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RESEARCH

# Cross-cultural adaptation and validation of the Moral Distress Scale-Revised for nurses

*Adaptação cultural e validação da Moral Distress Scale-Revised para enfermeiros*

*Adaptación cultural y validación de la Moral Distress Scale-Revised para enfermeros*

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**ABSTRACT**

**Objective:** Cross-culturally adapt and validate the Moral Distress Scale-Revised for nurses. **Method:** Quantitative, analytical cross-sectional study conducted with 157 nurses of two hospital institutions of Southern Brazil, one public and one philanthropic. Procedures conducted: cultural adaptation of the instrument according to international recommendations; validation for the Brazilian context. **Results:** Face and content validation was considered satisfactory as assessed by a specialist committee and a pretest. The instrument demonstrated satisfactory internal consistency through frequency and intensity analysis per question in the 157 items and per subgroups of the various hospital units. Cronbach's alpha was 0.88 for the instrument and between 0.76 and 0.94 for hospital units. Pearson's correlation found a moderate association for moral distress among nurses. **Conclusion:** The Moral Distress Scale-Revised – Brazilian version is a valid instrument for the assessment of moral distress in nurses.
**Descriptors:** Moral; Nursing; Nursing Ethics; Moral Development; Validation Studies.

**RESUMO**

**Objetivo:** Adaptar culturalmente e validar a *Moral Distress Scale Revised* para enfermeiros. **Método:** Estudo quantitativo, transversal analítico, realizado com 157 enfermeiros de duas instituições hospitalares do Sul do Brasil, uma pública e uma filantrópica. Realizou-se: a adaptação cultural do instrumento segundo recomendações internacionais; e a sua validação para o contexto brasileiro. **Resultados:** A validade de face e conteúdo foi considerada satisfatória mediante avaliação de comitê de especialistas e realização de pré-teste. Mediante análise de frequência e intensidade por questão nos 157 questionários e por subconjuntos das diferentes unidades hospitalares, o instrumento demonstrou consistência interna satisfatória, com alfa de Cronbach 0,88 para o instrumento e entre 0,76 e 0,94 para as unidades hospitalares. A correlação de Pearson identificou moderada associação de sofrimento moral nos enfermeiros. **Conclusão:** o *Moral Distress Scale Revised* – versão brasileira é um instrumento válido para ser utilizado na avaliação de sofrimento moral de enfermeiros.
**Descritores:** Moral; Enfermagem; Ética em enfermagem; Desenvolvimento Moral; Estudos de Validação.

**RESUMEN**

**Objetivo**: Adaptar culturalmente y validar la *Moral Distress Scale Revised* para enfermeros. **Método**: Estudio cuantitativo, transversal, analítico, realizado con 157 enfermeros de dos instituciones hospitalarias del Sur de Brasil, una pública y otra filantrópica. Se efectuó: adaptación cultural del instrumento según recomendaciones internacionales; y su validación para el contexto brasileño. **Resultados**: La validez de interfaz y contenido fue considerada satisfactoria según evaluación de comité de expertos y realización de prueba piloto. El instrumento demostró consistencia interna satisfactoria, aplicándosele análisis de frecuencia e intensidad por pregunta a los 157 cuestionarios y por subconjuntos de las diferentes unidades hospitalarias; con alfa de Cronbach 0,88 para el instrumento y de 0,76 a 0,94 para las unidades hospitalarias. La correlación de Pearson identificó

moderada asociación de sufrimiento moral de enfermeros. **Conclusión**: la *Moral Distress Scale Revised* – versión brasileña es un instrumento válido para ser utilizado en medición del sufrimiento moral de enfermeros.
**Descriptores**: Moral; Enfermería; Ética en Enfermería; Desarrollo Moral; Estudios de Validación.

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## INTRODUCTION

In the hospital setting, work can bring satisfaction when workers are allowed to develop their potential, resulting in professional recognition. It can also bring about the possibility of dissatisfaction when there are gaps between workers' expectations and the realities imposed by the work organization. In this sense, work, which can be a source of pleasure, can at the same time result in distress, at higher or lower intensities[1].

At work environments, nurses are responsible for coordinating the work of other nursing professionals, for planning and organizing it in ways that ensure adequate conditions for the care offered to patients, who need constant exchange of knowledge with health professionals, respect for their rights and recognition of their human condition, which reinforces the vital commitment of hospital nurses[2].

Moral distress is common in clinical practice, being especially noticed by nurses, since health care is an essentially moral activity that involves multiple actors, such as patients, families, health students, physicians and other professionals in the field[3]. It occurs when nurses are kept from acting in accordance to their knowledge or what they consider ethically correct, with the presence of cognitive-emotional dissonance[3]. It can also occur due to situations related to the type of activities to be conducted, disrespect for patient rights or workplace conflict[4-5].

It should be observed that, when professionals are under moral distress, their care actions can reflect the moral problems at hand, negatively interfering in patients' health potential, which results in low-quality care, professional dissatisfaction, absence of health advocacy, burnout, and even professional abandonment[6]. Additionally, there is a series of personal disorders that result in lack of patience, irritability, concentration problems, among other physical and psychological disorders[7-8].

There are studies in the international literature addressing this problem. Important findings were achieved through an assessment instrument titled Moral Distress Scale (MDS)[9]. It focuses, mainly, on dilemmas and ethical problems, therapeutic futility, unsafe working conditions, among others. Various behaviors related to moral distress can be found in different cultures[9].

Addressing this phenomenon can motivate reflection and possible action against ethical problems, whose complexities of factors affect health[6]. Thus, there is increasing investment in compact and precise instruments capable of assessing specific phenomena with clarity and depth for investigations. A review of the MDS, originally comprising 38 questions and a response scale from 1 to 7, had its version reduced to 21 questions, with responses ranging between 0 and 4, becoming capable of identifying intensity and frequency of moral distress in a simplified way among health professionals practicing at various hospital contexts, being renamed Moral Distress Scale-Revised (MDS-R)[4-5].

The revised instrument (MDS-R) adapted by Hamric, Borchers and Epstein (2012) was developed to be applied in quantitative studies, aiming to assess the intensity and frequency of moral distress among nurses and physicians, based on their professional perception of specific health work situations[4].

The instrument was created and validated in southeastern United States, with a sample of 323 health professionals, comprising questions addressing real moral distress situations related to patient care, ethical dilemmas related to the work institution; work relationships with physicians, nurses and medical students; involvement of patients and families in health care; situations of risk for patients; life extension and lack of professional qualification[4-5].

In Brazil, there are quantitative and qualitative studies addressing moral distress that are based on the MDS in its original form. They were conducted at various nursing work contexts, with results showing the presence of moral distress, especially in situations of lack of autonomy and support for the work team, disrespect for patient rights, therapeutic obstinacy, lack of public resources and feelings of impotence. However, there is no reduced assessment scale for moral distress in the Portuguese language. Therefore, this highlights the need for specific and compact instruments to verify phenomena experienced by nurses, capable of specifically identifying the main sources of moral distress.

Thus, this study is justified by the need to validate to Portuguese an instrument capable of identifying the frequency and intensity of moral distress for nurses at various health contexts, contributing to guide ethical practices in health and to widen research bases in the field.

## OBJECTIVE

Cross-culturally adapt and validate the Moral Distress Scale-Revised for Brazilian nurses.

## METHOD

### Ethical aspects

Ethical aspects were observed, according to guidelines from Resolution 466/12 of the Brazilian National Health Council. The study was approved by the local human research ethics committee.

### Study design, setting and period

This is a quantitative, analytical, cross-sectional study. Cultural adaptation of the instrument MDS-R was carried out according to guidelines from international scientific literature[4], and it was also validated for the Brazilian context. This process involved a translation and backtranslation of the items from the original English version of the instrument to Brazilian Portuguese, along with its face and content validation[10].

There was also a description of its psychometric properties related to its validity and reliability using Cronbach's alpha.

The final version of the data collection instrument was applied at two hospital institutions – "H1" and "H2" – both located at a municipality in southern Brazil. The first institution, named "H1", is a public university hospital that offers care exclusively for the Brazilian Unified Health System (SUS, as per its acronym in Portuguese) in the medical, pediatric, obstetrics, gynecologic, surgical, traumatology, adult ICU and neonatal ICU fields. It has 61 nurses, who are mostly public servants (single legal regime) and workers hired through a contractor regime, working 30 hours per week.

The institution "H2" is a philanthropic organization offering care for SUS, insured and private patients. It has three hospital units: general, cardiology and oncology, and psychiatric. The nursing team comprises 174 nurses ruled by the consolidation of labor laws (CLL), working 36 or 40 hours per week, according to location of practice.

Data collection occurred between August and September, 2015. Data collection instruments were delivered in visits to the institutions' units, when nurses were invited to participate in the study at their own workplaces and hours. After the ethics-related procedures, the instruments were handed directly to respondents in brown paper envelopes, with no identification, and collected right after being filled in, according to previous schedule.

**Population and sample: inclusion and exclusion criteria**

Participants were selected through non-probabilistic convenience sampling[11]; thus, all nurses of the aforementioned institutions who were at their work sites during the data collection period were invited to participate in the research, as long as they met the inclusion/exclusion criteria[11]. Inclusion criteria were: nurses; working at the selected hospitals; with over six years of experience at the institution. This length of time was chosen because it was considered adequate for their adaptation to routines and organizations. Exclusion criteria were: absence of work site at the time of data collection due to vacations, strikes, and leaves of absence; temporary workers.

For selection of sampling size, a specific formula was adopted. It had the aim of estimating the smallest possible sampling size for conducting a variety of statistical procedures[11]. Knowing both institutions' population, comprising 235 nurses, and applying the formula, the authors arrived at a minimum number of 145 respondents. Thus, in order to select the highest number of participants for achieving a safety margin, the resulting number was 157 nurses.

**Study protocol**

The original MDS-R comprises 21 questions organized in a 5-point Likert scale, with a frequency ranging from 0 (never) to 4 (very frequently) and intensity ranging from 0 (weak) to 4 (elevated). Its questions contemplate ethically controversial situations related to patient care, involving ethical dilemmas that make it possible to find the frequency of moral distress and its intensity for various health professionals[4].

Moral distress is identified through values in the Likert scale by using two procedures. First, the frequency is multiplied by the intensity (FXI), whose scores obtained per question can vary from 0 to 16, with higher scores correlating to higher distress in each question[4]. Then the overall moral distress index is found through the total sum of the scores obtained from FXI for each item in the 21 questions, resulting in a scale from 0 to 336, according to which higher scores mean higher moral distress[4].

To culturally adapt the MDS-R, six stages were followed, according to international guidelines that aim for complete instrument compliance by applying semantic, idiomatic, experiential and conceptual adaptation between the original instrument and the adapted version. These six stages are: initial translation; synthesis of translations; backtranslation; specialist committee; pretest; review of the adaptation process by researchers[10].

In the first stage, the initial translation, the instrument was sent to two independent bilingual translators for translation from English to Portuguese. One translator was aware of the objectives and concepts used in the scale; whereas the other did not know any information related to the objectives and themes of the instrument, so there would not be any exchange of information[10].

Afterward, a final version (synthesis) of the two translations was created, containing the discrepancies found and their resolutions, for later submission to the backtranslation process, in which the synthesis version was backtranslated to English by two other translators[10]. Both translators were not informed of the instrument's content and objectives, with the aim of avoiding wrong significants. After compiling the two documents resulting from the backtranslation, the backtranslated version of the instrument was achieved[10].

This version was sent to a specialist committee, comprising four nursing doctorate professors with wide-ranging experience in the theme. Semantic, cultural, idiomatic and conceptual equivalences were assessed, as well as the scale's face validity, approving it to be used in a pretest, developing the pre-final version of the instrument[10]. The version assessed by the specialist committee was applied to a sample of 30 nursing students of the Master's and/or Doctorate programs in nursing of a public university of southern Brazil. This was a pre-test.

The pre-test aimed to guarantee the scale's content validity, with the goal of confirming whether its items represented the content to be analyzed. The scale was applied individually so that each participant would report which parts were difficult and which were easy to fill in and possible suggestions and modifications to the questions, if necessary[10]. No changes were made after the pretest.

The last stage conducted after finishing the pretest had the aim of reviewing the adaptation process. In it, researchers made necessary adjustments to the scale, with the goal of facilitating its comprehension and feasibility in the selected sample, ensuring content consistency[10]. With this, the final version of the MDS-R - Brazilian version, was considered approved for use in the Brazilian context.

**Analysis of results and statistics**

The analyses of intensity and frequency of moral distress were verified by two procedures, first the multiplication of intensity and frequency individually for each question; and, afterward, general sum of scores obtained in the first stage. The association between the instrument questions and the hospital units was done through Pearson's correlation. The cultural

adaptation of the MDS-R instrument was authorized by the journal that hold its copyrights by electronic contact.

After applying the instrument to the selected sample, statistical tests were conducted in the Statistical Package for the Social Sciences (SPSS), version 23.0. The authors sought to verify whether the Brazilian version of the scale was able to measure the phenomenon with clarity and reliability, making it possible to reach the proposed objectives. For that end, Cronbach's alpha was verified after applying the questionnaires in order to guarantee the instrument's reliability[12].

Data were summarized per question after intensity and frequency analyses in the 157 questionnaires and per question subgroups in the hospital units, finding common factors in the work context based on the responses' mean[12]. Through Pearson's correlation, it was possible to correlate to the 99% level the experience of moral distress in work routine with the 21 situations presented in the instrument[12].

## RESULTS

Concerning the scale's face validity, the specialist committee showed consensus for all items, assessing them as pertinent and securing their semantic, cultural, idiomatic and conceptual coherence. All items were understood as they were, so the questions had few changes, mostly concerning writing style.

In question 14, "Increasing the dose of sedatives/narcotics for unconscious patients, which I believe will accelerate their death", there was a suggestion for changes in the sentence, adapting it according to the attributions of nurses, since the employed term refers to a medical attribution. Therefore, question 14 was proposed to be: "Administer a dose of sedatives/narcotics to unconscious patients when I believe it will hasten their death". Another accepted suggestion was to add to the instrument's instructions a brief definition of the term "moral distress" based on literature. The final scale's title in Portuguese is "*Escala de Sofrimento Moral Revisada para Enfermeiros*" or "Moral Distress Scale-Revised (MDS-R) – *versão brasileira*" (MDSR-VB).

After assessment by the specialist committee and pretest, the culturally adapted instrument was applied to the selected sample for instrument validation and to achieve psychometric results. Concerning sociodemographic data of the researched sample, the total 157 nurses were distributed between H1(33.1%) and H2 (65%), with most participants being women (88.5%), a mean age of 31.9%, with 22 years being the minimum age and 58 the maximum. The mean professional training length was (5.5) years, whereas the mean length of practice at the hospitals was 4.6.

Regarding work units, the Adult Inpatient Clinic had the highest concentration of nurses (23.6%), as well as the 36 weekly hours shift (49.7%). As for the type of care offered at the work units, there was a predominance of both SUS and private/insurance (46.5%). The study also found that undergraduate (49.7%) was the most frequent highest title among nurses, followed by graduate (39.5%). In order to verify the power of the association among the pre-existing questions, question q-22 was added to the final version of the instrument, which originally comprised 21 questions: "Generally, I experience moral distress in my work routine".

Two procedures were conducted to obtain the final score for frequency and intensity of moral distress. First, the multiplication of the frequency by the intensity was obtained, resulting in a score from 0 to 16. Soon after, the global moral distress index was found through the total sum of the score obtained from each item in the 21 questions, resulting in a scale from 0 to 336, according to which higher scores mean higher moral distress[4].

**Table 1 –** Scores referring to the frequency and intensity of moral distress found by nurses, Rio Grande, Rio Grande do Sul, Brazil, 2015

| Question | *Score* |
|---|---|
| 1. Offer care that has less than ideal quality due to pressure from managers or the institution to cut costs. | 4.38 |
| 2. Witness health professionals giving "false hopes" to patients or families. | 3.20 |
| 3. Follow the wishes of families to maintain life, even if it is not patients' best interest. | 4.14 |
| 4. Begin cardiorespiratory resuscitation when I believe that it will only prolong death. | 4.32 |
| 5. Meet families' requests to avoid discussing death with terminal patients who ask about it. | 3.53 |
| 6. Follow medical instructions in relation to exams and unnecessary treatments. | 5.83 |
| 7. Keep investing in patients with irreversible injuries who are kept on ventilators when no one will make the decision not to invest. | 4.24 |
| 8. Avoid taking action/reporting when I find out that a physician or nurse colleague made an error that goes unreported. | 3.28 |
| 9. Participate in a procedure with a physician who is administering inadequate care. | 3.15 |
| 10. Be forced to care for patients I do not feel qualified to treat. | 3.36 |
| 11. Let medical students conduct painful procedures on patients only to improve their skills. | 4.29 |
| 12. Administer therapeutic measures that do not alleviate patient suffering because physicians suppose increasing the dose of pain medication could cause death. | 2.99 |
| 13. Follow physicians' requests to avoid discussing patient prognostics with patients or their families. | 4.08 |
| 14. Administer a dose of sedatives/narcotics to unconscious patients when I believe it will hasten their deaths. | 1.32 |
| 15. Not take action on a witnessed ethical issue because the team member involved asked not to do anything. | 1.87 |
| 16. Follow families' wishes even when I do not agree with them, doing so for fear of professional complaints. | 1.80 |

To be continued

Table 1 (concluded)

| Question | *Score* |
|---|---|
| 17. Work with nurses or others health professionals (except for physicians) who are not qualified to perform care required by patients. | 4.52 |
| 18. Ignore suspicions of patient maltreatment by families/caregivers. | 1.78 |
| 19. Ignore situations in which patients are not correctly informed to guarantee educated consent. | 1.88 |
| 20. Observe problems in patient care due to lack of conditions to keep treatment continuity. | 3.52 |
| 21. Work with nursing professionals or other health professionals who I consider insecure. | 5.72 |
| General score | (92.22) |

**Table 2 –** Most common situations of moral distress identified by nurses according to hospital unit, Rio Grande, Rio Grande do Sul, Brazil, 2015

| Situation | I | C | II | C | III | C | IV | C | V | C | VI | C | VII | C |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Begin cardiorespiratory resuscitation when I believe that it will only prolong death. | 5.96 (5.69) | 1ª | 4.30 (4.66) | 7ª | 5.50 (5.30) | 8ª | 4.33 (4.52) | 5ª | 1.64 (2.61) | 19ª | 7.70 (5.71) | 2ª | 2.71 (4.76) | 10ª |
| Work with nursing professionals or other health professionals who I consider insecure. | 5.54 (5.27) | 2ª | 4.97 (5.25) | 4ª | 7.59 (6.16) | 1ª | 4.11 (5.34) | 6ª | 7.68 (6.15) | 1ª | 5.70 (4.49) | 7ª | 4.75 (3.76) | 1ª |
| Follow medical instructions in relation to exams and unnecessary treatments. | 5.42 (5.64) | 3ª | 5.76 (5.51) | 1ª | 5.91 (5.08) | 4ª | 6.33 (5.72) | 1ª | 5.82 (5.90) | 3ª | 9.40 (6.02) | 1ª | 4.42 (4.68) | 2ª |
| Keep investing in patients with irreversible injuries who are kept on ventilators when no one will make the decision not to invest. | 5.25 (5.78) | 4ª | 4.73 (5.05) | 5ª | 5.55 (4.93) | 6ª | 4.89 (5.07) | 4ª | 2.41 (4.17) | 16ª | 4.80 (4.56) | 10ª | 2.25 (3.81) | 12ª |
| Work with nurses or others health professionals (except for physicians) who are not qualified to perform care required by patients. | 5.00 (6.19) | 5ª | 3.62 (4.29) | 9ª | 6.41 (5.47) | 2ª | 2.50 (3.33) | 10ª | 5.86 (5.75) | 2ª | 6.10 (5.50) | 5ª | 3.33 (3.57) | 5ª |
| Let medical students conduct painful procedures on patients only to improve their skills. | 4.88 (5.78) | 6ª | 3.49 (5.27) | 10ª | 5.68 (5.59) | 5ª | 3.44 (3.65) | 7ª | 4.14 (5.10) | 7ª | 6.60 (6.04) | 4ª | 3.46 (4.29) | 4ª |

*Note: *C: Classification of questions according to order of relevance. Means and standard deviation verified for: I - Emergency; II - Adult Inpatient Clinic; III - Maternal-Child Inpatient Clinic; IV - Neonatal/Adult ICU; V - Surgical Center; VI - Administrative; VII - Others..*

**Table 3 –** Correlation of the 21 instrument questions with moral distress, Rio Grande, Rio Grande do Sul, Brazil, 2015

| Question | Slight, almost imperceptible | Mild, but defined | Moderate |
|---|---|---|---|
| Q01 | .182* | | |
| Q02 | .180* | | |
| Q04 | | .287** | |
| Q05 | | .209** | |
| Q06 | | .223** | |
| Q07 | .181* | | |
| Q08 | | .260** | |
| Q11 | .174* | | |
| Q12 | .167* | | |
| Q13 | | .311** | |
| Q14 | | .269** | |
| Q15 | | .355** | |
| Q16 | | .253** | |
| Q17 | | .279** | |
| Q19 | | .247** | |
| Q20 | | .390** | |
| Q21 | | | .516** |

*Note: *Correlation at the 95% level; + correlation at 99% level.*

Instrument reliability was tested through Chronbach's alpha, resulting in the value of 0.88, whereas the seven units' coefficients varied between 0.76 and 0.94. In its final version, the instrument was interpreted based on the situations of moral distress that achieved the highest means for intensity and frequency among nurses who practiced at different hospital units, sorted by relevance, as represented in Table 2.

To determine association power between the 21 instrument questions and moral distress, question q-22 was adopted, "Generally, I experience moral distress in my work routine", individually relating it to each question through Pearson's correlation, according to Table 3.

## DISCUSSION

Regarding the presented results, the use of the MDSR-VB at two hospital institutions allowed to identify specific situations of moral distress for different workplaces, showing the complexity of the ethical issues presented in these clinical contexts. Regarding the instrument's reliability, the obtained results represent very satisfactory indexes, especially when compared to the original instrument's validation[4-5], thus guaranteeing the reliability of the validated instrument for further studies.

The Cronbach's alpha of the MDS-R, Brazilian version, presented a 0.88 value for the instrument. This result is similar to the original MDS-R, for which internal consistency of the instrument's 21 questions, as measured by Cronbach's alpha, was 0.88[4]. Regarding the questionnaire subgroups, according to the work units in which they were collected, the Cronbach's alpha found varied between 0.76 and 0.94.

The obtained results enabled to organize data sorting questions by order of highest intensity and frequency of moral distress per hospital unit. Question q06, "Follow medical instructions in relation to exams and unnecessary treatments", was the question with the highest moral distress perceived by nurses (9.40), being felt mainly by those who do administrative work. The result is consistent with the MDS-R results, which also found the highest mean for this question as a source of moral distress[4].

In this sense, a study on moral distress in nurses emphasizes that issues related to working with physicians are strongly linked to the need to exert power in decision making among nurses, leading them to frequently act in contradiction with their beliefs and values, causing feelings of impotence in the presence of physicians, hiding their real knowledge, thus developing internal conflicts and possible loss of professional identify[13].

Moreover, it showed that nurses who have administrative jobs are constantly faced with changes in healthcare management policies , which might result in an increase in the number of increasingly complex legal and institutional guidelines, clinical orientations, protocols, strong emphasis on accountability, inadequate staff size and constant work pressure. These aspects and increasing social demands are directly associated with moral distress[8].

It should be emphasized that it is the professionals' responsibility when in administrative roles to carefully assess their technical, scientific, ethical and legal competence and only accept/determine roles and attributions when there is safety for practice, both for them and for patients. This fact emphasizes the relevance of further studies on rights and duties in the profession, since knowledge is a basis that enables and supports professional practice, as well as encourages decision making in an ethical and autonomous way[14].

Another situation shown in question q-4, "Begin cardiorespiratory resuscitation when I believe that it will only prolong death", was relevant mainly at emergency units (5.96), in which nurses found themselves more susceptible to moral distress. Similar data was found in the MDS-R study in which the same question demonstrated strong moral distress for physicians and nurses, with very similar frequency and intensity rates between these professional categories, resulting in a negative impact on work satisfaction[5].

In agreement with this study, national and international studies found elevated levels of moral distress in nurses who participated in situations of pain and suffering for patients undergoing life prolonging procedures, with no evidence of success[7-8,15-19]. The professionals had feelings of incapacity when carrying out their procedures and of violation of their ethical principles, which shows situations of great emotional vulnerability[17-18].

Seeing how treatments considered unnecessary could cause moral distress, it is necessary to motivate autonomy in nurses, which is strengthened by effective communication and harmonization in their work sites[20]. In a study with nursing workers in the extreme south of Brazil[17], therapeutic obstinacy was identified as a source of moral distress. It showed that initiatives such as meetings among teams and more open dialog between management and institutions could be great allies in handling ethical conflicts, which promotes problem-solving and manifestations of experienced difficulties[17].

Through Pearson's correlation analysis, values between 0.18 and 0.51 were obtained, placing most questions at the level *low but possible correlation*. It was possible to find one question at the moderate correlation level with moral distress, highlighting question q-21, "Work with nursing professionals or other health professionals who I consider insecure".

Therefore, the nurses' feelings of responsibility for keeping a well-functioning team increases the need to offer safety to patients, protecting them against damages resulting from lack of ability, negligence or imprudence from any health worker[14].

Studies with nurses practicing at hospital context in various countries found that working with health professionals seen as insecure strongly influences experiences of moral distress, decreasing decision-making capacity[6,16-20]. The main negative characteristic perceived in the work context was lack of ability of technical and scientific competence, which are crucial for conducting specific health activities[16]. Thus, the possibility of a negative impact on care quality can upset the essence of care, making it an alert ethical challenge[19].

### Study limitations

Study limitations involved the small sample of nurses practicing at two hospitals of a southern Brazil city, which does not enable the generalization of results. The authors emphasize the need to conduct further studies on moral distress in nursing at various contexts, in order to contribute for the transformation of reality and improvement of ethical behavior through better handling of situations at the workplace.

### Contributions for the fields of nursing, health or public policies

Contributions for the fields of nursing, health or public policies include the constant improvement of technical, scientific, ethical and cultural knowledge for the benefit of the population and for advancing the profession; as well as the development of a more pragmatic approach when handling situations of moral distress[14.20]. Although there were variations in frequency and intensity at different health units, it is evident that moral distress can occur in multiple clinical environments[19]. It is crucial to recognize and improve autonomy in nurses for their health attributions, especially when ethical values are compromised.

## CONCLUSION

Results show that the Moral Distress Scale-Revised – Brazilian version is an instrument capable of assessing situations of moral distress in nurses, contributing for the comprehension

of the relationship between the nature of work and situations of ethical conflict. The validation of the Portuguese version of the instrument is an important technology, obtaining indicators of potential situations that cause moral distress and providing relevant resources for nurses in the Brazilian context.

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