Original Article

Moral distress experienced by nurse managers in the context of federal university hospitals

Distresse moral vivenciado por gestores enfermeiros no contexto de hospitais universitários federais

Distrés moral vivenciado por gestores enfermeros en el contexto de hospitales universitarios federales

Michel Maximiano Faraco[1] https://orcid.org/0000-0003-0669-9257
Francine Lima Gelbcke[1] https://orcid.org/0000-0003-3742-5814
Laura Cavalcanti de Farias Brehmer[1] https://orcid.org/0000-0001-9965-8811
Flávia Regina Souza Ramos[1] https://orcid.org/0000-0002-0077-2292
Edison Luiz Devos Barlem[2] https://orcid.org/0000-0001-6239-8657
Graziele de Lima Dalmolin[3] https://orcid.org/0000-0003-0985-5788

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Corresponding author
Laura Cavalcanti de Farias Brehmer
Campus Universitário Reitor João David Ferreira Lima, s/nº, 88040-900, Centro de Ciências da Saúde, Bloco I, Room 480, Florianópolis, SC, Brazil.
E-mail: laura.brehmer@ufsc.br

Associate Editor (Peer review process):
Alexandre Pazetto Balsanelli (https://orcid.org/0000-0003-3757-1061)
Escola Paulista de Enfermagem, Universidade Federal de São Paulo, SP, Brasil

Abstract

Objective: To analyze the frequency and intensity of moral distress in nursing managers of Federal University Hospitals.

Methods: Cross-sectional study conducted with nursing managers working at different hierarchical levels of Federal University Hospitals through the application of the Brazilian Scale of Moral Distress in Nurses and a sociodemographic and working questionnaire. For analysis, we used descriptive statistics, chi-square test and t test for independent samples.

Results: 126 nurse managers participated in the study, 32 from the strategic segment and 94 from the operational one. We have observed a moderate level of frequency and intensity of moral distress, mean 3.07(SD=1.21) and 3.55(SD=1.35), respectively. The greatest means were related to the factors Work team, Safe and qualified care and Working conditions. When comparing groups, the operational manager had the highest levels of frequency and intensity, mean 3.33 (SD=1.20) and 3.76 (SD=1.26), respectively.

Conclusion: We have found that moral distress in managing nurses of federal university hospitals is at a moderate level of frequency and intensity, and nurses in the Nursing Manager group had the highest Moral Distress score when compared to the head group of the Nursing Division.

Resumo

Objetivo: Analisar a frequência e a intensidade de distresse moral em gestores de enfermagem de Hospitais Universitários Federais.

Métodos: Estudo transversal desenvolvido com gestores de enfermagem atuantes em diferentes níveis hierárquicos de Hospitais Universitários Federais por meio da aplicação da Escala Brasileira de Distresse Moral em Enfermeiros e questionário sociodemográfico e laboral. Para análise utilizou-se a estatística descritiva, teste de qui-quadrado e teste t para amostras independentes.

Resultados: Participaram do estudo 126 enfermeiros gestores, 32 do segmento estratégico e 94 do operacional. Um nível moderado de frequência e intensidade de distresse moral foi observado, com médias de 3,07(DP=1,21) e 3,55(DP=1,35), respectivamente. As maiores médias estiveram relacionadas aos fatores Equipe de trabalho, Cuidado seguro e qualificado e Condições de trabalho. Na comparação de grupos, o gestor operacional apresentou os maiores níveis de frequência e intensidade, com médias de 3,33(DP=1,20) e 3,76(DP=1,26), respectivamente.

[1]Universidade Federal de Santa Catarina, Florianópolis, SC, Brazil.
[2]Universidade Federal do Rio Grande, Rio Grande, RS, Brazil.
[3]Universidade Federal de Santa Maria, Santa Maria, RS, Brazil.
Conflicts of interest: none to declare.

Conclusão: Constatou-se que o distresse moral em enfermeiros gestores de hospitais universitários federais se encontra em nível moderado de frequência e intensidade, sendo que os enfermeiros do grupo Gestor de Enfermagem, apresentaram o maior escore de Distresse moral quando comparado ao grupo chefe de Divisão de Enfermagem.

Resumen

Objetivo: Analizar la frecuencia y la intensidad del distrés moral en gestores de enfermería de Hospitales Universitarios Federales.

Métodos: Estudio transversal desarrollado con gestores de enfermería que actúan en distintos niveles jerárquicos de Hospitales Universitarios Federales por medio de la aplicación de la Escala Brasileña de Distrés Moral para Enfermeros y el cuestionario sociodemográfico y laboral. Para el análisis se utilizó la estadística descriptiva, prueba chi-cuadrado y prueba t para muestras independientes.

Resultados: Participaron del estudio 126 enfermeros gestores, 32 del sector estratégico y 94 del operativo. Se observó un nivel moderado de frecuencia e intensidad de distrés moral, con promedios de 3,07(DP=1,21) y de 3,55(DP=1,35), respectivamente. Los mayores promedios estuvieron relacionados con los factores Equipo de trabajo, Cuidado seguro y calificado y Condiciones de trabajo. En la comparación de grupos, el gestor operativo presentó los mayores niveles de frecuencia y de intensidad, con promedios de 3,33(DP=1,20) y de 3,76 (DP=1,26), respectivamente.

Conclusión: Se verificó que el distrés moral de enfermeros gestores de hospitales universitarios federales se encuentra en un nivel moderado de frecuencia y de intensidad y los enfermeros del grupo Gestor de Enfermería presentaron la mayor puntuación de Distrés moral cuando comparado con el grupo jefe de la División de Enfermería.

Introduction

The concept of Moral Distress (MD) describes the experience of nurses in situations that prevent them from acting according to their own moral judgment, that is, the suffering for not following the correct course of action due to barriers of different orders (personal, organizational and systemic), inhibiting the exercise of moral agency. This construct has been expanding over the last decades, incorporating new conceptual nuances, application scenarios and different professionals.[1-3]

MD, a phenomenon initially reported in clinical practice, has been studied in various fields of nursing practice. In the hospital area, it is recognized that nurse managers develop numerous dynamic and complex activities, with direct repercussions on the continuity and quality of care.[4] It is in this context that these professionals may find some difference between real and prescribed work in the organization of nursing work, related to the division of work, team conflicts, staff deficit, inadequate infrastructure, intense work pace or lack of autonomy and the fragmentation of care.[5,6]

When the various organizational interests are at odds with the individual will and ethical awareness, feelings of fragility, exhaustion and anguish may emerge, enhancing the perception that personal integrity has been compromised.[7]

Ethical-moral challenges need to be analyzed in their professional and institutional specificities, which is why the nursing managers of Federal University Hospitals (FUH) stand out. These play a strategic role in the quality of care and in teaching and research activities, essential characteristics of these organizations. Under a new governance structure and management policy concept of the Brazilian Hospital Services Company *(Ebserh)*, they manage the largest contingent of health professionals, ensuring the continuous maintenance of socio-humanist practice and ethical standards, in addition to mediating conflicts of interest and institutional and professional values.

Due to concerns about costs, external metrics and organizational expectations, managers may feel unable to translate their moral beliefs into actions based on ethics and, thus, moral pain sets in. This is detrimental not only to the nurses' well-being, but also to clinical practice as a whole.[8]

Given the understanding that ethical aspects and DM have become part of the hospital environment, the importance of the debate on this subject is raised. Assessing the intensity and frequency of MD between the different levels of nursing management at the FUH makes it sensitive and perceptible given the particularities of daily challenges and the new governance model proposed by *Ebserh*. In this sense, this study aimed to analyze the frequency and intensity of moral distress among nursing managers at HUF linked to *Ebserh*.

Methods

Cross-sectional study conducted in Federal University Hospitals under the management of Bhserc *Ebserh*. The network of FUH linked to *Ebserh* consists of 40 (forty) hospitals. Data collection took place in 30 (thirty) FUH/*Ebserh* who agreed to participate in the study and was carried out from December/2019 to May/2020.

According to the hierarchical model of *Ebserh's* management, the head of the Nursing Division (ND) is established as the highest level of the nursing governance structure, with one ND head per hospital (N=40), with each FUH having, obligatorily, a nursing division in its hierarchical structure. In the operational core, there were the Nursing Managers (NM), considered the other heads, leaders of units or nursing services.

The study population consisted of nurses in management positions (including interim) or in the leadership role of any Nursing Service in the FUH/*Ebserh*. The criterion that excluded the participant from the study considered the heads of other professional categories who assume leadership in nursing temporarily or accumulate functions, even if temporarily.

It was not possible to determine the sample universe of NM, as there is no uniformity in university hospitals regarding the number and denomination of care units, which vary according to the size of the hospital, organizational issues specific to the institutions and management positions held by reference nurses in care units.

The calculated sample size was 118 participants (ND = 30 and NM = 88). For this calculation, we used the WINPEPI Program (version 11.65), considering a power of 80% and a significance level of 5% and the ratio of three NM participants to each ND (3:1). As this is a comparative and pioneering study with these populations, we opted for the sample calculation by Effect Size. It was defined by the use of non-probabilistic convenience sampling.

This study had the participation of 126 nurse managers (ND=32 and NM=94), linked to 30 FUH/*Ebserh*. During the data collection period, there was a replacement in the positions of two ND who had already responded to the instrument and were kept in the sample. Among the invited NM, four were excluded for not meeting the inclusion criteria.

Sociodemographic and labor variables were established and the Brazilian Scale of Moral Distress in Nurses (BSMDN-Br) was applied, which proposes to measure the frequency and intensity of MD, conceived by 49 questions that indicate the triggering situations of MD in a double Likert Scale of 0 to 6, for frequency and intensity (0 = never, up to 6 = very frequent; and, 0 = none, up to 6 = very intense; respectively).[9] The situations gathered in the scale express the identity of six factors: Recognition, power and professional identity (F1=11 questions); Safe and qualified care (F2=11 questions); Defense of values and rights (F3= 8 questions); Working conditions (F4= 6 questions); Ethical infractions (F5= 6 questions); and, Work teams (F6= 7 questions).

Data were collected online (electronic form). As a strategy to minimize sample losses, all ND heads were recruited, requesting, for each one, support to forward the collection instrument and encourage the participation of other NM nurses in their institution.

For the purpose of analyzing the mean MD frequency and intensity scores, the following ranges were used as parameters: low (0-1.99); moderate (2.00-3.99); and, high (4.00-6.00). The product of the MD frequency and intensity means for each of the 49 questions generated a new variable for each item, (FxI), between 0 and 36, and the higher the score, the higher the MD identified per question.

After coding and categorization, the collected data were tabulated in an electronic spreadsheet (database) and analyzed using the IBM Statistical Package for Social Sciences (SPSS) software, version 25.0. Categorical variables were presented in their absolute (n) and relative (%) frequencies. The proportions of sociodemographic and labor characteristics between the groups (ND and NM) were compared using the chi-square test. According to the results of the Shapiro-Wilk

normality test, the independent t test was used to calculate and compare the means among the groups. The significance level adopted for the bivariate tests was 0.05.

The Free and Informed Consent Form was sent online to the participants and they agreed to participate in the research through the same device. As single-center research with co-participating institutions, data collection, as the only stage of the research carried out in hospitals, after approval by the Research Ethics Committee #3.549.474/2019, respecting the ethical aspects in its entirety, with no conflicts of interest, real or potential, of any nature.

Results

Participants in the ND group had a predominant profile with the following characteristics: female (n=29; 90.6%), over 50 years of age (n=18; 56.3%), academic training for more than 20 years (n=21; 65.6%), working as a nurse for over 16 years (n=19; 59.4%), exercising management activity for at least 16 years (n=12; 37.5%), acting as head of ND for between one and five years (n=17; 53.1%), has specialization/residence (n=13; 40.6%), with training in the area of management (n=22; 68 .8%); statutory (n=28; 87.5%), has a single contract (n=25; 78.1%) and workload on mean up to 40 hours per week (n=17; 53.1%), large part in small hospitals with up to 199 beds (n=15; 46.9%), in the Northeast region (n=14; 43.8%).

Participants in the NM group had the following predominant characteristics: female (n=87; 92.6%), aged between 20 and 39 years old (n=66; 70.2%), academic training between 11 and 15 years (n= 36; 38.3%), working as a nurse for up to 10 years (n=38; 40.4%), exercising management activity for less than five years (n=62; 66.0%), acting as head of ND between one and five years (n=58; 61.7%), with specialization/residence (n=46; 48.9%), but without training in the area of management (n=60; 63.8%), CLT (n=48; 51.1%), with a single contract (n=71; 75.5%) and workload on mean up to 40 hours per week (n=75; 79.8%), large part in medium-sized hospitals between 200 and 399 beds (n=42; 44.7%), in the Northeast region (n=38; 40.4%).

Variables with significant differences were observed between the ND and NM groups (chi-square test) when comparing the sociodemographic and labor characteristics: age (p<0.001), time since graduation (p<0.001), additional education (p= 0.022), training in the area of management (p=0.001), length of experience (p<0.001) and experience in management (p<0.001), type of employment (p<0.001) and weekly workload (p= 0.007).

Chart 1 presents the analysis of the mean frequency and intensity of MD factors between the ND and NM groups of the FUH/*Ebserh*. There is statistical significance difference between the groups in relation to Frequency (p<0.001) and Intensity (p=0.004) of MD, in which nurses in the NM group have higher mean frequency (3.33) and intensity (3.76) when compared to ND (2.48; 2.99, respectively).

Table 1. Frequency and intensity of Moral Distress among groups of nurse managers (ND=32 and NM=94)

Variables	Overall Mean (SD)	ND* Mean (SD)	NM† Mean (SD)	P‡
Frequency				
F1: Recognition, power and professional identity	2.97 (1.39)	2.18 (1.20)	3.23 (1.35)	<0.001
F2: Safe and qualified care	3.44 (1.32)	3.06 (1.26)	3.57 (1.33)	0.058
F3: Defense of values and rights	2.33 (1.63)	1.07 (0.86)	2.76 (1.61)	<0.001
F4: Work conditions	3.45 (1.43)	3.06 (1.34)	3.58 (1.45)	0.076
F5: Ethical infractions	2.73 (1.51)	1.90 (1.33)	3.02 (1.47)	<0.001
F6: Work team	3.75 (1.14)	3.67 (1.08)	3.78 (1.17)	0.613
Overall (F)	3.07 (1.21)	2.48 (0.92)	3.33 (1.20)	<0.001
Intensity				
F1: Recognition, power and professional identity	3.44 (1.57)	2.63 (1.62)	3.72 (1.46)	0.001
F2: Safe and qualified care	3.91 (1.40)	3.67 (1.53)	3.99 (1.35)	0.264
F3: Defense of values and rights	2.96 (1.79)	1.82 (1.68)	3.35 (1.66)	<0.001
F4: Work conditions	3.68 (1.47)	3.29 (1.46)	3.81 (1.46)	0.086
F5: Ethical infractions	3.44 (1.73)	2.76 (1.93)	3.67 (1.60)	0.009
F6: Work team	3.93 (1.22)	3.78 (1.27)	3.98 (1.20)	0.406
Overall (I)	3.55 (1.35)	2.99 (1.33)	3.76 (1.26)	0.004

*ND - Nursing Division group; †NM - Nursing Managers group; ‡ t test for independent samples; Interpretation of the mean MD frequency and intensity score: 0-1.99 = low; 2.00-3.99 = moderate; 4.00-6.00 = high.

Based on the mean scores, a moderate level of frequency and intensity (3.07 and 3.55, respectively) of MD is observed among the managing nurses of the FUH/Ebserh. The highest means were related

Table 2. Main triggering situations of Moral Distress among groups of nurse managers (ND=32 e NM=94)

Situations	Overall		ND*		NM†	
	F‡ x I§ (SD)	*Rank*	F‡ x I§ (SD)	*Rank*	F‡ x I§ (SD)	*Rank*
Working with an insufficient number of professionals for the demand	20.32 (11.17)	1	20.31 (12.18)	2	20.32 (10.87)	1
Experiencing work overload conditions	20.16 (11.19)	2	20.47 (12.31)	1	20.05 (10.85)	2
Recognizing the lack of resolvability of health actions due to social problems	18.95 (10.93)	3	17.41 (11.08)	3	19.48 (10.89)	4
Recognizing that the physical structure of the service is insufficient	18.88 (12.35)	4	16.81 (11.84)	5	19.59 (12.50)	3
Recognizing that the physical structure of the service is inadequate	18.52 (12.40)	5	16.41 (13.27)	7	19.24 (12.08)	6
Working under pressure due to insufficient time to reach goals or accomplish tasks	18.40 (12.62)	6	15.81 (13.46)	11	19.28 (12.27)	5
Recognizing insufficient access to the service for the user	18.17 (12.34)	7	16.16 (12.73)	9	18.86 (12.20)	7
Recognizing damage to care due to inadequate integration between services/sectors	17.44 (10.64)	8	16.38 (11.38)	8	17.80 (10.42)	9
Experiencing conflicting relationships regarding the attributions of health team members	17.10 (10.63)	9	13.63 (9.78)	13	18.28 (10.70)	8
Recognizing that the patient/user's demands for continuity of care are not met	17.08 (11.47)	10	16.06 (11.79)	10	17.43 (11.41)	10
Working with an incomplete multiprofessional health team	16.71 (11.13)	11	16.88 (11.47)	4	16.66 (11.08)	13
Working with unprepared nurses	16.53 (10.41)	12	15.53 (11.17)	12	16.87 (10.18)	12
Recognizing inappropriate routines and practices to the patient's safety	15.91 (10.79)	13	13.00 (9.58)	17	16.90 (11.04)	11
Working with unprepared nursing assistants and technicians	15.64 (10.82)	14	16.63 (11.68)	6	15.31 (10.55)	21

*ND - Nursing Division group; † NM - Nursing Managers group; ‡F - Frequency; §I - Intensity; BSMDN-Br - Brazilian Scale of Moral Distress in Nurses; Note: *Score variation per item 0-36*

to factor F6 (Work team), F2 (Safe and qualified care) and F4 (Working conditions); and minors linked to F1 (Recognition, power and professional identity), F5 (Ethical infractions) and F3 (Defense of values and rights).

Regarding the frequency and intensity of MD, it is verified that the mean of the groups differed significantly in the factors F1 ($p<0.001$; $p=0.001$, respectively), F3 ($p<0.001$) and F5 ($p<0.001$; $p=0.009$, respectively). In all factors, the NM MD frequency and intensity means were higher when compared to the ND means.

Based on BSMDN-Br predictive situations of MD, table 2 classifies the main situations that trigger MD among nurse managers of FUH/*Ebserh*. Thus, it allows us to identify that the ND and NM groups generally come closer in agreement regarding the most distressing items. Working with an insufficient number of professionals for the demand and experiencing conditions of work overload were the main situations that triggered MD. Working under pressure due to insufficient time to reach goals or perform tasks and to recognize routines and practices that are inadequate for patient safety is more distressing for the NM group (NM_{rank}=5 and 11; ND_{rank}=11 and 17, respectively). Working with an incomplete multidisciplinary health team and with unprepared nursing assistants and technicians is identified as one of the main causes of MD among the DN group (ND_{rank}=4 and 6; NM_{rank}=13 and 21, respectively).

Discussion

In the organizational structure of *Ebserh*, governance is formed by a Superintendence, three managers (administrative, healthcare and teaching and research), divisions, sectors and units. Nurses can occupy positions throughout the hierarchical structure, however, they must occupy the Nursing Division (ND), which is considered the highest level of the governance structure, led by nurses, technical heads of the institution by the nursing team, who have a closer relationship with health care and management, and seek to continuously articulate theory and practice.[10] This profile was reflected in the data found, in which the participants of the ND group, in relation to the NM group, have the best level and longer training time, working as a nurse and experience in management.

The adversities of the nursing work process, relational and structural conflicts and the experience of multi-cause MD risk factors require rectitude at all levels of management and demand different assertive strategies that can be linked to: professional training; development of managerial skills; job satisfaction; work load; maintenance of service quality; conflict resolution and need for teamwork.[11-14]

In the context analyzed, we found that the MD is present among the managing nurses of the FUH/*Ebserh* at a moderate level, results that are

consistent with the findings of other more recent studies,[15-17] even pointing out the chance of taking the professional to give up his job or even a career.[16]

In the ND group, the nurse manager with greater professional experience may have developed an accurate moral sensitivity, with robust ethical competence and courage to act in response to conflicting demands. With experience, one can recognize the ethical value of relationships and problem solving, triggering moral deliberation.[18-20] A manager profile with a higher degree of moral resilience is assumed. The ability to face moral problems and not develop the MD. Moral resilience involves critical capacity as a goal of the profession and a virtue that allows for maintaining individual commitments and with the interests of the vulnerable.[3]

In both groups of managers, the highest MD scores were related to the Work Team, having as reference the dimensioning and qualification of professionals. Given the different needs and levels of complexity of a hospital, we have observed that nursing management is especially concerned with the organization of work and nursing human resources.[21]

Nurses in the ND group are technically responsible for the nursing service with the Nursing Councils and other legal instances.[10] Thus, the establishment of the quantitative-qualitative framework of nursing professionals in the FUH/*Ebserh* is a direct competence of the ND. This condition can support the fact that - Working with an incomplete and unprepared team - is identified as one of the main situations that triggers MD.

Nurse managers need to ensure a contingent trained in a timely manner and qualified to meet the daily care and technological needs of the profession and multidisciplinary. There is, effectively, a relationship between the MD and the quantity-quality of nursing professionals.[22,23]

The high productivity, characteristic of the nursing work organization model, work overload, highlights the under-dimensioning of personnel, associated with variables that reveal the versatility and multifunctionality of nursing practices, with an emphasis on agility and immediate availability, threatening the health of the worker, the user and the quality of care.[24]

In all these situations, it is possible to generate a risk for the continuity of - Safe and qualified care - considered the second largest triggering factor for MD among participants. As patient safety and the practice environment deteriorate, there is a tendency for the level of MD to increase.[25] Positive changes in the organizational environment (ethical climate) have been shown to decrease moral distress, increase job satisfaction and reduce staff turnover. [2,26,27]

Working conditions are the basic predictive situations that trigger a higher level of MD. This finding is in line with a Brazilian cross-sectional study and may reflect vulnerabilities in the care environment, such as work overload and precarious working conditions, impacting the safety of professionals and patients.[28]

Nurses in the NM group act as heads of organizational units provided for in the hierarchical structure or are a reference for nursing, acting in the coordination of teams in care units (without occupying a position). It is in the NM group that the anxieties related to - Recognition, power and professional identity; - Defense of values and rights; - Ethical infractions - gained significance in frequency and intensity of MD. It is recognized that nursing is a mostly female profession and historical-social confrontations permeate gender issues, represented by efforts to conquer spaces and struggles for power symmetry, freedom in decision-making (and action itself), valuation and recognition.[29,30] The care environment reveals different levels of decision-making freedom, as well as responsibilities. Possibilities of intensely experiencing moral distress, as well as autonomy and greater ethical expressiveness are especially affected by the hierarchical organizational atmosphere, which can emphasize the professional and social power of the participants, or potentiate triggers for the generation of abuse and discrimination.[19,31]

It is known that the MD is a unique experience, considering internal and external ele-

ments that weigh on the professional experience. Recognition, power and professional identity are built over time and the identity structure of nurses, in particular, arises from the perception of themselves and their work, influenced by interpersonal relationships, by the organization of work and by the numerous experiences of moral problems in its daily life.[28,32] Facing ethical problems can compromise the moral integrity of nurses and, although the intensity of the MD may dissipate to some degree, a moral residue tends to accumulate.[3]

The managers of the NM group, govern finalistic work processes, directly linked to relational particularities in the care environment, are situated in a context of frequent situations with ethical implications, which involve the defense of values and rights. In the micro-spaces where nurses work, the exercise of patient advocacy carries challenges to protect human dignity, promoting health education actions and effective communication, overcoming the limits imposed by the work environment.[33] This includes the need to strengthen professional relationships, the construction of ethical climates compatible with the exercise of autonomy, the progressive construction of moral competences, moral courage.[34,35]

As responsible for organizing the operational structure, the NM nurse articulates with the highest level of the nursing governance structure, the ND. In this case, the relational tensions and demands increase ethical conflicts. Working under pressure due to insufficient time to reach goals or perform tasks was one of the most distressing predictors for the NM group, pointed out as a variable that impacts the intensity of nursing work.[24]

MD can be seen as a social experience, with the potential to destabilize the group in a collective awareness movement.[7] The nursing managers of the FUH/Bhserc *Ebserh* may share the same intra or extra organizational restrictions or barriers and, aware of the moral problem, be prevented from acting in accordance with their ethical principles. This collective perception of MD experience could be observed in both groups when the subject is Work team, or when the anguish is related to the Defense of values and rights, in which the NM group demonstrates a higher level of moral distress.

The results of this study can hardly ensure a strong cause-and-effect relationship, since it becomes practically impossible to establish, measure and control all the variables, taking into account the method adopted. It is understood that additional studies addressing this population are needed, highlighting that the instrument used in this research was recently validated.

Conclusion

It was found that moral distress in managing nurses of federal university hospitals is at a moderate level of frequency and intensity, and nurses in the NM group had the highest MD score when compared to the ND group. Nurses in the ND group, due to their greater experience and training, suggest a higher level of sensitivity and moral competence. However, if on the one hand professional experience supports ethical perception and moral deliberation, on the other hand, it can generate moral residue and low moral engagement in the long term. In addition, it is the NM nurse who has the greatest contact with daily moral problems in the care environment, as well as suffering from the tensions and demands emanating, in particular, by the ND, thus expanding ethical situations and conflicts and, possibly, the MD.

Collaborations

Faraco MM contributed to the study design; collection, analysis and interpretation of data; writing the article; relevant critical review of the intellectual content and final approval of the version to be published. Gelbeck FL collaborated with the study design; analysis and interpretation of data; writing the article; relevant critical review of the intellectual content and final approval of the version to be published. Brehmer LCF contributed to the study design; collection, analysis

and interpretation of data; writing the article; relevant critical review of the intellectual content and final approval of the version to be published. Ramos FR contributed to the writing of the article; relevant critical review of the intellectual content and final approval of the version to be published. Barlen E contributed to the writing of the article; relevant critical review of the intellectual content and final approval of the version to be published. Dalmolin GL contributed to the writing of the article; relevant critical review of the intellectual content and final approval of the version to be published.

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