new organizational arrangements related to the nursing care model impacted nurses' practice, the use of nurses is justified of this setting for this study.

Participants were chosen intentionally, including nurses who worked on the day shift in ICU and those who worked on the night shift were excluded if they were on statutory holidays or licensed to work in the service. The option for the day shift considered that there are singularities between the organization of day and night work in the hospital, which could potentially be significant for the common data analysis, and may be configured by bias in the research.

Initially, a sample of 20 nurses was considered, of which 2 were on statutory holidays, therefore meeting the exclusion criteria defined for the study. Of the other nurses, after being invited, 12 accepted to participate and 6 refused to participate.

Data were collected in February 2016, through interviews guided by a semi-structured script, which were conducted at the hospital itself, in a restricted location, at a previously scheduled time, recorded on an electronic device, lasting about thirty minutes. All interviews were conducted by a previously trained researcher, who introduced himself to the interviewee, and elucidated the objectives, ethical aspects, collecting the interviewee's consent. The interview was made available to the interviewee, who could hear it, so that, considering it necessary, modify, exclude or add some information.

The interviews were transcribed in full and data were submitted to thematic content analysis, according to the chronological poles of pre-analysis, material exploration and treatment of results, and data inference and interpretation. Pre-analysis was based on material organization and skimming, with the demarcation of the central themes. Material exploration and treatment of results allowed to make

them meaningful and valid. The last step consisted of data inference and interpretation.[13]

The research was carried out in accordance with the ethical principles expressed in the Declaration of Helsinki and in Resolution 466 of 2012 of the Brazilian National Health Council (*Conselho Nacional de Saúde*), was submitted to ethical review and approved by the Research Ethics Committee of *Universidade Federal de Minas Gerais*, under Opinion 1,237,831. All participants signed an Informed Consent Form, expressing their agreement to participate in the study and awareness of discomfort, risks and benefits of the research. In order to guarantee anonymity, all statements were coded as "Nur" (nurse), followed by the number of the respective interview.

Results

From analysis of the results, ethics expressions and moral distress emerged, with two analytical categories being delimited.

Ethics expressions: influence of values, virtues, relationships, and work organization

Nurses believe that humanization can evoke responsibility and empathy, these values and virtues being fundamental to the exercise of ethical care.

First of all, humanization that goes hand in hand with empathy, which are the fundamental values that I believe in, responsibility, empathy, humanization ... I also believe that patience (Nur 8).

Being ethical, being human, trying to provide the patient and people with a certain comfort. Be polite, know how far you can go, go gently, politely, with respect to the moment the person is experiencing. I think that ethics covers everything. Try to give quality assistance, within the knowledge I have. Doing for others what I would like maybe they would do for me (Nur 2).

For participants, ethical conduct should also be based on the codes and norms of the profession, which establish professional rights and duties regarding care.

Trying to be as fair as possible, often not based on what I think is fair, but based on what we have today palpable of legislation, rights, duties (Nur 6).

Ethics is expressed in ICUs supported by moral values and virtues, and by the code of professional ethics, and suffers interference from relational and organizational factors that, many times, offer obstacles to the exercise of ethics by nurses. Among these obstacles, nurses point out that imbalances in power relations between members of the multidisciplinary team make the autonomous practice of nursing unfeasible, mainly fostered by the greater appreciation of medical knowledge.

The hospital in this study is, from the places I have worked, the most medical centered place I have ever known in my life. Everything here is very medical-centered, everything revolves around medical knowledge. And as much as there is the discourse that nurses here have autonomy, our autonomy is for dressing and managing our scale, the rest, our autonomy is very small (Nur 1).

For nurses, the greater appreciation of medical knowledge in practices imputes to them a practice that is often unfeasible and devalued, subject to medical determinations. In fact, for Nur 9, there is a differentiated valuation in the work developed by auxiliary and supervisor nurses within interprofessional relationships, attributing meaning to imbalance in the physician-nurse relationship existing in this space, due to the change in the nursing care model proposed by EBSERH.

The medical issue here, that I came from another institution, "Hospital X", the medical and nurse treatment is different, although there are two teaching hospitals, the treatment is completely different. I believe that there, as we were supervising nurses, the way for the physician to hear what nursing had to say about the progress of that patient was seen in a way, we here continue to send higher education

nurses in the same way, only ours says care nurses do not have the same value (Nur 9).

Here the physician does not assess the patient, does not do a physical exam. The entire assessment of the patient is done by the nurses, it is the nurses who pass on the information. And even with our concern, they do not value our knowledge at all. Most of the times the patient undergoes a medical intervention, he only underwent medical intervention because there was a recognition of the need by a nurse before (Nur 1).

Nurses also attribute to the invisibility of their practice the lack of definition of the nursing team's duties and the feeling of not belonging to the multidisciplinary team.

I think that nurses have to have a space with nurses, a team professional because up to now, there is not! What are nurses' roles, what is their importance in the team? Because the team still doesn't accept it as a professional (Nur 11).

For nurses, lack of communication is another important barrier to ethics practice. Among the situations pointed out by nurses, there is absence of communication among team members, whether oral or written, and organization.

The difficulty I think is this, the issue of internal communication that one of the six goals of patient safety in the hospital is effective communication, and the hospital does not communicate effectively (Nur 3).

We have many resident errors, many medical errors. Wrong prescriptions, for example, are problems that we have all the time, verbal prescriptions that are often not recorded, which ends up falling on the nursing team (Nur 6).

Participants point to the team's lack of communication with patients, highlighting situations of iatrogenic omission, the discussion about therapeutic limitation and patient depersonification that

happens during "bedside rounding". It is noteworthy that the term "bedside rounding" refers to the visit of health professionals to patients who are restricted to the hospital bed, performing care assessment and planning.

A patient goes to the operating room intubated and sedated for emergency surgery. I think it is ethical to ask a patient if his family is aware that he is going to the block, because it happened to change the time of cardiac surgery for the patient that would be in the afternoon, they changed the time to morning and nobody paid any attention to that. When the family arrived to visit the patient and where is this patient? It's already there on the block. His sister asked "guys, what if my brother dies?" I didn't even have the opportunity to say goodbye or say anything (Nur 2).

Iatrogenesis or limitation of care, as it is established in a work relationship. How should this be handled with the family and society? It must be included in the medical record, but most of the time it will be stifled in the hospital environment. These are ethical issues that I consider important to discuss (Nur 8).

What kills, what bothers us a lot is their relationship (physicians) with patients. During the bed run there are 12, 15 people running the bed with the conscious patient, talking about the exam, and then sometimes they are talking about the 305 patient exam in front of the 308. The patient's eyes widen! Then you have to say to him "no guy, calm down, he is not talking about you" (Nur 1).

Moral distress in intensive care nursing practice

The results indicate that there are times when nurses are faced with situations with which they do not agree and are not able to modify them, experiencing, in such a way, moral distress.

For instance, a patient who has a prescription for laxative. I reported that the patient had evacuated at night, four times. And there comes

in the prescription again a laxative! So, what are you there for? Nobody cares about that information! You don't even have an opportunity to say that on the shift! Nurses are there at the bedside! The physician doesn't listen to you, and then I have to run after him "look, physician! This laxative circulates here because he no longer needs it!" (Nur 12).

You don't have a coordinator, nothing. No one who listens to you. The person listens to you and says like "oh ok, we will solve ...", but it seems that he is saying what you want to hear, but in fact it will not have worked. It's sugar-coating! But it doesn't solve anything, it's like they have two ears, one to enter and the other to leave. Sometimes you notice something about the scale, the service and can reflect, but so what?! What are you going to do with that? Nobody listens to you; the multidisciplinary team does not listen to you! You try to do a job and nobody wants to hear you, so, whatever, right?! (Nur 12).

The evidence of moral distress was manifested in nurses' statements when it was impossible to perform patient advocacy, either in the absence of the necessary care, as stated by Nur 11, or in situations of therapeutic obstinacy, as shown by Nur 8.

When I was on duty, the patient was already complaining of severe pain, without venous access. We tried unsuccessfully to access the medication! We communicated the need for central access to it, but the physicians went to the bed race and did not do the procedure. I discussed it with a colleague because they think they need to discuss the cases all before solving patients' problems. I remember exchanging her in pain, vacuuming, bathing and she moaned! I was getting very distressed, I left here very distressed! It was a situation of a lot of conflict, anguish, frustration! I left frustrated because I didn't do what I could for the patient! I asked for intramuscular medication, but he said she could wait for the procedure. So, I became nothing, because I spoke, the patient got worse and nothing was done (Nur 11).

The patient was diagnosed in limited care. We are not going to take too much action on this patient, just maintaining his dignity. He had hypotension and the physician asked to run the volume and provide material for central access. I asked if I would change access even with limited diagnosis. The physician said yes. It is a measure that I do not agree with! If the patient is limited, and already has a central access with an infectious focus and if he is not going to invest, why change the central access? It is an extra expense, more suffering, more exposure to invasion! Then I did it, because I am subject to a medical prescription. The decision of conduct is his! I argued, he saw that I felt it, I made it clear to him that I did not agree, and yet he wanted to maintain the conduct (Nur 8).

Discussion

The results of this study show that the ethics expressions are related to nurses' practice, considered a moral action that aims to achieve patient care by meeting their needs.[14]

Data indicate that nurses are morally sensitive to everyday ethical issues, relate the existence of moral problems to situations inherent to the context of team relationships, to the relationship with the institution itself, with patients and family members, and also to the practice of patient advocacy.

Moral sensitivity can be treated as an attribute or individual ability to detect and recognize its ethical-moral aspect in a situation. There is evidence that nurses' perception of the ethical-moral aspects involved in care, as well as the way these nurses deal with ethical issues at work has a multifactorial influence, expressing itself differently in each nation.[7,10] Such evidence is supported by the reasoning that moral sensitivity is related to culture, professional training, religion, experiences in reflective action about oneself, about the other, about norms and institutions and, with subjectivations possible throughout life.[4,7,10,14]

The development of moral sensitivity is continuous, progressive[14] and fundamental for the identification of ethical issues that arise in the context of

nurses' work in intensive care, offering tools for the definition of moral problems, as well as to support deliberations before the problem posed.[7] In this way, moral sensitivity is configured as an essential attribute to nurses' work in intensive care centers, given the need for professionals to be permanently reflective on the best conduct to be taken to achieve care. In the context of intensive care, nurses do not need to act clinically, critically and ethically in an environment emotionally charged by the severity of clinical cases, the high technology required for care and the complexity of the care provided.[5,15]

A study[5] identified that the moral sensitivity of nurses who work in intensive care units can be stratified by its components into three categories: moral awareness, spontaneous moral perception, and benevolent motivation. Moral awareness comprises science by nurses of the ethical principles expressed in the professional code of ethics, which becomes the guiding instrument for ethical problems diagnosis at work and ethical action guide on these problems. Spontaneous moral perception reflects nurses' ability to recognize ethical issues that involve a given situation, such as the definition of the ethical problem, the feelings of those involved in this situation and the impacts of actions on those involved. Benevolent motivation participates nurses' will to do what they believe to be correct aiming at patients' good, sensitizing themselves based on personal values.[16]

These findings support the results of this study, in which it was also possible to perceive that the foundations of benevolent ethics apply to the moral sensitivity of nurses' practice. Personal values and virtues that make up features of his identity were pointed out as guiding ethical practice, mentioning respect, empathy, the desire to do to others as he would like to be done to himself, and are considered as a guide to practice with excellence.[17] The values applied in moral action characterize ethical care and still greatly influence deliberations.[6,8,18]

Sensitivity to problematize situations that involve ethical aspects, combining personal values and virtues, professional knowledge, organizational structure, team relationships, protocols, standards and codes of ethics becomes a fundamental element for moral deliberation.[15] Such articulation between moral awareness, spontaneous moral perception and benevolent motivation allows nurses to deliberate, tracing prudent and responsible solutions to a certain moral problem,[15] and, in addition, to transcend ethical problems so that they do not constitute barriers to the exercise of care.[5] A study on moral sensitivity in nurses' practice in the inpatient unit showed the relevance of professional training based on the development of skills and abilities that allow nurses to mobilize and articulate knowledge and values for decision-making in their daily work.[19] The importance of ethical training of intensive care nurses in order to develop skills, values and moral sensitivity was also evidenced in literature.[5]

Nurses' ethical commitment to ensure patient care and advocacy was expressed in their practice. Studies indicate that, relating to patient care and advocacy in their singularities, the main role of nurses' work has in its essence, a direct relationship with morals and the fundamental activity of nursing can be seen in patient advocacy.[20,21]

The practice of patient advocacy expresses ethics in this setting, and is configured as an objective of nurses' work regarding care.[22] Advocacy is constituted by a set of practices that involve professional efforts to guarantee patients' interests within the scope of their rights, in access to information for making decisions about their health, in the reach of goods and services necessary for their care.[15,21,23] Patient advocacy in pain, or in palliative care, as pointed out in the results of this study, was also listed as a field of advocacy practices by nurses in another study.[20]

This action is enhanced through the adopted nursing care model, which brings nurses closer to the assistance and recognition of patients' needs under their care, also contributing to the development of nurses' moral sensitivity.

However, data point out that it is not enough for nurses to do the job in the way they deem most appropriate. Factors inherent in interpersonal relationships and work organization cross practice, often offering barriers to deliberations according to their moral judgment, culminating in nurses' experience of moral distress.[7]

Moral distress occurs in the midst of "microspaces of power in which professional practice is developed",[21] an environment in which relationships take place and where subjects involved have the possibility to deliberate on everyday moral problems. In these microspaces, conflicting situations are created that are related to the dynamics of work in the organizational context, capable of weakening ethical practices in the work context.[7]

Considering the statements, conflicting situations have emerged that weaken ethical practices and widen imbalances in power relationships between team members (especially between physicians and nurses), lack of definition of the nursing team's duties and absence of effective communication in the context of work. Isolated or together, it was noticed that these barriers make it impossible for nurses to practice patient advocacy, which is a situation that generates moral distress.[21]

In the field of power relations imbalances, nurses refer that medical knowledge guides care in the ICU of this study, which is why they perceive themselves as submissive to medical work. They also report having their autonomy and their scientific knowledge curtailed and their work reduced to compliance with prescriptions, which is pointed out as an unethical situation by nurses and a generator of moral distress.[7,9,10] A field of ethical conflicts is constructed in the dispute for power,[7,24] since not all the team members' knowledge is valued in deliberations of the emerging ethical-moral problems.

However, it is worth mentioning, as pointed out in a study on nurses' moral deliberations regarding hospitalization by court order[15], that there are differences in the nature of medical and nursing work. Medical practice focuses on what should be done to cure the disease, using all therapeutic possibilities. Nursing practice, directed to caring for and meeting patients' needs, focuses on the relationship, proximity and advocacy, and often offers subsidies for the discussion of how far the therapeutic investment should go, without obstinacy.[15]

The data revealed in this research support what was elucidated in another study[15] on the nature of nurses' work. It was possible to perceive that insensitivity to recognize the nature of professions limits their autonomy and impediment of nurses to manifest themselves through dialogue with the team generates moral distress before the impossibility of acting according to their moral judgment. The power struggle generates ethical conflicts and can be mobilized by lack of cohesion between the team and by ignorance of the role of the other in the context of work.[24]

It is noteworthy that practicing law presupposes taking over a position that can generate conflicts between team members, since it potentially unveils different opinions about better patient care, unbalancing power relationships, "especially between medicine and nursing".[23]

Nurses in this study report that they perform direct care activities at patients' bedside, as established by the rearrangement of the nursing care model proposed by EBSERH and realize that this position qualifies care and enhances the practice of patient advocacy. However, they also realize that other team members do not recognize the bedside assistance activities that they develop as differentials for qualified care, relating it to smaller activities, which in other times were performed only by nursing technicians.

In this case, the division of management and care work of nurses gains social and political aspects, since it reaches the dimension of professional autonomy.[25] Nurses who perform mostly healthcare activities are not able to participate in team discussions, generating feelings of invisibility and devaluation in them. Such invisibility makes their practice discredited before society and their peers, influencing the quality of care, ethics and motivation of nurses.[9]

Allied to this fact, there is the manifestation by the nurses interviewed regarding their perceptions of the absence of the role of coordination in the defense of nurses and their autonomy. In such a way, they perceive themselves out of practice, limited to interfere in the deliberative processes that involve care, with indications that their moral deliberations about the problems defined in daily life stagnate or do not materialize.

Nurses' autonomy must be guaranteed in practice, considering that nursing is a profession legiti-

mized by the laws of professional practice in which Law 74.98/86 and Decree 94.406/87 can be cited, and by the historical and social construction of the profession, based on solid, robust, critical, and reflective scientific training.[25]

Nurses' perceptions of work invisibility are manifested in another obstacle to ethical practice, pointed out in the results, which refers to lack of effective communication between among multidisciplinary team members, as well as between the team, patients and family members.

Situations in which essential information to patients are not communicated are highlighted, especially when planning care or limiting therapeutic assistance due to the clinical condition's severity and irreversibility. Especially these situations generate moral distress for nurses, because, recognizing them as a moral problem, they are unable to intervene in them as they deem correct due to the existing communicative barrier.

In the field of communications, the results show the presence of medical prescriptions that happen verbally and iatrogenic care omission, judged as unethical practices by nurses. Lack of communication, among other factors, is pointed out in a study,[21] as a daily situation in nurses' work that reflects the experience of deleterious feelings at work, such as the impotence to meet patients' needs, culminating in anguish and dissatisfaction.

It is clear that the set of organizational, relationship and communication barriers that present themselves at work generate difficulties for nurses to deliberate in accordance with their moral judgment in their practice, generating moral distress in this professional, especially when it is impossible to practice patient advocacy.

It is important to highlight the relevance of the institutional organization with regard to the results of this study. It is the organization's role to outline the course of work of the professional teams, offering support for reducing stressors, promoting autonomy and dialogue, ensuring structure and sufficient inputs for practice, mobilizing the team's cohesion in favor of qualified care.[26] From the results, it was noticed that there are gaps in the organization of nurses' work that fosters the emergence of moral

problems arising from competing tensions between the logic of nurses' practice and the institutional logic that still overestimates medical knowledge in the therapeutic management of clinical cases.

The findings of this study corroborate the data pointed out by another study that mentions that among the main organizational barriers to the practice of advocacy by nurses, the relationship with the medical team, lack of time due to high workload, ineffective communication with patients or with multidisciplinary team members, nurses' impotence and lack of autonomy stand out.[23]

The feelings expressed by nurses that are related to the experience of moral distress at work, such as discomfort, frustration, anguish, invisibility, express professionals' dissatisfaction with work; therefore, they refer to the importance of seeking alternatives for coping with the distress through the construction of spaces of more expressive ethical practices in this setting.

In this regard, the results allowed to reaffirm that the strengthening of discussions about ethical practice in moments of in-service education, as well as its expansion during graduation, is a positive strategy for the recognition of ethical situations in daily life, development of moral values, qualification of professional conduct and coping with moral distress, reflecting positively on the care provided by nurses in ICUs.[22]

Therefore, it is suggested to adopt moments of discussion among professionals, aiming at strengthening ties, fostering dialogue between the team, management and service users. Such attitudes can have a positive impact on care, as well as reduce moral distress among professionals, culminating in a space of greater ethical expression.

Still, it is necessary to develop strategies to bring professional values closer to organizational values, so that the experience of care by nurses happens in a more ethical space, which considers the excellence of practice and subjectivities that involve the act of caring for.[17]

The results of this study made it possible to explore a specific phenomenon related to nurses in an ICU in a single hospital that adopts the global model of care as a model of nursing care. Thus, more stud-

ies should be conducted so that these issues can also be explored in other nurses' work spaces. It should be noticed, however, that, considering that ethics are inherent to nurses' practice, the results of this investigation can be applied, supporting discussions about the construction of ethical relationships that envision patient care considered as the object of doing health.

Conclusion

This study made it possible to understand ethics and moral distress expressions in intensive care nursing practice, relating mainly to the care and relationships that are established in the context of work. Patient advocacy proved to be the most expressive form of ethics in nurses' work, denoting their ethical commitment to the care of excellence and defense of patients' needs. In contrast, it was noted that intervening factors such as lack of clarity as to the nature of the work and the duties of each member of the multidisciplinary team, imbalances in power relations, as well as lack of communication among the multidisciplinary team, triggered an environment conducive to the emergence of moral problems, whose outcomes pointed to gaps in ethical practice. It is important to consider that, especially considering the impossibility of practicing patient advocacy, nurses' situations of moral distress were revealed, including residual marks of this experience on themselves.

Acknowledgments

Collaborations

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