http://dx.doi.org/10.1590/0104-07072017000990017

CONSTRUCTION OF THE BRAZILIAN SCALE OF MORAL DISTRESS IN NURSES - A METHODOLOGICAL STUDY

Flávia Regina Souza Ramos[1], Edison Luis Devos Barlem[2], Maria José Menezes Brito[3], Mara Ambrosina de Oliveira Vargas[4], Dulcineia Ghizoni Schneider[5], Laura Cavalcanti de Farias Brehmer[6]

[1] Ph.D. in Philosophy and Nursing. Professor, *Programa de Pós-Graduação em Enfermagem* (PEN), *Universidade Federal de Santa Catarina* (UFSC). Florianópolis, Santa Catarina, Brazil. E-mail: flavia.ramos@ufsc.br
[2] Ph.D. in Nursing. Professor, Undergraduate and Post Graduate Nursing Course of the *Universidade Federal do Rio Grande*. Rio Grande, Rio Grande do Sul, Brazil. E-mail: ebarlem@gmail.com
[3] Ph.D. in Administration. Professor, *Programa de Pós-Graduação em Enfermagem, Universidade Federal de Minas Gerais*. Belo Horizonte, Minas Gerais, Brazil. E-mail: brito@enf.ufmg.br.
[4] Ph.D. in Nursing. Professor, Nursing Department, PEN/UFSC. Florianópolis, Santa Catarina, Brazil. E-mail: ambrosina.mara@ufsc.br
[5] Ph.D. in Nursing Professor, Nursing Department, UFSC. Florianópolis, Santa Catarina, Brazil. E-mail: dulcineiags@gmail.com
[6] Ph..D in Nursing. Professor, Nursing Department, UFSC. Florianópolis, Santa Catarina, Brazil. E-mail: laura.brehmer@ufsc.br

ABSTRACT

Objective: to develop an instrument called the Brazilian Scale of Moral Distress in Nurses, in order to measure the intensity and frequency of moral distress.

Method: a methodological research described in three steps: 1) definition of the theoretical framework (Background); 2) Instrument design; and 3) instrument composition. Step 2 integrated the literature review and survey to identify elements / situations triggering moral distress. The sample consisted of 771 nurses, from the 27 states of Brazil, working in different services.

Results: moral distress situations analyzed by the survey were analyzed in five rounds involving a group of researchers, producing an analytical matrix with nine categories and 72 subcategories, which subsidized the formulation of the initial questions, and improved and collated with the findings of the literature (validation of criterion). Three other rounds were performed for the composition of the instrument, with 57 questions and a double Likert scale, with successive revisions of the content, language, format and layout, including the evaluation by experts / judges and analysis of the results of the pre-test (face/content).

Conclusion: explore specific conditions of the Brazilian context of nurses' work and the validation of the instrument produced will allow the understanding of the theme of moral suffering in the Brazilian nursing scenario. Constructing instruments capable of measuring expressions of moral distress can validate ethical problems already described with adapted instruments.

DESCRIPTORS: Nursing research. Moral. Suffering. Scales. Validation studies.

CONSTRUÇÃO DA ESCALA BRASILEIRA DE DISTRESSE MORAL EM ENFERMEIROS – UM ESTUDO METODOLÓGICO

RESUMO

O**bjetivo:** desenvolver um instrumento denominado Escala Brasileira de Distresse Moral em enfermeiros, para medição da intensidade e frequência do distresse moral.

Método: pesquisa metodológica descrita em três etapas: 1) definição do marco teórico (*background*); 2) concepção do instrumento; e 3) composição do instrumento. A etapa 2 integrou a revisão da literatura e survey para identificar elementos/situações desencadeadoras de distresse moral. A amostra consistiu de 771 enfermeiros, dos 27 estados do Brasil, atuantes em diferentes serviços.

Resultados: foram analisadas situações de distresse moral apreendidas pelo *survey*, em cinco rodadas envolvendo grupo de pesquisadores, produzindo uma matriz analítica com nove categorias e 72 subcategorias, que subsidiaram a formulação das questões iniciais, aprimoradas e cotejadas com os achados da literatura (validação de critério). Outras três rodadas foram realizadas para composição do instrumento, com 57 questões e dupla escala Likert, em sucessivas revisões do conteúdo, linguagem, formato e layout, incluindo a avaliação por experts/juízes e análise dos resultados do pré-teste (validação de face/conteúdo).

Conclusão: explorar condições específicas do contexto brasileiro do trabalho de enfermeiros e a validação do instrumento produzido permitirá compreender o tema do sofrimento moral no cenário da enfermagem brasileira. Construir instrumentos próprios capazes de aferir expressões de distresse moral pode referendar problemas éticos já descritos com instrumentos adaptados.

DESCRITORES: Pesquisa em enfermagem. Moral. Sofrimento. Escalas. Estudos de validação.

CONSTRUCCIÓN DE LA ESCALA BRASILEÑA DE DISTRÉS MORAL EN ENFERMEROS - UN ESTUDIO METODOLÓGICO

RESUMEN

Objetivo: desarrollar un instrumento denominado Escala Brasileña de Distrés Moral en Enfermeros, para medir la intensidad y frecuencia de la distracción moral.

Método: investigación metodológica descrita en três etapas: 1) definición del Marco teórico (background); 2) concepción del instrumento; y 3) composición del instrumento. La etapa 2 integró la revisión de la literatura y la encuesta para identificar elementos/situaciones desencadenantes de distracción moral. La muestra fue formada por 771 enfermeros, de los 27 estados de Brasil, actuantes en diferentes servicios.

Resultados: se analizaron situaciones de distracción moral aprehendidas por la encuesta, en cinco rondas involucrando grupo de investigadores, produciendo una matriz analítica con nueve categorías y 72 subcategorías, que subsidiaron la formulación de las cuestiones iniciales, mejoradas y cotejadas con los hallazgos de la literatura (validación de la literatura) criterio). Otras tres rondas se realizaron para la composición del instrumento, con 57 preguntas y doble escala Likert, en sucesivas revisiones del contenido, lenguaje, formato y diseño, incluyendo la evaluación por expertos/jueces y análisis de los resultados del pre-test (validación de cara/contenido).

Conclusión: explorar condiciones específicas del contexto brasileño del trabajo de enfermeros y la validación del instrumento producido permitirá comprender el tema del sufrimiento moral en el escenario de la enfermería brasileña. La construcción de instrumentos propios capaces de medir expresiones de distensión moral puede referir problemas éticos ya descritos con instrumentos adaptados.

DESCRIPTORES: Investigación en enfermería. Moral. Sufrimiento. Escalas. Estudios de validación

INTRODUCTION

Moral Distress (MD) has been studied since the 1980s, initially in the United States, as a manifestation also defined as anguish, distress or suffering in situations in which nurses recognize the most correct course of action to take, but fail to take it due to external or internal barriers, generating a feeling of impotence or inability to perform the action defined as ethically adequate.[1-3] Studies characterize it as a phenomenon that can be differentiate into types and phases (initial, reactive, persistent),[2,4] affecting moral integrity and leading to serious consequences for the professional, in addition to those generated by morally improper actions.[5-6]

MD has become the object of analysis in different realities, countries and types of care units where nurses work.[7] Recent studies[8-10] amplify the concern about different health team professionals, detecting the presence of MD in professional groups and as a significant predictor of the intention to leave the profession or place of work. Higher levels of MD were identified among those involved in direct patient care when compared to physicians, being negatively correlated with the ethical work climate and positively related to the tendency to abandon work.[11]

Differences among professionals refer to higher scores of MD among nurses and other non-medical professionals (in relation to physicians), a relationship inversely associated with age for other health professionals and directly associated with years of experience in nurses only. The relationship with *Burnout* Syndrome and the predisposition of profession abandonment was relevant for non-medical professionals.[12] The implications and similarities between MD and burnout were also observed in Brazil.[13]

From this type of analysis, it is important to recognize the importance of not only relating the MD problem to demographic data and real work situations, but also to re-examine it under different theoretical contributions,[14] as in a feminist approach[15] or in relation to concepts that have significance for the profession.[6] The importance of discussing the scope and limits of the construct and the researches performed until now is highlighted.[16-17]

The Corley[18] - Moral Distress Scale - is a pioneer in MD studies, resulting in applications and adaptations for different health facilities. Its translation and validation, and subsequent adaptation, were performed in Brazil in 2012 and 2014.[19] The adapted Brazilian version of Corley extended the findings to the nursing team, with approximately five constructs: lack of competence in the work team, disrespect for autonomy, insufficient working conditions, denial of the nursing role to be an advocate for the terminally ill patient, and denial of the nursing role to be the patient's advocate.[19]

Based on the results produced, there was an interest in filling a gap - especially in Brazilian studies in institutional or local contexts in order to construct a Brazilian MD scale for nurses - as specific characteristics of the health services scenarios and the historical transformations in Brazil require a more accurate look at this context and professionals. While recognizing the use of scales as insufficient to respond to the complexity of the object,

they can provide important information for further advancement in knowledge regarding the MD area. In regards to Brazil, it is time to build instruments capable of measuring expressions of MD itself, being able to refer aspects of the work already detected with the use of translations and also revealing particular dimensions, and even making international comparisons possible .

Different measurement instruments have been used in nursing, produced specifically by researchers in the area or related areas. For such use and application, the most common studies are validation and cultural adaptation, because it is rational that available instruments are tested and adapted, until the need to develop a new tool is made evident. The investment of nursing in this type of research is recent in Brazil, however there are already several instruments being used, some of which have already been validated by nurses, especially for clinical application, focused on objective or subjective phenomena of the patient, educational processes and experiences and attitudes of the professionals themselves.[20-23]

In order to evaluate the priority of translation/adaptation studies or development of instruments it is necessary to consider the specificity of the object of study. When it comes to work realities, problems or ethical-moral experiences extremely diverse in nature, adapting what has been produced in different scenarios can be drastically limited. An everyday question of the work of Brazilian nurses, for example, can even be imagined by an American nurse and vice versa. The way in which the profession has historically conformed in each context produces diversity in terms of legal and formative framework, political and technological models to which it adheres, organization and interprofessional relations, among others. This fact can determine great differences in ethical experiences and the process of moral suffering.

The methodological study described in this article was developed specifically on MD with the objective to develop an instrument called the Brazilian Moral Distress Scale for Nurses to measure the intensity and frequency of moral distress.

METHOD

Methodological studies contribute to increase rigor in research, because they investigate their own data collection or organization methods, developing, validating and evaluating tools and research methods.[24] Measurement is a fundamental activity of science, since it allows quantifying observations about events, people, objects and processes, broadening their understanding of them. Psychrometric measurements are important in the field of social sciences, as they refer to psychological and social phenomena explored from variables of interest. Although it is based on statistical methods, its role is not separate from theory development; on the contrary, measurements and theories are related in mutual contribution. Theories are fundamental for the design of measurement instruments and measurements in order to evaluate and correlate indicators and constructs, strengths and deficiencies of theories.[25]

The expected attributes of an instrument refer to its validity, reliability, sensitivity, responsiveness and practicality.[26] There is an obvious advantage of instrument adaptation studies, from the economic point of view and for the interest of robustness and universalization of these tools,[27] especially in epidemiological research.

This study was integrated into the research project, multicentric in character, which analyzes the process of moral distress/suffering in nurses in different health work contexts in Brazil. The research followed the guidelines established by Resolution N. 466/12 of the National Health Council and was approved by the Human Research Ethics Committees of the three Universities involved in the multicentric project, with the following final opinions: 602.598-0 in 02 / 2014 (UFSC); 602.603-0 on the 01/31/2014 (Federal University of Minas Gerais / UFMG) and 511.634 on the 01/17/2014 (Federal University of Rio Grande / FURG). The opinion obtained with FURG under the number 144/2013, approved the second stage of the research.

The developed scale applies to the establishment of measures of MD intensity and frequency of nurses working in different working contexts in Brazil. The development of instruments or questionnaires follows five sequential steps: 1) definition of the theoretical framework; 2) Instrument design; 3) formatting and analysis of data; 4) validation; and 5) establishing reliability.[28]

RESULTS

This article details the steps that, although followed a specific orientation for the study in focus, correspond to steps 1, 2 and 3 above.[28] Step 1 represents the theoretical basis of the study, singularly

constructed by the researchers, through interpretations and analysis of the available literature on the problem, including already validated scales, hypotheses or original questions about the object in its delimited context, target public, study objectives and justification of relevance. The product of this step was the foundation for the study definitions. For stage 1, the term conceptual framework was adopted and stages 2 and 3 encompassed the design and elaboration of the instrument. On the other hand, these stages, are constituted of stages and procedures that demonstrate the complexity of methodological researches and their potential contribution to the analysis of other objects. Figure 1 summarizes the procedures adopted in each of the 3 steps, as described below.

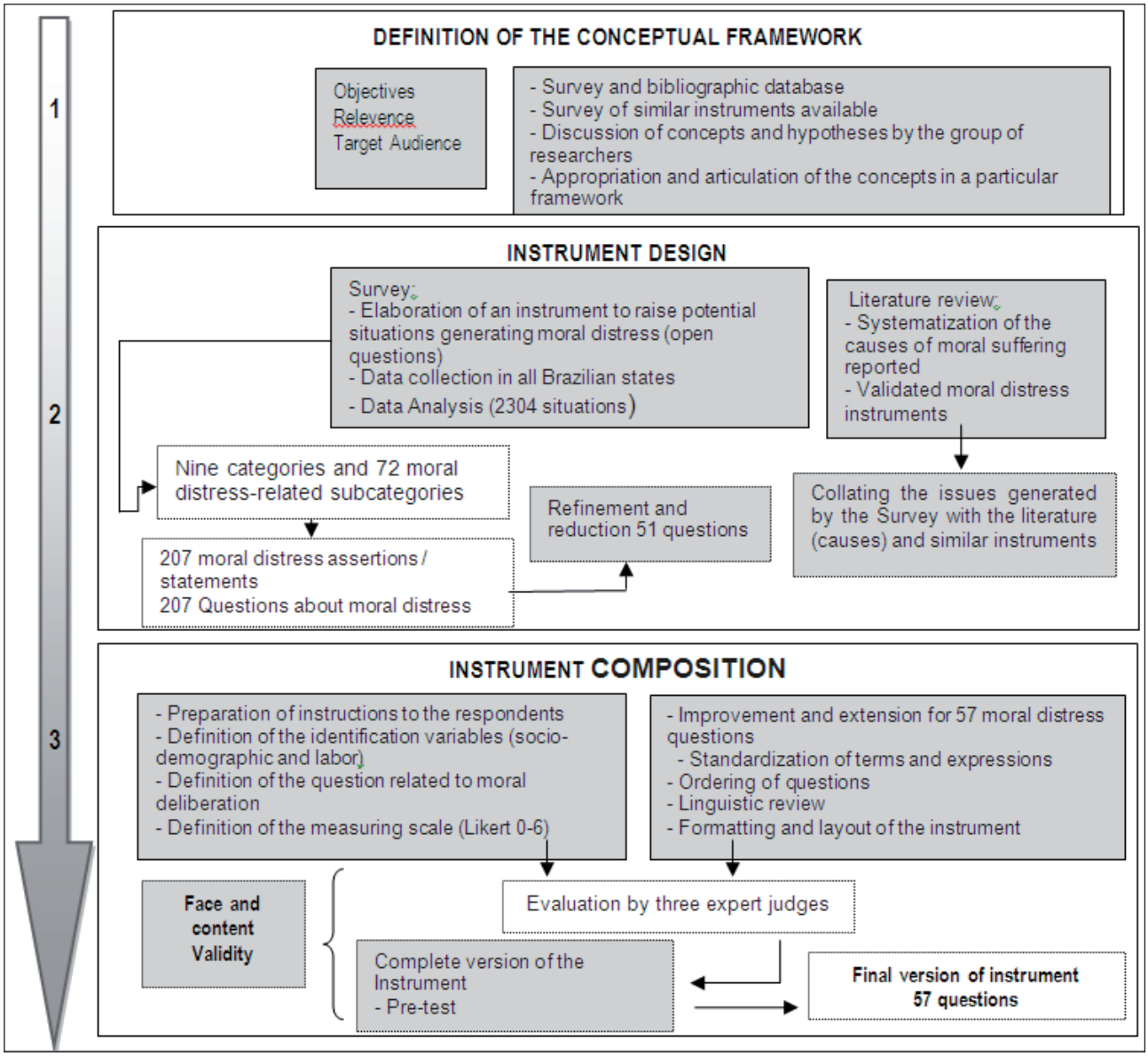
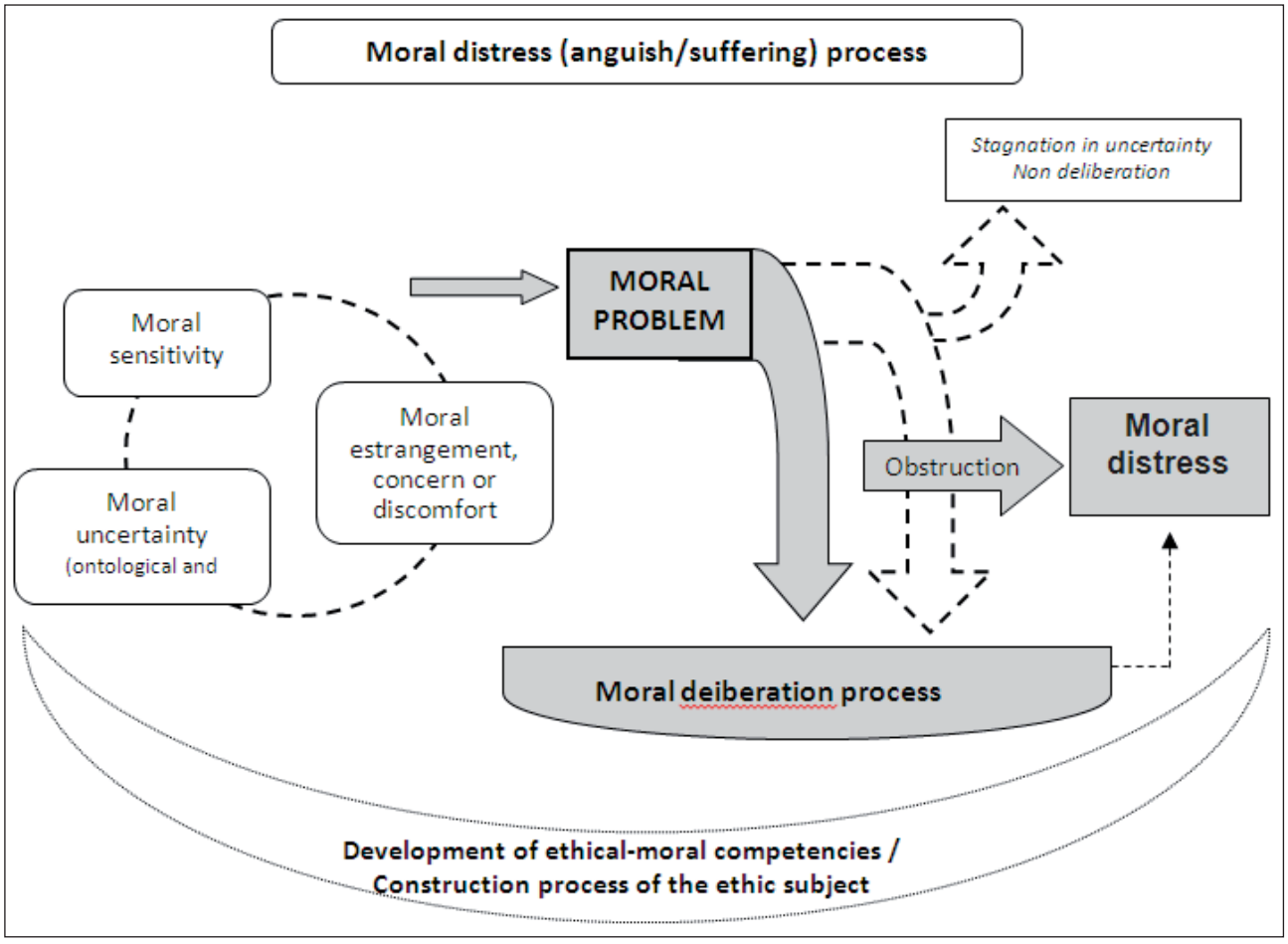


Figure 1 - Schematic representation of the methodological study stages

Step 1: conceptual framework

The definition stage of the conceptual framework was developed within the scope of the same project, in the first stage of the study, previously published in full and briefly summarized below (Figure 2). The conceptual elements for the MD analysis were proposed through discussions which were carried out by the team of researchers. MD is understood: as an articulating process, with several concepts related to moral experience, such as uncertainty or moral discomfort (inherent to the human

condition and professional practice, the latter linked to the insufficiency of knowledge regarding the work circumstances and the element of discomfort in relation to morality (indispensable for a moral problem to be criticized and the ethical content of recognized actions) and moral deliberation (a method of practical reason and a tool for solving moral problems, in relation to different stakeholders and supported by values and knowledge); and as a process that has the moral problem as its starting point (the reason behind moral reflection on the situation and on oneself, closely related to moral sensibility) and culminates in deliberate processes that are impeded, interrupted or impaired, failing to achieve a better course of action and producing consequences for the professional himself (although it also includes the possibility of reassessment after deliberation and distress due to misunderstandings and unexpected results).



Source: Ramos et al, 2016[17]

Figure 2 - Schematic matrix - Conceptual framework for the analysis of the process of moral distress

Step 2: instrument design

This stage involved the content elaboration of the instrument in the form of statements or questions, according to the objective of measuring attitudes, knowledge, perceptions or opinions.[28] In order to define the content and elements to be explored, step 2 articulated two methods, which were developed in 2014 and 2015: a survey for initial exploration of the object in the studied reality and the literature review revision already begun in step 1, but resumed with specific focus on the causes of MD.

The literature review was characterized as integrative and focused on the specific question of identifying the causes of MD in nurses in the literature. The search for studies in this subject was performed from February to March 2014 and updated in May 2015, including all its databases

of the Virtual Health Library (VHL). The inclusion criteria included full available articles which were published in Portuguese, English or Spanish, accessed through the boolean operator AND, with the following terms contained in the title or abstract: Moral Distress AND Nurse, Moral Distress AND Nursing, Moral Suffering AND Nurse, Moral Suffering AND Nursing. Duplicate studies were excluded from databases, review articles, institutional publications, government documents, theses and dissertations.

A total of 708 articles were identified, of which 105 were repeated. 490 of the 603 articles were excluded because they did not answer the study question (causes of MD) or because they were not available online in full. The sample consisted of 113 articles which were analyzed in their entirety. The information on: title, authors, years, periodical, database, design, scenario and context of the study and causes of MD were compiled in an Excel worksheet. Afterwards, an update was performed which focused on the consequences of MD in 86 articles published until July 2015.[29] Nine published articles were added after the first collection in order to highlight possible new elements regarding the causes and to improve the conceptual framework (step 1).

The causes of moral distress were related to ten categories: 1) Therapeutic futility/terminality; 2) Interpersonal conflicts/behaviors / values; 3) Team devaluation /disrespect; 4) Disrespect for patient / family autonomy / privacy; 5) Negligence / malpractice / discrimination in care; 6.) Lack of decision making; 7) Insufficient human / material resources; 8) Harassment; 9) Ethical dilemmas; and 10) Political / hierarchical interference. Each of these categories was analyzed separately by two different researchers, considering the articles that addressed these causes in order to produce a synthesis of the situations related to MD. The two syntheses were performed by a third researcher, who elaborated a single and final synthesis on the main ideas that represented the category. This analytical result served as a foundation for the deepening and refinement of the issues produced through the second method of this design stage, the survey, as described below.

In spite of the quantitative characteristics of the survey, the quantification of the findings was not highlighted because independent of statistical significance, categories with new contributions and relationships between the data were valued, because their purpose was to point out elements or causes of MD in order to compose the instrument /scale.

The survey was performed through the application of an open questionnaire in which the concept of moral suffering was presented and participants were asked to report up to five situations that caused them to experience moral suffering. The questionnaire was applied to a convenience sample of nurses specializing in Nursing Care Lines, a distance education modality, promoted by the Ministry of Health and coordinated by the Nursing Department of the Federal University of Santa Catarina (UFSC) and executed by the same and other partner institutions. The collection took place in one of the simultaneous face-to-face meetings in the capitals of the 27 federative units of Brazil (26 States and Federal District) in October 2014. Approximately 1050 nurses were present at the meeting and after being invited 771 of them answered the questionnaire and signed the Term of Free and Informed Consent.

The answers obtained were inserted in an Excel spreadsheet, generating a total of 2,304 citations or excerpts related to MD situations highlight by each subject. Given the character of the data (direct mention of the cause, without narrative or justification), the analysis was limited to thematic categorization. The first procedure consisted in categorizing the citations by content similarity, initially in the workshop of the research group (including the researchers from the 3 three universities), until the construction of nine categories (Table 1) and 72 subcategories resulting from the professionals' answers to the questions.

Table 1 - Frequency of categories / codes in the survey findings

Code/categories	n	%
Working condition (CT)	529	22.96
Professional relationships (RP)	524	22.74
Work organization (OT)	316	13.72
Professional competence (CP)	293	12.72
Conflict(CO)	264	11.46
Other (O)	186	8.07
Care quality (QC)	112	4.86
Access(AC)	80	3.47
Total	**2304**	**100**

Based on the generated matrix, the total responses were coded by pairs of researchers, each code (CT, for example) had a set of subcategories (CT1, CT2 ... CT10). These results were described regarding the characterization of the sample and fre-

quency of potentially triggering situations of MD.[30] Afterwards, five rounds of instrument elaboration were developed, considered as part of this stage 2, which included:

• Round 1: elaboration of assertions representative of triggering situations of MD from the Excel worksheet. The categories and subcategories represented the allowance for the pairs of researchers to elaborate one to four questions per subcategory, in order to maintain coherence with the concept of MD (example: the subcategories " Function/Deviation from function" and " Performing the competence of the other" generated the assertions "Perform actions that are not inherent to their function" and "Perform actions for which they are not technically prepared")

- Round 2: initial review of the assertions based on the categories, by three researchers, with actions of reordering, exclusion and grouping of repetitive / similar contents, generating 207 potential questions from the instrument;
- Round 3: in the complete group of researchers (multicentric), the reduction was made, by grouping and pertinence of the questions, resulting in an instrument with 87 questions;
- Round 4: collating the questions with the findings of the literature review performed by three researchers, confirming the applicability of the same and indicating elements not yet clearly contemplated in the instrument. Readjustments in the presentation were generated however no new questions were generated;
- Round 5: new revision, carried out by the coordinating researcher, including linguistic aspects, reduction, inclusion, grouping and adaptation for 51 questions.

Step 3: instrument composition

This stage was directed to the selection, drafting and final ordering of the component parts of the instrument, the instructions to the respondents, the measurement scales, layout and format, considering the planned data analysis.[28] Thus, the following aspects were defined: – data related to sociodemographic and labor variables to characterize the sample (sex, current Brazilian State, training, link number, identification of the link considered to be the main/principal type, level of attention and sector/unit, length of professional experience and weekly working hours); – presentation of the concept of MD used; – adoption of a double Likert scale (intensity and frequency) with 6 points, 0=never, up to 6=very frequent (frequency) and 0=none, up to 6=very intense (intensity); - instructions for completing the scale.

This version of the instrument was submitted to the final rounds, which are part of the composition stage and the first validation technique:

- Round 6: face validity, through a group of experts / judges consisted of 3 researchers in the area. They received the instrument and guidelines via e-mail, evaluated it regarding the content, ordering and language requirements, providing suggestions for improving the instrument. Considering the content of the suggestions, the objective of this round was reached with only one feedback from the experts;
- Round 7: final revision of the content, language, format and layout, performed by the research group of the coordinating institution, considering the results of the face validity - evaluation by experts / judges, resulting in the final instrument with 57 questions.
- Round 8: analysis of the results of the pre-test, or content validation, confirming the instrument questions to satisfactorily contemplate the intended content.

Considering the recommendations of the literature[25] and the variability of the population, a pre-test was chosen as the last procedure of this step which included a sample of 30 (thirty) nurses from three different Brazilian states, from the south and southeast regions which was performed by researchers in a face to face situation. This number is compatible with what is recommended for cultural adaptation studies of instruments.[31] Respondents were asked to report questions in order to identify aspects of comprehension, clarity and organization. The time of each application varied between 14 and 40 minutes, with an average time of 20 minutes. The results were subsequently analyzed by a group of researchers from the institution coordinating the study, confirming the adequacy of the instrument.

Validation in the process of proposing a new instrument

For the description of the steps, according to the model adopted, the clarification of the actions in its logical sequence was prioritized, regardless of how these actions are denominated as steps or types of validation.

However, it is necessary to consider the relationship between the construction and the validation of instruments, as interdependent processes or as moments of a single process, since the first assumes, addresses or completes with the second.

The search for precise and reliable instruments leads to the development of tests and parameters capable of assuring the desired attributes in an instrument, impacting the importance of validation procedures in the processes of construction and adaptation of instruments and the existence of different methods to evaluate their psychometric properties. Only in terms of content validation, one of the widely used types, does the literature reveal a diversity of conceptual bases and measurement methods, and even denominations and concepts, in order to relate the limitation of this type of validation to its subjectivity.[26]

In this study, the face validity was referred to through a committee of experts or judges, while the content validation as obtained through pre-test, was based on a referential that considers the adaptability of these techniques to verify the semantic, cultural and conceptual equivalences (face validity) and confirms that the items of the instrument represent the content of the analysis (content validity).[32] As another reference, the two techniques, based on expert evaluation and pre-test application, refer to the content validity; the term face validity is not used, but the comparison of the items of the instrument with the theories proposed in the literature, allowed by the bibliographic review, may be applicable to the criterion validity.[25]

Normally, the subjective content of these validations is compensated by the stage or type of construct validation, achieved by statistical tests, on which there is also no consensus or a single model, which relies on the verification of the characteristics and reliability of the constructs, the reliability or consistency of the scales. Exploratory factorial analyzes are applied, allowing groups of variables associated with each other to express constructs,[32] relating the conceptual level to the operational level (items or measurement questions of the constructs).[25] This type of evaluation integrates the basic research, but is not the object of this article, as assumed in the presentation of the methodology.

It is necessary to situate the procedures adopted and described in this study as important parts of a process, giving a broader consideration when the moments of construction and validation are articulated. In spite of such a distinction between the three chosen stages of the methodological study (Figure 1), these also partially incorporate the validation process (face, criterion and content), without prejudice to the later stage of construct validation of statistical tests. Contrary to any loss, such a time division of the process will allow the development of more robust studies and more comprehensive scenarios, in feasible terms and with more consistent products from a theoretical and empirical point of view.

CONCLUSION

The development of a Brazilian instrument to measure the intensity and frequency of MD in nurses responds to a need and broadens the understanding of the topic in a perspective that considers the moral aspects, the Brazilian political and social scene in which nursing coexists with diverse obstacles in its practice. A detailed description of the steps required to construct a MD measurement scale can be used in the elaboration of other Brazilian scales and, therefore, this study fulfills its objective.

The scientific rigor applied at each stage has contributed to the elaboration of a scale that can be applied to different Brazilian realities. Studies of this nature are incipient in Brazilian nursing and need to be disclosed in order to support the construction of knowledge that contributes to more objective evaluation of diversity in the nursing practice.

Escala brasileira de distresse moral em enfermeiros

Age:_____ Sex: ( ) Female ( ) Male Regional State of work:_____
Graduation Year:_____
Other Higher Education Courses: ( ) No ( )Training ( ) Specialization /Residency
( ) Masters ( ) PhD

Number of places of employment : ( ) 1 ( ) 2 ( ) 3 ( ) 4
The information provided can only refer to a job / link, according to the type of service or level of attention. If you work in different services (example: basic care and inpatient clinic) we ask that you only choose one to consider in your answers (as the main one).
What is your work / link that will be considered to answer this instrument?
Type: ( ) public ( ) private ( ) mixed
Level of attention: ( ) primary health care ( ) medium complexity ( ) high complexity
Unit/Sector:
( ) 1. Basic Unit / ESF / Health Center
( ) 2. Outpatients/ Polyclinic
( ) 3. CAPs (Psychosocial care center)
( ) 4. Pre-hospital Care / SAMU
( ) 5. Emergency / UPA
( ) 6. Adult inpatient clinic
( ) 7. Pediatric inpatient clinic
( ) 8. Psychiatric inpatient clinic
( ) 9. Obstetric inpatient clinic/ obstetric center
( ) 10. Adult ICU
( ) 11. Neonatal/Pediatric ICU
( ) 12. Surgical Department
( ) 13 Other: _____

Length of professional career _____ Weekly Working Hours:_____ Type of contract ( ) permanent ( ) temporary

Consider the following definition (JAMETON, 1984; CORLEY, 2002): Moral distress (also translated as anguish or moral distress) is an experience or situation in which: • you know what ethically appropriate attitude to take, and • you believe that you cannot take such action because of obstacles, limitations or conflicts in the workplace. in other words, one cannot act according to one's knowledge or moral precepts

Now: 1) Consider the situations presented in the table below.

2) Are they present at the place of your main job? (only link or one identified as a reference to respond to this instrument).

3) Indicate if situations are present in your work and if they are causes of moral suffering for you:

- on the first scale on the right, indicate **the frequency** at which the situation occurs, **0 = never, up to 6 = very frequent** - on the second scale on the right, indicate **the intensity of the distress of suffering / moral distress** that you experience in the situation, **from 0 = none until 06 = very intense**.

	Situation	Frequency Never èèuntil very frequent							Intensity None èèuntil very intense						
		0	1	2	3	4	5	6	0	1	2	3	4	5	6
1	Work with insufficient number of professionals to attend the demand														
2	Working with an incomplete multiprofessional health team														
3	Experience conditions of work overload														
4	Working with unprepared physicians														
5	Working with unprepared nurses														
6	Working with unprepared nursing technicians and nursing assistants														
7	Working with other unprepared professionals from other categories														
8	Experience situations with students who are not adequately prepared														
9	Work with unprepared managers														

	Situation	Frequency Never èèuntil very frequent							Intensity None èèuntil very intense						
		0	1	2	3	4	5	6	0	1	2	3	4	5	6
10	Recognizing the insufficient education actions in the work area														
11	Recognizing that the consumption material is insufficient														
12	Recognizing that the consumption materials is unsuitable														
13	Recognizing that the fixed equipment/material available are insufficient														
14	Recognizing that the fixed equipment / material available are inadequate														
15	Recognizing that the service facilities are insufficient														
16	Recognizing that the service facilities are unsuitable														
17	Feeling discriminated by/in relation to other professionals														
18	Feeling unappreciated in relation to other professionals														
19	Executing actions that are not inherent in one's function														
20	Perform actions for which you are not technically prepared														
21	Experiencing omission by the physician														
22	Experiencing imprudence by the physician														
23	Experiencing omission by the nurse														
24	Experiencing imprudence by the nurse														
25	Experiencing omission by professionals from other categories														
26	Experiencing imprudence by professionals from other categories														
27	Recognizing the insufficient service access for the user														
28	Recognizing that the users' welcoming is inadequate														
29	Recognizing that the patient/user's demand for continuing care are not attended														
30	Recognizing the lack of problem solving ability of health actions due to social problems														
31	Recognizing the lack of problem solving ability due to the low quality of attendance														
32	Recognizing that educative actions involving the user are insufficient														
33	Experiencing disrespect for the humanized care practices recommended in public policies														
34	Recognizing routines and practices that are unsuitable for professional safety														
35	Recognizing routines and practices that are inappropriate to patient safety														
36	Recognizing routines and practices that are inappropriate to the relatives/companions' safety														
37	Recognizing care losses due to inappropriate integration among the services/sectors														
38	Having one's autonomy limited in the decision about the nursing team's specific conducts														
39	Experiencing conflicting relations concerning the health team members' attributions														
40	Working under pressure due to the insufficient time to reach goals or accomplish tasks														
41	Recognizing situations insulting to the professional														
42	Recognizing situations of disrespect for the professional's privacy														
43	Recognize situations of insubordination / indiscipline of the mid-level staff to the nurse														
44	Experience the suspension and postponement of procedures for reasons that are contrary to the needs of the patient / user														
45	Experience or participating in unnecessary care behaviors to the patient / user's conditions / needs														

	Situation	Frequency Never èèuntil very frequent							Intensity None èèuntil very intense						
		0	1	2	3	4	5	6	0	1	2	3	4	5	6
46	Experiencing care conducts that ignore the patients' beliefs and culture														
47	Feeling disrespected by hierarchical superiors														
48	Recognizing ethically incorrect attitudes of managers or hierarchical superiors														
49	Feeling pressured to go along or silence in response to frauds for the benefit of the institution														
50	Feeling pressured by the user due to situation one cannot intervene in														
51	Recognize that a court decision interferes with health care priorities														
52	Feeling impotent to defend the patient's autonomy														
53	Recognizing situations of disrespect/mistreatment by professionals towards the user														
54	Recognizing situations of disrespect for users' right to privacy/intimacy														
55	Recognizing situations of disrespect for the user's right to confidentiality/secrecy														
56	Recognizing situations of disrespect for patients and relatives' right to information														
57	Feeling unable to defend the user in situations of social vulnerability														

REFERENCES

1. Jameton A. Nursing practice: the ethical issues. Prentice-Hall: Englewood Cliffs; 1984.
2. Jameton A. Dilems of moral distress: moral responsibility and nursing practice. Awhonns Clin Issues Perinat Womens Health Nurs. 1993; 4(4):542-51.
3. Corley MC, Minick P, Elswick RK, Jacobs M. Nurse moral distress and ethical work environment. Nurs Ethics. 2005; 12(4):381-90.
4. Epstein EG, Delgado S. Understanding and addressing moral distress. Online J Issues Nurs [Internet]. 2010 [cited 2014 Feb 02]; 15(3):25-34. Available from: http://www.nursingworld.org/MainMenuCategories/EthicsStandards/Courage-and-Distress/Understanding-Moral-Distress.html
5. Lunardi VL, Barlem ELD, Bulhosa MS, Santos SSC, Lunardi Filho WD, Silveira RS, et al. Sofrimento moral e a dimensão ética no trabalho da enfermagem. Rev Bras Enferm. 2009; 62(1):599-603.
6. Barlem ELD, Ramos FRS. Constructing a theoretical model of moral distress. Nurs Ethics [Internet]. 2015 Aug [cited 2015 Jun 27]; 22(5):608-15. Available from: http://nej.sagepub.com/content/early/2014/10/31/0969733014551595
7. Mccarthy J, Gastmans C. Moral distress: A review of the argument-based nursing ethics literature. Nurs Ethics. 2015; 22(1):131-52.
8. Trautmann J, Epstein E, Rovnyak V, Snyder A. Relationships among moral distress, level of practice independence, and intent to leave of nurse practitioners in emergency departments: results from a national survey. Adv Emerg Nurs Jl. 2015 Apr-Jun; 37(2):134-45.
9. Cardoso CML, Pereira MO, Moreira DA, Tibães, Ramos FRS, Brito MJM. Moral Distress in Family Health Strategy: experiences expressed by daily life. Rev Esc Enferm USP. 2016; 50(Esp):86-92.
10. Renno HMS, Ramos FRS, Brito MJM. Moral distress of nursing undergraduates: myth or reality. Nurs Ethics. 2016; 23(1):1-9.
11. Whitehead PB, Herbertson RK, Hamric AB, Epstein EG, Fisher JM. Moral distress among healthcare professionals: report of an institution-wide survey. Journal of Nursing Scholarship. 2015 Mar; 47(2):117-25.
12. Dodek PM, Wong H, Norena M, Ayas N, Reynolds SC, Keenan SP, et al. Moral distress in intensive care unit professionals is associated with profession, age, and years of experience. Journal of Critical Care. 2016 Feb; 31(1):178-82.
13. Dalmolin GL, Lunardi VL, Barlem ELD, Silveira RS. Implications of moral distress on nurses and its similarities with Burnout. Texto Contexto Enferm. 2012; 21(1):200-8.
14. Musto LC, Rodney PA, Vanderheide R. Toward interventions to address moral distress: navigating structure and agency. Nurs Ethics. 2015; 22(1):91-102.
15. Peter E, Liaschenko J. Moral Distress reexamined: a feminist interpretation of nurses' identities, relationships and responsabilites. J Bioeth Inq. 2013 Oct; 10(3):337-45.
16. Johnstone MJ, Hutchinson A. 'Moral distress' – time to abandon a flawed nursing construct? Nurs Ethics. 2015 Feb; 22(1):5-14.
17. Ramos FRS, Barlem ELD, Brito MJM, Vargas MA, Schneider DG, Brehmer LCDF. Conceptual framework for the study of moral distress in

nurses. Texto Contexto Enferm [Internet]. 2016 [cited 2017 Jan 25]; 25(2):e4460015. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-07072016000200328

18. Corley MC. Moral distress of critical care nurses. AM J Crit Care. 1995; Jul 4(4):280-5.
19. Barlem ELD, Lunardi VL, Lunardi GL, Tomaschewski-Barlem JG, Almeida AS, Hirsch CD. Psycometric characteristics of the moral distress scale in Brazilian nursing professionals. Texto Contexto Enferm [Internet]. 2014 [cited 2015 Jun 27]; 23(3):563-72. Available from: http://www.scielo.br/scielo.php?pid=S0104-07072014000300563&script=sci_arttext
20. Silva MC, Peduzzi M, Sangaleti CT, Silva D, Agreli HF, West MA, et al. Adaptação transcultural e validação da escala de clima do trabalho em equipe. Rev Saúde Pública [Internet]. 2016 Ago [cited 2017 Jan 25]; 50:52. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0034-89102016000100237&lng=pt. http://dx.doi.org/10.1590/S1518-8787.2016050006484
21. Timm M, Rodrigues MCS. Adaptação transcultural de instrumento de cultura de segurança para a atenção primária. Acta Paul. Enferm. 2016; 29(1):26-37.
22. Rosanelli CLS, Silva LMG, Gutiérrez MGR. Adaptação transcultural do caring ability inventory para a língua portuguesa. Acta Paul. Enferm. 2016; 29(3):347-54.
23. Echevarria-Guanilo ME, Dantas RAS, Farina Junior JÁ, Faber AW, Caballero JA, Rajmil L. Reliability and validity of the Brazilian-Portuguese version of the Burns Specific Pain Anxiety Scale (BSPAS). Int J Nurs Stud. 2011 Jan; 48(1):47-55.
24. Lima DVM. Desenhos de pesquisa: uma contribuição ao autor. Online Braz J Nurs [Internet]. 2011 Apr-Aug [cited 2017 Jan 25]; 10(2). Available from: http://www.objnursing.uff.br/index.php/nursing/article/view/3648/html_1
25. Devellis RF. Scale development: theory and applications. 3rd ed. University of North Carolina, Chapel Hill: Sage; 2012.
26. Costa ANM, Coluci MZO. Validade de conteúdo nos processos de construção e adaptação de instrumentos de medidas. Ciênc Saúde Coletiva [Internet]. 2011 Jul [cited 2017 Jan 16]; 16(7):3061-8. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232011000800006&lng=en
27. Reichenheim ME, Moraes CL. Operationalizing the cross-cultural adaptation of epidemiological measurement instruments. Rev Saude Publica. 2007; 41(4):665-73.
28. Radhakrishna RB. Tips for developing and testing questionnaires/instruments. Journal of Extension. 2007; 45(1):1-4.
29. Ramos FR, Barth PO, Schneider AMM, Cabral AS, Reinaldo JS. Consequências do sofrimento moral em enfermeiros: revisão integrativa. Cogitare Enferm. 2016 Apr-Jun; 21(2):1-13.
30. Ramos FRS, Silva CC, Montenegro LC, Caçador BS, Barlem ELD, Brito MJM. Experiences of Moral Distress in Nurses' Daily Work. International Archives of Medicine [Internet]. 2016 [cited 2017 Jan 05]; 9(1):1-12. Available from: http://imed.pub/ojs/index.php/iam/article/view/1622
31. Beaton DE, Bombardier C, Guillemin F, Ferraz MB. Guidelines for the process of cross-cultural adaptation of selfreport measures. Spine. 2000; 25(24):3186-91.
32. Hair Jr JF, Black WC, Babin BJ, Anderson RE, Tatham RL. Multivariate Data Analysis 7th ed.. Upper Saddle River, NJ: Pearson Prentice Hall; 2009.

Correspondence: Mara Ambrosina de Oliveira Vargas
Avenida Tom traugott Wildi 500 ap 203 bloco D
88056800 - Florianópolis, SC, Brasil
E-mail: ambrosina.mara@ufsc.br

Recived: February 21, 2017
Approved: August 03, 2017