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ETHICAL ISSUES EXPERIENCED BY NURSES DURING COVID-19: RELATIONSHIP WITH MORAL DISTRESS

Janaína Cassana Mello Yasin[1]
Edison Luiz Devos Barlem[1]
Évilin Diniz Gutierres Ruivo[1]
Gustavo Baade de Andrade[2]
Rosemary Silva da Silveira[1]
Laura Cavalcanti Farias Bremer[2]

[1]Universidade Federal do Rio Grande, Programa de Pós-Graduação em Enfermagem. Rio Grande, Rio Grande do Sul, Brasil.
[2]Universidade Federal de Santa Catarina, Programa de Pós-Graduação em Enfermagem. Florianópolis, Santa Catarina, Brasil.

ABSTRACT

Objective: to analyze associations between moral distress and ethical issues experienced by nurses during COVID-19.
Method: this is a quantitative, cross-sectional study, carried out with 101 nurses working in university hospitals, between March and May 2022, through socio-occupational issues, ethical implications that lead to moral distress, and the Ethical Issues Experienced by Nurses in Emergency Questionnaire, adapted and validated for Brazilians. Descriptive statistics, ANOVA, Pearson's chi-square and multiple linear regression were used, and $p<0.05$ was adopted.
Results: the 9 elements attributed to ethical implications were classified with some degree of importance for moral distress, with the highest average in the following items: I feel a commitment, responsibility and moral obligation to provide care to the infected population (4.26) and I have the knowledge or experience to work on the frontline of COVID-19 (3.44). The association of moral distress with ethical issues showed that individuals who attributed high importance to ethical implications also had ethical issues at a moderate/high level, emphasizing a higher mean in questions of "patient care" (4.07). It was evident that participants' moral distress was more affected by the following constructs: "perception of hospital measures against COVID-19" (p=.000), "ethical issues in patient care" (p=.000) and "perception of social stigmatization" (p=.000).
Conclusion: when relating ethical issues to moral distress, it was possible to show that COVID-19 generated an abrupt change in nurses' work routine, which hinders adequate decision-making in situations involving issues beyond care, but also at a professional and organizational level, leading to the experience of moral distress.

DESCRIPTORS: Nursing. COVID-19. Ethics, Nursing. Moral. Adult Health.

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PROBLEMAS ÉTICOS VIVENCIADOS POR ENFERMEIROS DURANTE À COVID-19: RELAÇÃO COM O SOFRIMENTO MORAL

RESUMO

Objetivo: analisar associações entre sofrimento moral e problemas éticos vivenciados por enfermeiros durante à COVID-19.
Método: estudo quantitativo, transversal, realizado com 101 enfermeiros atuantes em hospitais universitários entre março e maio de 2022, por meio de questões sociolaborais, implicações éticas que levam ao sofrimento moral e do *Ethical Problems Experienced By Nurses In Emergency Questionnaire* adaptado e validado para brasileiros. Empregou-se estatística descritiva, ANOVA, Qui-quadrado de Pearson e regressão linear múltipla, e adotou-se p<0,05.
Resultados: os 09 elementos atribuídos às implicações éticas foram classificados com algum grau de importância para o sofrimento moral, apresentando maior média nos seguintes itens: sinto compromisso, responsabilidade e obrigação moral em prestar cuidados à população infectada (4,26) e possuo conhecimento ou experiência para atuar na linha de frente à COVID-19 (3,44). A associação do sofrimento moral aos problemas éticos demonstrou que os indivíduos que atribuíram alta importância às implicações éticas também apresentavam problemas éticos em nível moderado/alto, ressaltando maior média nas questões de "cuidado ao paciente" (4,07). Evidenciou-se que o sofrimento moral dos participantes foi mais afetado pelos seguintes construtos: "percepção das medidas hospitalares contra a COVID-19" (p=,000), "problemas éticos no atendimento a pacientes" (p=,000) e "percepção da estigmatização social" (p=,000).
Conclusão: ao relacionar os problemas éticos ao sofrimento moral, foi possível evidenciar que a COVID-19 gerou uma mudança abrupta na rotina de trabalho dos enfermeiros, o que dificulta a tomada de decisão adequada diante situações que envolve questões além do cuidado, mas também em nível profissional e organizacional levando a vivência de sofrimento moral.

DESCRITORES: Enfermagem. COVID-19. Ética na Enfermagem. Moral. Saúde do adulto.

PROBLEMAS ÉTICOS VIVIDOS POR ENFERMEROS DURANTE LA COVID-19: RELACIÓN CON EL SUFRIMIENTO MORAL

RESUMEN

Objetivo: analizar asociaciones entre sufrimiento moral y problemas éticos vividos por enfermeros durante la COVID-19.
Método: estudio cuantitativo, transversal, realizado con 101 enfermeros que actúan en hospitales universitarios, entre marzo y mayo de 2022, a través de cuestiones sociolaborales, implicaciones éticas que conducen al sufrimiento moral y del *Ethical Issues Experienced by Nurses in Emergency Questionnaire*, adaptado y validado para brasileños. Se utilizó estadística descriptiva, ANOVA, chi-cuadrado de Pearson y regresión lineal múltiple, y se adoptó p<0,05.
Resultados: los 9 elementos atribuidos a implicaciones éticas fueron clasificados con algún grado de importancia para el sufrimiento moral, con mayor promedio en los siguientes ítems: Siento compromiso, responsabilidad y obligación moral de brindar atención a la población infectada (4,26) y tengo conocimiento o experiencia para actuar en la primera línea de COVID-19 (3,44). La asociación del sufrimiento moral con los problemas éticos mostró que los individuos que atribuían alta importancia a las implicaciones éticas también presentaban problemas éticos en un nivel moderado/alto, destacando un promedio más alto en cuestiones de "atención al paciente" (4,07). Se evidenció que el malestar moral de los participantes se vio más afectado por los siguientes constructos: "percepción de las medidas hospitalarias frente al COVID-19" (p=,000), "problemas éticos en la atención al paciente" (p=.000) y "percepción de estigmatización social" (p=,000).
Conclusión: al relacionar los problemas éticos con el sufrimiento moral, se pudo evidenciar que el COVID-19 generó un cambio abrupto en la rutina de trabajo de los enfermeros, lo que dificulta la toma de decisiones adecuadas en situaciones que involucran cuestiones más allá del cuidado, pero también a nivel profesional y organizacional que lleva a la experiencia del sufrimiento moral.

DESCRIPTORES: Enfermería. COVID-19. Ética en Enfermería. Moral. Salud del Adulto.

INTRODUCTION

The coronavirus pandemic, COVID-19, which emerged at the end of December 2019 in Wuhan, China, is considered the greatest public health emergency of international importance in recent times. Quickly, the number of cases increased radically, spreading worldwide. On March 11, 2020, the World Health Organization declared COVID-19 a pandemic, making it a global concern[1].

Health professionals who are involved in the care and treatment of patients with COVID-19 are more likely to become infected than the general population, especially nurses who are on the front lines of care, constantly staying with patients infected[2]. This causes them to experience an exacerbated burden of ethical issues related to fear of contagion, concern for their family's health, lack of trust and support from their organization, and fear of suffering social stigma[3–4]. Consequently, they suffer greater psychological pressure, which can lead to several aggravating factors, such as post-traumatic stress disorder, fear, depression and moral distress[5].

In situations of moral distress, individuals recognize the ethically correct action to follow, but do not perform it due to limitations or circumstances that go beyond their competence[6]. In view of this, when professionals are repeatedly unable over time to perform actions that they consider ethically correct, a "moral residue" is created permeated by negative feelings that are perpetuated and grow more and more intensely in the face of new experiences[7- 8].

Meanwhile, while caring for these confirmed or suspected COVID-19 patients, nurses are facing barriers related to the health system for safe and effective care, which makes ethical decision-making difficult[5,7–9]. These circumstances that involve divergences between one or more values are characterized as ethical issues that require professionals to recognize and confront them in order to then make assertive decisions[10].

Moral distress and ethical issues are associated with situations related to nurses' daily work, such as unequal distribution of resources, low staffing for the job, perception of controversial professional practices and therapeutic resistance[11–12]. During COVID-19, ethical issues included a lack of personal protective equipment (PPE), potential shortage of ventilators, high severity and mortality of critically ill patients, and non-existent family visits, restricted to limited telephone contact[3–5,7–9,13–14].

Even before the pandemic, nurses already had higher levels of moral distress[11–12] when compared to other health professionals. Research carried out on the psychosocial risks of health professionals identified that the COVID-19 pandemic was associated with an increase in psychosocial risks at work, implying significant emotional consequences for these professionals[4]. Such phenomena raise concerns about the impact of COVID-19 on nurses' well-being[7–8,14].

Research on nurses' moral distress during the pandemic showed that levels of moral distress increased [13–16], which was influenced by aggravating factors such as rationing and screening due to scarce resources, stigma, fear and stress. Research carried out in China [17], the first country to go through the crisis, describes the impact of the pandemic on health professionals, identifying a high incidence of anxiety (45%), depression (50%) and distress related to COVID-19 (71%). Moreover, the COVID-19 pandemic was one of the most significant challenges faced by health professionals, especially nurses, who reported more severe symptoms of depression, anxiety and anguish[7–8,16–17].

Thus, it is extremely important to explore the relationship between moral distress and ethical issues experienced by nurses in the face of the risks imposed by a pandemic in the Brazilian context [18–19], since recognizing the associations between ethical issues and moral distress in themselves and in others improves understanding at an organizational level about moral distress, in order to recognize and accept professionals' afflictions and intervene early so that care providers have the power to act and know that there are resources to help them in difficult situations before moral distress becomes

worse. Considering the above, the objective was to to analyze associations between moral distress and ethical issues experienced by nurses during COVID-19.

METHOD

This was a quantitative, descriptive and cross-sectional study, following the STrengtheneing the Reporting of OBservational studies in Epidemiology (STROBE) [20] recommendations, carried out in two hospitals (H1, H2) in southern Brazil, located in two different municipalities (M1 and M2). H1 is a medium-sized federal public university hospital, located in M1, with a capacity of 237 beds. H2 is also a federal public university hospital, located in M2, a medium-sized municipality, and has 175 beds. The two hospital institutions have civil servants who have been selected by both the Unified Legal Regime (RJU – *Regime Jurídico* Único) and the Consolidation of Labor Laws (CLT – *Consolidação das Leis do Trabalho*). The staff of nurses working on the front line against COVID-19 at the two university hospitals is made up of 133 professionals, 90 from H1 and 43 from H2, with a minimum representation of responses: 50% plus one from each institution.

Of the total, 101 nurses selected through non-probabilistic convenience sampling participated in this study, in order to reach the largest number of participants. For the sample calculation, StatCalc of the EpiInfo program version 7 was used, with a 95% confidence level, which required a minimum sample of 99 participants.

Inclusion criteria for sample selection were limited to being a nurse directly involved in nursing care or management of units that provided care to patients with COVID-19. As exclusion criteria, nurses who were in remote work were considered due to risk factors related to the pandemic and the absence of participant due to vacation, leave or benefit.

Data collection took place after authorization by the Teaching and Research Management of the two selected university hospitals, from March to May 2022. Then, the link with the Informed Consent Form was forwarded, pointing out the objective and other precepts ethics as a guarantee of anonymity and confidentiality of information. Only after acceptance by nurses could the research instrument be completed. The research was carried out online using the free and open digital technology of Google Docs, from Google Company Inc. The invitation was sent by email weekly, for four consecutive weeks, until the desired sample was met.

For data collection, a questionnaire composed of three parts was used: the first semi-structured with mixed questions that made it possible to identify participant characteristics, such as age, gender, marital status, maximum title, job tenure, whether they had children, or they lived with family members in the risk group and variables regarding their actions during COVID-19.

The second part was composed of questions associated with the main ethical implications in the care provided by nurses in situations of ethical conflicts evidenced during COVID-19, which can lead to moral distress, which were drawn from a literature review of national and international scientific findings on the subject. The guiding question for bibliographic search was: what is the knowledge produced about ethical issues in nurses' daily work during COVID-19? Descriptors were "Nursing", "Coronavirus", "Moral" and "Ethics in nursing" in the Virtual Health Library DeCS (Descriptors in Health Sciences). In the PubMed research portal (digital file produced by the US National Library of Medicine), a selection of works was carried out in the Medical Literature Analysis and Retrieval System Online (MEDLINE) database, using the Medical Subject Headings (MeSH) "Coronavirus", "Nursing" and "Ethics" with the Boolean operator AND in both searches. The searches were carried out through online access in May 2021.

Complete research articles, presenting abstract for first analysis and focusing as main subject the ethical issues encountered in nurses' daily work during the COVID-19 pandemic, were included. There were no language restrictions. From the analysis of review studies, nine items divided into three elements were extracted (patient and family (three items); nurse and team (three items); and system and organization (three items)), in which participants should mark on a scale from 1 to 5, where 1 is not true and 5 is completely true, the order in which they agree with the situations.

And the third consisted of a self-administered instrument: Ethical Issues Experienced by Nurses in Emergency Questionnaire [21], validated and standardized for use in Brazil in accordance with international guidelines [22]. This is a Korean instrument, originally in English, which seeks to investigate the ethical issues experienced by nurses in emergency situations in public health through 16 questions in 5 constructs: ethical issues in patient care; perceived risk of infection and willingness to work; perception of social stigmatization; agreement with hospital infection control measures; and perception of hospital measures, measured using a 5-point Likert scale with response intervals ranging from 1 ("totally disagree"), 2 ("strongly disagree"), 3 ("neither disagree nor agree"), 4 ("strongly agree") and 5 ("totally agree").

Ethical Issues Experienced by Nurses in Emergency Questionnaire data were submitted to exploratory and confirmatory factor analysis, and the results were grouped into five response groups called constructs, with factor loadings above 0.50. The instrument's level of reliability was verified using composite reliability, which presented an internal consistency value of 0.86; the constructs' coefficients presented values between 0.76 and 0.87, proving the reliability of generated constructs.

Data analysis was performed by double typing in Microsoft Excel 2016 and then inserted into the Statistical Package for the Social Sciences (SPSS) software version 22. Descriptive analysis was used through frequency distribution and position measurements and dispersion (mean and standard deviation), and analysis of variance (ANOVA) was used for the variables of ethical implications with the problems generated in the instrument. To associate moral distress and ethical issues, the chi-square test was used, in which variables were dichotomized, i.e., moral distress categorized as low (0 to 2.80) and moderate/high (2.81 to 5) and ethical issues in low agreement (1 and 2.80) and moderate/high agreement (2.81 and 5), considering the Likert scale range.

Finally, for the analysis of the instrument's factors that have a greater prediction for moral distress, multiple linear regression was used. Data normality was verified using the Kolmogorov-Smirnov test, and $p<0.05$ was adopted as significant for all associations [23].

The research was approved by the Research Ethics Committee and complied with all ethical precepts.

RESULTS

The research had the participation of 101 nurses working in university hospitals in two municipalities located in southern Rio Grande do Sul, with 79 participants in H1 and 22 in H2, with a mean age of 39.9 years (SD 7.8). Only 3% (3) were aged 60 years or older, predominantly female (84.2%; 85) and with children (68.3%; 69). Regarding marital status, 41.6% (42) were married, 30.7% (31) were single, 19.8% (20) were in a stable relationship, and 7.9% (8) were divorced. Furthermore, 66.3% (67) have up to 15 years of job tenure, 26.7% (27) 16 to 25 years and 6.9% (7) more than 25 years of job tenure.

As for degree, 48.5% (49) have specialization, 29.7% (30), master's degree, 9.9% (10), doctoral degree, 5.9% (6), residency, and 5.9% (6), undergraduate degree. Moreover, when asked about COVID-19 infection, 55.4% (56) of participants reported having been affected by SARS-CoV-2, and 95% (96) were vaccinated with 3 doses of COVID-19 vaccine.

It is possible to observe in Table 1, through the descriptive analysis of this study, that all situations were classified with some degree of importance for nurses' moral distress, highlighting issues related to factor "patient care" (4.07) as the main factors that lead to moral distress. Item 7 stood out, "I feel commitment, responsibility and moral obligation to provide care to the infected population" (4.26), with the highest mean, subsequent to item 1, "It is stressful for me to report the death of a patient with COVID-19" (4.00), and "It is stressful for me to think that I will not be able to provide quality care due to lack of supplies" (3.95), which had the highest average of responses.

The second most prevalent factor was "nurse and team" (3.32), with Q8, "I have the knowledge or experience to work on the frontline of COVID-19" (3.44) and, finally, factor "institution and organization" (2.99), with the highest average item being Q4, "I know my right to refuse care due to lack of supplies" (3.95). It was found, therefore, that nurses' moral distress is related to issues of conflict between moral duty and care as well as the lack of material resources, as shown in Table 1.

Table 1 – Responses on the ethical implications of nursing care that can lead to moral distress when caring for patients during COVID-19. Rio Grande, RS, Brazil, 2023 (n=101).

Variable	$\bar{X}$*	SD †
Patient Care	4.07	.166
Q1 It is stressful for me to think about communicating the death of a patient with COVID-19.	4.00	1.208
Q3 It is stressful for me to think that I will not be able to provide quality care due to lack of supplies.	3.95	1.284
Q7 I feel commitment, responsibility and moral obligation to provide care to the infected population.	4.26	.934
Nurse and Team	3.32	.098
Q5 It is stressful for me to think that I will need to choose who should or should not be assisted due to the lack of inputs.	3.28	1.632
Q6 I believe that all patients have equal rights to care, regardless of age and history of comorbidities.	3.26	1.245
Q8 I have the knowledge or experience to work on the frontline of COVID-19.	3.44	1.108
Institution and Organization	2.99	.430
Q2 I witnessed the ethical dilemma related to the shortage of PPE.	2.98	1.385
Q4 I know my right to refuse care due to lack of supplies.	3.43	1,268
Q9 I believe I have received specific training to work on the frontline of COVID-19.	2.57	1.117

Descriptive statistics; *x̄: mean; †SD: standard deviation.

It also stands out, through ANOVA, a statistically significant difference between the variables "It is stressful for me to think about communicating the death of a patient with COVID-19" (F(1)8.846; p=.004), "It is stressful for me to think that I will not be able to provide quality care due to lack of supplies" (F(1)6.822; p=.005) and "I feel a commitment, responsibility and moral obligation to provide care to the infected population" (F(1) 4.489; p=.002) with the ethical issues experienced by nurses during COVID-19.

For the association between the ethical implications that result in moral distress with ethical issues, Pearson's chi-square test was used, which is described in Table 2.

Table 2 – Association between ethical implications that result in moral distress with ethical issues, 2023 (n=101).

Variables		Ethical issues		
		Low n(%)	Moderate/ high n(%)	P*
Q1 It is stressful for me to think about communicating the death of a patient with COVID-19	Low Moderate/high	9 (9.8) 22 (21.8)	30 (29.7) 70 (69.3)	p<0.05*
Q2 I witnessed the ethical dilemma related to the shortage of PPE.	Low Moderate/high	15 (14.9) 16 (15.8)	27 (26.7) 43 (42.6)	p<0.05*
Q3 It is stressful for me to think that I will not be able to provide quality care due to lack of supplies.	Low Moderate/high	14 (14.9) 17 (16.8)	17 (16.8) 52 (51.5)	p<0.05*
Q4 I know my right to refuse care due to lack of supplies.	Low Moderate/high	7 (6.9) 24(23.8)	20 (19.8) 50 (49.5)	p>0.05
Q5 It is stressful for me to think that I will need to choose who should or should not be assisted due to the lack of inputs.	Low Moderate/high	16 (15.8) 15 (14.9)	20 (19.8) 50 (49.5)	p<0.05*
Q6 I believe that all patients have equal rights to care, regardless of age and history of comorbidities.	Low Moderate/high	6 (5.9) 25 (24.8)	11 (10.9) 59 (58.4)	p>0.05
Q7 I feel commitment, responsibility and moral obligation to provide care to the infected population.	Low Moderate/high	2 (2) 29 (28.7)	4 (4) 66 (65.3)	p<0.05*
Q8 I have the knowledge or experience to work on the frontline of COVID-19.	Low Moderate/high	4 (4) 27 (26.7)	19 (18.8) 51 (50.5)	p<0.05*
Q9 I believe I have received specific training to work on the frontline of COVID-19.	Low Moderate/high	15 (14.9) 16 (15.8)	36 (35.6) 34 (33.7)	p<0.05*

*Chi-square test with significant value at p< 0.05.

From Table 2, it was found that the highest prevalence of moral distress was in individuals who attributed high importance to ethical implications and had ethical issues at a moderate/ high level. Items related to Q1, “It is stressful for me to think about communicating the death of a patient with COVID-19, followed by Q7, “I feel commitment, responsibility and moral obligation to provide care to the infected population” and Q6, “I believe that all patients have equal rights to care, regardless of age and history of comorbidities”, showed greater associations between moral distress and ethical issues.

Q4, “I know my right to refuse care due to lack of supplies”, and Q6, “I believe that all patients have equal rights to care, regardless of age and history of comorbidities”, did not show a significant association with the ethical issues experienced by nurses during COVID-19.

And finally, Table 3 presents the multiple linear regression using the enter method with the variables from the Ethical Issues Experienced by Nurses in Emergency Questionnaire, adapted and validated for Brazilians(ethical issues in patient care, perceived risk of infection and willingness to work, perception of social stigmatization, compliance with infection control measures, and perception of hospital measures against COVID-19), to determine the factors that present the greatest prediction between ethical issues and moral distress in the care provided by nurses during COVID-19.

Table 3 – Multiple linear regression of predictors of ethical issues that are most associated with nurses' moral distress in COVID-19. Rio Grande, RS, Brazil, 2023 (n=101).

Variables	Beta β)	T*	P †	Tolerance	VIF ‡
F1 – Ethical issues in patient care	.408	7.962	.000 †	.905	1.105
F2 – Perceived risk of infection and willingness to work	.155	2.173	.032 †	.796	1.256
F3 – Perception of social stigmatization	.321	4.629	.000 †	.842	1.187
F4 – Compliance with infection control measures	.120	.075	.075	.920	1.087
F5 – Perception of hospital infection control measures	.501	7.298	.000 †	.858	1.166

Multiple Linear Regression: *T: t test; †: Significance level p<0.05; ‡ VIF: variance inflation factor.

The analyzes resulted in a statistically significant model (F (5.95) = 30.441; p < 0.001; R^2, 616), showing that partiicpants' moral distress was more affected by the F5 constructs "perception of hospital measures against COVID-19" (β=.501; p=.000), followed by F1 "ethical issues in patient care" (β=.408; p=.000) and F3 "perception of social stigmatization" (β=. 321 p=.000). It was demonstrated, therefore, that nurses present greater moral distress when faced with ethical issues related to management, risk of infection and social stigma. Furthermore, the test obtained an adjusted coefficient of determination (R2) of 616, representing 61% of the explanation of the variation in factors associated with nurses' moral distress during COVID-19.

With regard to the error autocorrelation test for regression analysis, the Durbin-Watson statistic was used, obtaining a value of 1.896, indicating that there was no autocorrelation. Furthermore, the absence of multicollinearity was identified, with the tolerance for the test: 842 – 920, greater than 0.1, and the variance inflation factor (VIF): 1.087 – 1.187, lower than the reference level of 10.

DISCUSSION

The pandemic experienced by health professionals is a completely atypical situation, full of conflicting situations, which, if not recognized in its moral and ethical dimension, can lead nurses to treat it as normal, an ethically challenging situation. A study carried out with nurses working in adult clinics identified that not facing ethical issues can negatively affect ethical decision-making and, consequently, the quality of nursing care [24], leading to moral distress.

In this perspective, professionals identified a real risk of moral distress during the pandemic, evidenced by the classification of all ethical implications with a degree of truth. This condition is consistent with international findings during COVID-19, which present a degree of risk for moral distress during the initial period of the pandemic [16,25]. This approach gives the team a shared exposure to morally challenging situations that lead to moral distress.

The data obtained from items related to ethical implications in the care provided by nurses during COVID-19 in this research exemplify situations related to the pandemic that are conducive to the development of moral distress, being influenced mainly by issues related to care, to the nurse and the team and to the institution/management. Similar to this finding, it was identified that moral distress during the pandemic is determined by situations related to the patient and family, the work unit and the organizations' resource management[7–8,15,19].

Furthermore, it was evidenced that the moral distress identified in nurses can be caused both by specific situations of care practice and be triggered by causes that extend to the unit/team and organization/system levels, highlighting the importance of coping strategies aimed at to

psychoeducational actions as a means of intervention and training to deal with situations of ethical issues that lead to professionals' moral distress[25].

Even in the face of uncertainties, it was found that the nurses participating in this study feel the obligation and moral responsibility to provide care in catastrophic situations, even recognizing the right to refuse care if the situation causes damage to their own health. Studies with nurses about ethical dilemmas identified that they did not recognize the right to refuse to develop care if there is a risk of their own, but they are motivated and influenced by their moral obligation to treat patients and provide help to Israeli society [26], demonstrating that the care dimension ogoes beyond the disease, but the responsibility of professionals with an emergency situation in public health.

Our findings demonstrate that professionals report stress when having to report the death of a patient with COVID-19 out of empathy with family members who were unable to say goodbye. Similar to the result obtained in this research, in Holland it was found that the levels and causes of moral distress as well as the ethical climate identified among professionals were related to the inability to provide psychosocial care to patients and their families due to the need for social distancing [27]. This situation has an adverse consequence for shared ethical decision-making, which directly reflects on the humanization and qualification of care.

In this study, 70% of professionals feel prepared to act on the frontline of COVID-19. In this regard, research carried out with nurses showed that 82.7% of respondents claimed to have the knowledge and experience to work with COVID-19 and that the institution where they work had clear political guidelines for treating patients [26]. Proper training reduces the ethical issues experienced by nurses and is associated with lower levels of moral distress [19,25,28].

The lack of inputs was one of the items considered by nurses as aggravating moral distress. Likewise, a multicenter study carried out with health professionals in Ethiopia [29] reported that lack of inputs and organizational support showed higher levels for all measures of moral distress and risk to professionals' mental health.

In the analysis of the relationships between moral distress and ethical issues, it was identified that the moral distress of the professionals interviewed is mainly influenced by the perception of hospital measures against COVID-19, followed by ethical issues in patient care and by the perception of social stigmatization, evidencing the breadth of issues that lead to illness of professionals.

In this pandemic, health professionals were relocated from their sectors, being forced to work in an unknown clinical environment and with patients with characteristics and clinical course that required very specific critical decisions. This situation can make professionals feel unprepared to deal with a pandemic scenario full of ethical and emotional problems, a variable related to moral distress [2,25,27].

From this perspective, in the United States, the presence of moral distress, burnout and changes in nurses' mental health during COVID-19 was observed, showing that nurses who experience and recognize ethical issues feel more burdened and stressed, and may not being able to provide the care they would like to critically ill patients, potentially increasing the risk of moral distress or burnout as well as symptoms of post-traumatic stress, anxiety and depression [14].

Nurses are leading actors in clinical patient care during COVID-19, especially with regard to decision-making processes [7,18]. Given this, their decision-making requires moral sensitivity so that they can recognize and face ethical issues in a way that does not result in moral distress. Moral sensitivity is a fundamental skill that encourages nurses to identify the ethical and moral component of each experienced situation, differentiating it from ordinary circumstances in nursing practice and directing them towards making morally adequate decisions [30], and, consequently, reduce the experience of moral distress.

However, it is considered that this study makes a contribution to clinical practice, since using different identifying elements of ethical issues experienced by nurses corroborates a care practice based on ethical, individual and professional values as a way of helping professionals to overcome difficulties and interruptions in their daily work and thus reduce moral distress. Thus, it is essential that qualifications and training be offered on the importance of ethics in nursing practice, in order to promote greater qualification that contributes to the recognition and resolution of ethical issues and thus to reduce nurses' moral distress resulting from stagnation in the face of problem situations [7,18].

The research had as limitations the fact that it is cross-sectional, which prevents the establishment of cause and effect, demonstrating the need for longitudinal research and with larger samples. In addition to this, the generalizability of its results, since it was carried out with a specific sample of nurses from two university hospitals selected by convenience sampling during the COVID-19 pandemic. We highlighted the incipient research carried out in Brazil on the ethical issues experienced by nurses in the context of outbreaks, epidemics and pandemics as well as their relationship with moral distress. Therefore, more research is needed to analyze this relationship in different national contexts.

CONCLUSION

The SARS-CoV2 pandemic represents a major challenge at several levels: for public health management, regarding the discovery of new therapeutic and vaccine resources; for hospitals, which needed to readjust resources in order to meet demand; and especially for health professionals, who submitted to develop care in a completely risky and unknown scenario, leading them to experience a range of ethical issues that can lead to moral distress.

The findings of this study identified that the greater the perception of ethical issues, the greater the risk of moral distress. As ethical issues related to stigma, patient care and organizational support are more associated with nurses' moral distress, showing that the causes of moral distress are not only at the patient level, but also at the professional and health system levels.

Finally, it is important to highlight that research in this area is extremely necessary to understand its long-term impact in order to provide scientific evidence for the development of strategies for recognizing and coping with ethical problems during the current pandemic and future public health emergencies.

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NOTES

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CONTRIBUTION OF AUTHORITY

Study design: Yasin JCM, Barlem ELD, Ruivo EDG, Andrade GB, Silveira RS, Bremer LCF.
Data collection: Yasin JCM, Barlem ELD, Ruivo EDG, Andrade GB, Silveira RS, Bremer LCF.
Data analysis and interpretation: Yasin JCM, Barlem ELD, Ruivo EDG, Andrade GB, Silveira RS, Bremer LCF.
Discussion of results: Yasin JCM, Barlem ELD, Ruivo EDG, Andrade GB, Silveira RS, Bremer LCF.
Writing and/or critical review of content: Yasin JCM, Barlem ELD, Ruivo EDG, Andrade GB, Silveira RS, Bremer LCF.
Review and final approval of the final version: Yasin JCM, Barlem ELD, Ruivo EDG, Andrade GB, Silveira RS, Bremer LCF.

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CONFLICT OF INTEREST

There is no conflict of interest.

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CORRESPONDING AUTHOR

Janaína Cassana Mello Yasin
janinhacm@gmail.com