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Original Article

Moral distress in everyday nursing: hidden traces of power and resistance

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Objective: To know the strategies of resistance adopted by nursing staff, facing situations of moral distress, from an ethical perspective. Method: The authors conducted qualitative research through semi-structured interviews, with fifteen nursing staff members of a university hospital in the extreme south of Brazil, using textual discourse analysis and the theoretical reference of Foucault. Results: Two categories were constructed: denial of oneself and the other - in which one perceives that the nursing staff can perform actions that are governed predominantly by immobility and conformism, avoiding confrontations with whoever represents power in situations that provoke moral distress in them; possibility to care for oneself and for the other - in which nursing workers in situations that provoke moral distress for them exercise power and endurance. Conclusion: it was perceived that some professionals seem to use ethical coping strategies, in order to ensure and preserve their professional values. However, often the choice of some nursing professionals may be to relapse into immobility and the absence of building strategies of endurance. This situation may represent their reduced exercise of power and insufficient resistance in the face of ethical problems, contributing to the intensification of their invisibility in the area of health.

Descriptors: Burnout, Professional; Power; Ethics; Nursing.

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Introduction

In daily professional life, many situations seem to reflect suffering and distress for the nursing staff. We highlight the power relationships with patients, supervisors and the various teams in the health area, involving moral issues and values related to identified fragilities in care, insufficient nursing staff, lack of material resources and the predominantly bureaucratic work organization, cold and technical[1].

The nursing professional can experience intense discomfort, not always understood clearly and precisely, which can be identified as moral distress (MD), a feeling resulting from inconsistency between his actions and his personal and professional convictions[2-3]. Thus, when the nursing staff and other health workers face limitations in their capability to practice ethically, feeling forced to compromise their personal values and norms, they can experience MD[4].

In the daily professional routine, several clashes are required of the nursing staff, from the protection of patients, the interests of health institutions, even their own personal needs and desires, often forgotten or trivialized, related to the exercise of autonomy, the care of oneself and the other, involving relationships of power and resistance simultaneously, commonly not even perceived. These relationships present immediacy as an outstanding feature, and similarly, that permits and sustains the differences, segregates everything that makes an individual an individual, separating him from his relationships with others, fragmenting it from everyday life and connecting it to himself, reinforcing his own identity, not always positively[5].

The identity with nursing and its values, and the recurrence of these situations leads to the need to rethink the practice of nursing through a prism of power relationships, reviewing relationships and actions from an ethical-aesthetic perspective. It requires questioning: finding strange daily facts, with established relationships, intrigue with what is considered natural, since the risk lies in the most obvious and banal, demonstrating the need to revise rationalities imposed by society[5] and also by the construction of subjects and of nursing workers.

The understanding of power as relationships of immanent forces with the possibility of resistance allows a new look at the various relational fields of nursing, revealing that struggles, knowledge, practices and coping strategies have enabled the defense of moral and professional values, influencing the moral construction of the nursing staff subjects, mainly in the situations arising from the experience of MD[6].

This research was justified by the need to explore MD in nursing professionals, considering specifics of their daily lives and understanding the individual from his relationships of power and resistance. Thinking about actions and reactions in the nursing context, the following question guided this research: *which strategies of resistance has the nursing staff been adopting in situations of MD, to ethically practice the profession?*

The objective of the study was *to know the strategies of resistance adopted by nursing staff, in situations in which they are facing MD, from an ethical perspective*. The relevance of the research is based on the understanding that the recognition of ethical resistance strategies used can significantly contribute to nursing, serving as a *catalyst*[5] for facing any conflicting situation that may lead the worker to MD and the users to inadequate moral circumstances.

Method

This was a qualitative study, conducted in a medical clinic unit with 49 beds, of a university hospital located in southern Brazil. This unit was staffed by a nursing team consisting of nine nurses, 15 technical nurses and 18 auxiliary nurses, distributed across four shifts. Based on the presentation of the proposal and the invitation to the nursing staff, five nurses, six technical nurses and four auxiliary nurses, were intentionally selected through nonprobability sampling of convenience of the "snowball" type; all were identified with the letter E, for nursing followed by sequential numbering. In this type of sampling a subject is selected to perform the first interview; at the end of the interview, she indicates another subject with the characteristics needed for the study objective. We tried to interview the nursing staff that, in view of their colleagues interviewed, carried out ethical resistance in situations of MD. This research did not aim to establish distinctions between the professional categories, seeking only resistance strategies developed by the collective[5].

Data was collected through a semi-structured interview guide that contained the following questions: *what strategies do you usually use in situations of MD in your daily life? Do you face resistance against your actions?* The investigation lasted until the time when the subjects indicated by the interviewees, using the "snowball" technique, were exhausted in the environment selected for this study.

The interviews were recorded, with an average duration of 30 minutes, occurring in the months of

February to June of 2011. After transcription, Textual Discourse Analysis (TDA)[7], that moves between content analysis and discourse analysis, was performed. The process began with the separation of the data, by the method of fragmentation of the interviews into units of meaning, enabling the generation of other sets of units derived from empirical and theoretical dialogues, along with the interpretations that were performed. In this model of interpretation of meanings, voices were assigned to the data to better understand the text.

Subsequently the fragmentation moved into the articulation of meanings among their similarities, in a process called categorization. During this step, units of meaning were clustered by similarity and approximation, into intermediate categories, generating two categories of analysis[7]. The ethical guidelines were entirety obeyed, using the terms of free and informed consent, and data collection was conducted only after approval of the ethics committee (opinion no. 70/2010 of the local ethics committee).

Results

From the data analysis two categories listed below were constructed: *denial of self and other*; *possibility of taking care of oneself and others*. Shows the structural model for construction of the categories, and presents the results.

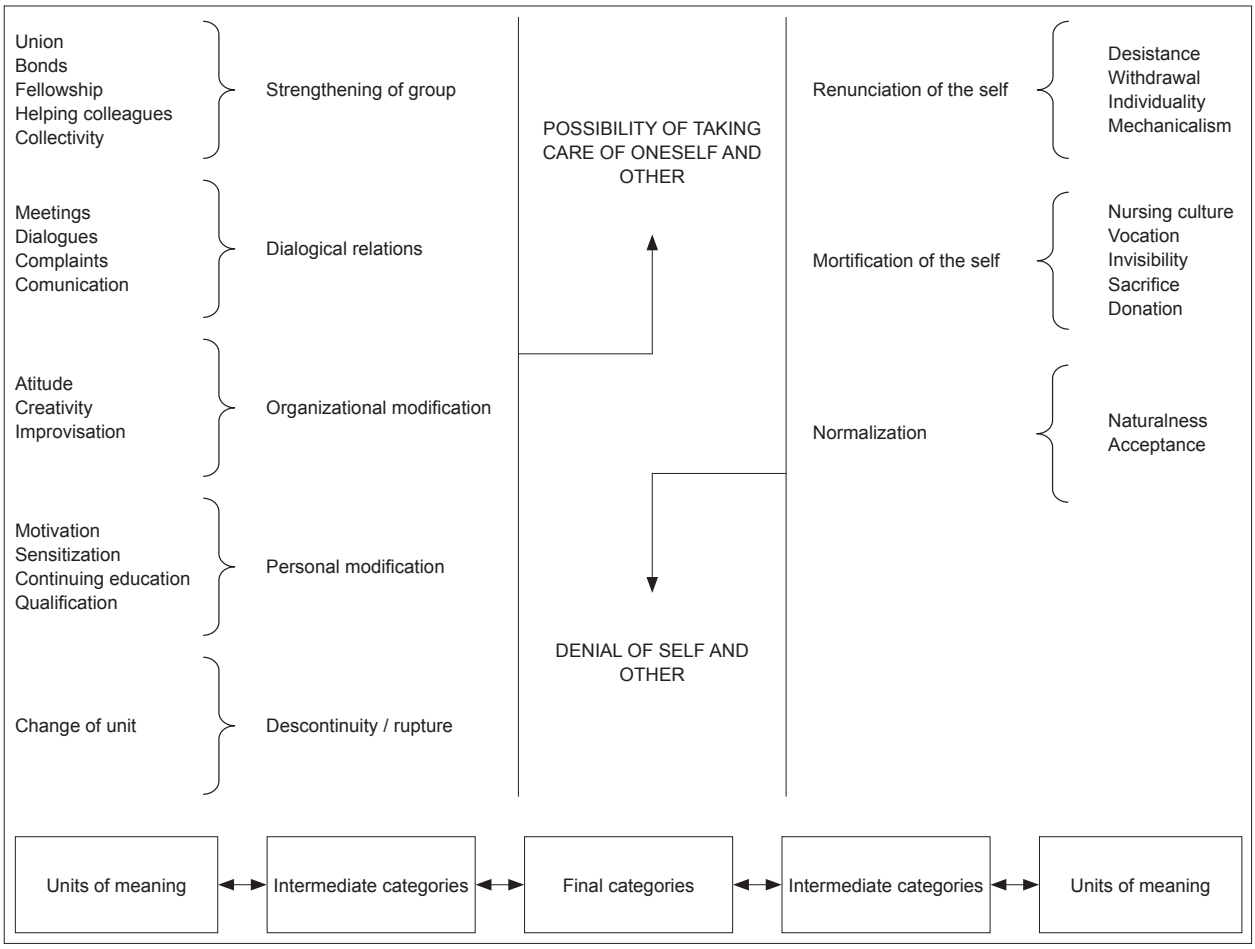

Figure 1 - Structural model of category construction. Rio Grande, RS, Brazil, 2012

Denial of self and other

Strategies of individualism and acceptance of situations that trigger the experience of MD are present in this category, in an apparent denial of oneself and of one's own values, by avoiding one's involvement in the resolution of problems, limiting oneself to minimal contact with patients, prioritizing a reduced number of visits to a few patients or guiding one's actions with the understanding that nursing is a profession of giving and personal sacrifice.

We can see the acceptance and conformity with everyday professional practices, even if recognized as inadequate, possibly associated to a belief in its

immutability and to what is expected and recognized as the profession itself: *I see daily that many professionals suffer and even many professionals who are accommodated, they continue to suffer, but sometimes people are so submerged in suffering and in that doing nothing, in that stagnation, that they can not see that they need to get out of it; that not being involved also brings suffering, and a lot* (E1).

It is possible to perceive distancing and adoption of evasive conduct of the nursing staff in facing patients, avoiding involvement in the pursuit of qualification of care offered, limiting themselves to fragmented actions, emergencies, being punctual, recognized as what is possible. An apparent desistance in defense and preservation of professional values can be evidenced in the demonstrations of workers in relation to patients, or even as to their professional identity: *I gave up! I do not want more, I give it up. I will not fight anymore, I'm not going to discuss it further, and principally I will not expose myself more* (E6).

Due to the high demand for services and the limited number of nursing personnel, a situation highlighted as a source of MD, the decision of workers to prioritize patients who, in their opinions, seemed to need nursing care in greater quantity, more urgent and complex, was also perceived, which seemed to ensure to those professionals some personal gratification and comfort: *to get relief and return for the next shift, I only saw those patients who really needed me. For these patients I devoted more and developed my knowledge more and then I felt a bit better* (E5).

Given the difficulty of performing confrontations in an attempt to modify and qualify the organizational environments, when working conditions are shown to be even more precarious, with shortage of material resources, some actions were guided by individualism and seemed to be the most commonly developed strategies: *You come to work and lack materials; many people, unfortunately this is our nursing culture, many people have the material, but hide it in their things, hide it in their closets, saying "Ah! You cannot, if I do not hide it, it will be lacking for me"* (E8).

It was possible to observe, then, that some workers seemed to see nursing as a profession associated with donation and personal mortification, facing a high work demand, favoring the acceptance of an apparent mission of sacrifice and suffering, associated with those engaged in nursing. Therefore, a naturalization of sacrifice attributed to the nursing profession can serve as a form of possible resistance, blurring the perception of MD: *When you enter the nursing area you have to know that you'll have to give* (E10). *I always tried to overcome in some ways, such as to leave a time of rest for accomplishing all activities* (E5); *This is nursing, it is for those who like it and is not for everyone* (E6).

Possibility of taking care of oneself and others

In this category, there were ethical strategies for facing MD and the necessity to emergently tailor the work context, in order to ensure better standards of patient care and for the professional team. Meetings, changes in protocols and routines, the seeking of professional qualification and training were strategies commonly identified, usually starting from decisions taken by the group that recognized their weaknesses: *awareness, qualification, training, being valued, all this motivates the group. Each day that trainings happen, I see that the team is different than other days* (E12).

Problems related to organization of work, especially as it related to the lack of material resources for its execution, were usually addressed through the use of the nursing professional's creativity, a value highlighted by respondents as inherent to the profession. It can also be understood as a strategy of resistance in the face of MD, given the difficulties experienced: *if I don't have a packet of gauze, the first reaction I have is anger. "Hey, I don't have a package of gauze!" Then, you stop to think and it turns to indignation, "Ah! If I don't have gauze it is not my problem, the patient will not have a dressing!" That's a lie! I'm not going to leave the patient without a dressing. I'll leave, I'll get it in another unit, I'm going to be creative and try to change the dressing of that patient* (E9).

To demonstrate initiative and creativity seemed to reflect positively on the group, strengthening the team spirit and encouraging the sense of patient advocacy on the part of nursing staff, providing feedback mechanisms of creativity, investment in organization of work, and especially denouncing the morally incorrect situations. Still, given the perceived transgression of moral values, a weakening of care given to patients, and coping difficulties of persons involved in those situations, some workers, from a reflective process and as a practice of self-care, chose to turn away from those work environments: *you see some things happen and you want to leave the unit. It is impossible to see things going like that* ... (E7).

Discussion

The study demonstrates that, in daily work, when faced with MD, the nursing staff may perform actions that were guided predominantly by immobility and conformism, avoiding direct confrontation with those

who are in power in situations they experienced. They could exercise power through emergency actions and reactions, and also, they constructed collective actions and reactions. In this sense, an attempt by nursing professionals could be seen to develop a new economy of power relationships, in the use of resistance as a true chemical catalyst in front of the whole relationship of power[5].

Possibly without fully understanding the relationships of power in which they were immersed and the exercises of power that they implemented, either acting and reacting, or omitting, nursing professionals manifested discomfort when they recognized they were not executing the actions they believed to be the most correct, experiencing the effects of MD, even if they could not identify it as such. Such situations demonstrated the need for turning a critical and questioning eye toward the nursing profession and its surroundings, paying the utmost attention to everything that seems natural, small, banal, uninteresting or obscure, such as the daily practices and even the small gestures that go unnoticed in the everyday activities[8].

It seems interesting to note that no professional interviewed mentioned the word power when asked about the situations they faced in their daily work, possibly because they did not identify the power relationships in which they were immersed. However, the poor visibility of nursing was repeatedly mentioned.

Reinforcing a historical posture of kindness, giving and sacrifice, the first category of analysis demonstrated that some professionals adopted strategies of individualism and continued sustaining and reinforcing the view that the nursing work related to the exercise of practices based on self-sacrifice and denial of the self, participating in games of power that reinforced the lack of visibility of the profession. Thus, the acceptance and *apparent immobility in facing what exists* may be understood as a coping strategy for MD, by the decision of nursing professionals, silently and in an apparent omission, to execute what they believed would cause less suffering. For these professionals, it seemed less painful to follow orders, to obey what was instituted and follow what the organization decided, without expressing a form of ethical and transformative resistance[8], instead of executing what might seem to them to have been most correct[9].

By dissociating the subjectivity of the individual, transforming it in a quiet and disciplined manner[10-11], imposing a new way of being and to establish their professional relationships, some professionals stated they had related to the patients in a fragmented and distant manner. By choosing to withdraw from the patients and not coping with situations that generated MD, these nursing professionals apparently chose not leave the profession, but its values and in the end, the very ideals of nursing[12].

Still, derived from those situations, traces of renunciation and mortification of the self in the context of nursing practice can be seen, situations that can lead to loss of personal liberty, and states in which few possibilities for change can be perceived[13], with possible compromise of the actions of care.

The forms of resistance perceived as renunciation, the acceptance of everyday situations and mortification of professional interests led to the realization that to reflect on problems experienced by nursing staff and the resultant MD, we cannot only focus on how the power relationships are constructed and deconstructed in nursing and in health, also advancing the way that nursing professionals are transformed into subjects, if they subjectified and governed themselves, not always as ethical beings[10].

By mentioning the term government, mainly alluding to the government of self and others, we are focused on the analysis of the second category presented. In this, there were the strategies of resistance modifiers, primarily in the organizational context of the hospital institution and the environments where nursing practice developed, becoming personal modification strategies, through creativity, reflection or qualification.

The discourse in this context was in dialogical relationships, whether in denouncing situations recognized as disrespectful for subjects and professional values, consisting of the exercise of power, demonstrating that the minutia of technical discourse can generate positive results when used as resistance in facing situations that lead to MD[14], characterized also as an expression of self-care of the workers[15].

Constituting itself as an important tool for conveying information, many professionals believed that reporting incorrect acts seemed to be the most effective resistance, since this attitude may result in significant changes in the quality of care. Thus, the candid speech known as *parrhesia*, the exercise of dialogue and denunciation, was noted as a technique itself, as a strategy of resistance to MD, from an ethical perspective, present in the context of professionals of this study[15].

The professionals, in the use of strategies for care of the self and others, predominantly opted for collective

actions, showing that "to constitute itself as a subject that governs implies that the entity has been incorporated as a subject who takes care of itself "and also of others [16]. Thus, one of the fundamental points in the practices of self, and of care of the self, is that they do not constitute exercises of solitude, but engage in the field of collective practices, strengthening the group spirit, "care of the self appears, therefore, intrinsically linked to a service of the soul which includes the possibility of a game of trade with each other and a system of reciprocal obligations ", reinforcing the responsibility of the nursing professionals with the patients[17].

From a personal point of view, taking care of oneself is to turn to oneself as a subject of action, and to personal relationships with others[15]. Self care is a vital act, represented by the infinite and complex variety of activities that the professional performs during his existence. As a human construct, it is the result of a socializing process involving customs, habits, attitudes, beliefs, values; representing, therefore, self-value, sensitivity, and the commitment with society and with himself[18].

In the context of the study, the care of oneself can be understood "as a set of experiences that modify the subject, whose purpose is to establish for himself an ethical and aesthetically active lifestyle"[19]. Thus, the need to care for oneself would be associated to the exercise of power, the personal domain of practices and desires, beyond the necessity of reflection, since there is no technique, no professional skills that can be acquired without the exercise of constant reflection[20].

Among the skills highlighted by respondents, creativity stood out as fundamental to ensure the care of patients, mainly because of the constant situations of inadequate material resources and nursing personnel.

An issue to be highlighted concerns the time spent to put this creativity into practice. Although creativity has been highlighted as relevant to ensuring patient care, the time taken to exercise it can become extensive, compromising the quality and continuity of care being dispensed to patients. Ambiguously, creativity can simultaneously serve as resistance and, also, as a source of MD, requiring constant professional zeal regarding the administration of the time available to carry out one's work.

Still, when MD is present and the professional perceives she is powerless to confront the context that causes her suffering, her choice of separation can constitute a barrier to be crossed, not only as an evasive way of facing the problems experienced, but also as a possibility of a positive resistance. Thus, the request for change in work unit can be a strategy to try to ensure the preservation of professional values and continuity of a skilled performance in other environments, avoiding an apparent conformity to what exists, despite the maintenance and continuity of the conditions considered inadequate in the previous work unit.

The highlighted situations demonstrated that no relationship of power existed without resistance, without instability, without flight or escape, without the possibility of an eventual inversion of the intensity of the relationship of forces. The present power relationships among the nursing professionals implied a desire to struggle, confront, an inclination to follow one's own course of action and development, to become effective strategies of action[5].

Possibilities for change in power relationships are concrete realities to the nursing professionals who seek to construct forms of resistence that go beyond a simple acceptance of the context as it appears. A level of awareness that allows the understanding of the tenuous lines that power weaves in the life of every professional, in their multiple relationships with other beings, becomes necessary to allow them a moral posture consistent with the practice to be exercised[10].

The practice identified in interviews as defense of the patients interests, a term related to care and advocacy, showed in its essence an ethical and aesthetic relationship. It was possible to observe in situations in which they used creativity, or when facing adversities from an ethical perspective, that patient advocacy could generate relief for nursing professionals, or differently, greater intensity of MD when the nurses could not perform this role in the manner that matched their ideals [19] and what they believed.

Patient advocacy is an important dimension of nursing care, and is considered a fundamental value of the profession. Although not an exclusive attribute of nursing, because advocacy is also practiced by other health professionals, it is a role that merits attention in this research. Situations of MD reinforced the need for resistance by nursing staff to act as patient advocates, mainly because of the nature of their work, their proximity to the patient and the character of the continuity of nursing care. Within situations integral to patient advocacy, they perceived the reinforcement of their autonomy, building relationships of therapeutic care and improving the quality of communication between nursing professinoals and patients[20].

Finally, it is understood that, in the daily work, it can be difficult for nursing professionals to recognize, individually, the problems of disrespect for the rights that affect their patients and which they must face. If the objective of nursing is primarily the care of patients and the protection of their interests, it is emphasized that this target needs to be achieved collectively, because only in this way is nursing enhanced as a profession[21].

Final considerations

Along with the problems of daily work faced by the subjects in this research, resulting in situations of MD, it was perceived that some professionals seemed to use ethical coping strategies in order to ensure and preserve their professional values. However, many times the option of some nurses regressed into immobility and an absence of the construction of ethical strategies of resistance. This situation may represent their reduced exercise of power and insufficient resistance against ethical problems, contributing to the intensification of their invisibility in the health area.

In order to cope with those situations that result in MD, nursing professionals need to exceed dimensions of apparent conformism that, sometimes, they encounter, possibly still believing that the resolution of most problems in their daily work is in the profession itself and not in their relationships, leading to action in an isolated, and not collective, manner.

It is important to move forward in this context, considering that concrete forms of modification of work environments result from the relationship built with others, the exercise of power relationships and resistance within an ethical perspective, i.e., the encounter of collective possibilities that favor interpersonal relationships and the preservation of professional values, in the search for coping with everyday problems and the consequent MD.

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