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The experience of moral distress by nursing residents

La experiencia del sufrimiento moral de los residentes de enfermería

A vivência do sofrimento moral pelos residentes de enfermagem

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Abstract

This study aims to analyze the experience of moral distress (MD) by nursing residents of a university hospital in the city of Rio de Janeiro; to identify what generates MD in nursing residents of a university hospital in the city of Rio de Janeiro; to identify how nursing residents perceive the intensity and frequency of moral distress in the practice of a university hospital in the city of Rio de Janeiro. This is a quantitative, descriptive and cross-sectional study. Data were collected through a questionnaire for sociodemographic and training characterization, and through a MD assessment scale, analyzed using simple statistics. The 104 incoming residents between 2017 and 2020 participated, from eleven specialization programs. As for the experience of MD, 69.2% (72) recognized experiencing situations that result in MD. In the analysis of the data, three categories emerged Lack of competence in the work team, Disrespect for the patient's autonomy and Denial of nursing as a patient's advocate. Interpersonal relationship situations indicated a high score of intensity and moderate frequency, related to the experience of MD. Events that generate MD need to be discussed in the search for resolutions, considering that they affect the residents' mental health and generate physical and mental exhaustion, and on nursing care.

Descriptors: Nursing; Nursing Ethics; Non-Medical Internship; Residence; Moral Distress.

Resumén

Este estudio tiene como objetivo analizar la experiencia de sufrimiento moral (SM) por residentes de enfermería de un hospital universitario en la ciudad de Río de Janeiro; identificar qué genera SM en residentes de enfermería de un hospital universitario de la ciudad de Río de Janeiro; identificar cómo los residentes de enfermería perciben la intensidad y la frecuencia del sufrimiento moral en la práctica de un hospital universitario de la ciudad de Río de Janeiro. Se trata de un estudio cuantitativo, descriptivo y transversal. Los datos fueron recolectados a través de un cuestionario de caracterización sociodemográfica y formativa, ya través de una escala de evaluación SM, analizados mediante estadística simple. Participaron 104 residentes entrantes entre 2017 y 2020, de once programas de especialización. En cuanto a la experiencia de SM, el 69,2% (72) reconoce vivir situaciones que resultan en SM. En el análisis de los datos surgieron tres categorías: Falta de competencia en el equipo de trabajo, Falta de respeto a la autonomía del paciente y Negación de la enfermería como defensora del paciente. Las situaciones de relación interpersonal indicaron una alta puntuación de intensidad y moderada frecuencia, relacionadas con la vivencia de la EM. Los eventos que generan DM necesitan ser discutidos en la búsqueda de resoluciones, considerando que impactan en la salud mental de los residentes y generan desgaste físico y mental, y en el cuidado de enfermería.

Descriptores: Enfermería; Ética en Enfermería; Pasantía no Médica; Residencia; Sufrimiento Moral.

Resumo

Este estudo tem como objetivos analisar a vivência do sofrimento moral (SM) pelos residentes de enfermagem de um hospital universitário no município do Rio de Janeiro; identificar o que gera SM nos residentes de enfermagem de um hospital universitário no município do Rio de Janeiro; identificar como os residentes de enfermagem percebem em intensidade e frequência o sofrimento moral na prática de um hospital universitário no município do Rio de Janeiro. Trata-se de um estudo quantitativo, descritivo e transversal. Os dados foram coletados por um questionário para caracterização sociodemográfica e da formação, e por uma escala de avaliação do SM, analisados por estatística simples. Participaram 104 residentes ingressantes entre 2017 e 2020, de onze programas da especialização. Quanto à vivência do SM, 69,2% (72) reconheceram vivenciar situações que resultam em SM. Na análise dos dados emergiram três categorias: Falta de competência na equipe de trabalho, Desrespeito à autonomia do paciente e Negação da enfermagem como advogada do paciente. As situações de relação interpessoal indicaram score alto de intensidade e moderado de frequência, relacionados a vivência de SM. Eventos que geram SM precisam ser discutidos na busca de resoluções, considerando que impactam na saúde mental dos residentes e geram desgaste físico e mental, e no cuidar de enfermagem.

Descritores: Enfermagem; Ética em Enfermagem; Internato Não Médico; Residência; Sofrimento Moral.

Introduction

Nursing care is based on and guided by the principles and standards set out in the Nursing Code of Ethics, which deals with ethical and moral issues related to the conduct of assistance by the nursing team. Routinely, the professional nurse is faced with conflicts and ethical issues related to the care provided to the patient, communication with the multidisciplinary team, the relationship with the institution that is permeated with values, beliefs, customs and priorities that often differ from those chosen by the professional, which may end up generating moral distress (MD)[1,2].

The MD is understood as a psychic impairment related to facing a situation in which the person perceives himself to be prevented from acting and behaving in accordance with what he considers correct according to his moral judgment. In Brazil, the work of nursing professionals is permeated by factors that generate suffering such as multiple bonds, precarious working conditions, devaluation, low remuneration, lack of autonomy and other situations that have a negative impact on the health of the professional[3-6].

It is also noteworthy that in the institutional context there are some factors that negatively influence and that can generate MD, issues such as the relationship with end-of-life patient care, limited resources, work overload, personal/professional conflicts and little autonomy[4].

In this situation, nursing residents are inserted in the context of hospital public health, a space for professional practice and nurses' specialization, in the form of in-service training, which enables them to achieve professional improvement and the development of technical-scientific and ethical competences; in addition, the residency provides the articulation of knowledge related to research, care, extension and nursing education. The residency course is a period that allows nurses to recognize themselves as professionals and to face unique, complex and serious situations, as well as a period of personal and professional construction[7,8].

The residency course requires great effort in the development of the daily routine of care practice and the various theoretical activities. Thus, these nurses are exposed to factors that contribute to generating stress and suffering, such as sleep deprivation, fatigue, care burden, excessive administrative work, problems related to the quality of teaching and the educational environment[9]. It is understood that residency is a time of changes for personal and professional life, which requires the resident to adapt to the work environment and to new interpersonal relationships with the nursing and multiprofessional team, situations that can generate difficulty for insertion in the work environment and, consequently, suffering.

In this sense, some studies point to the consequences on the physical health of professionals that are expressed by signs such as tremors, sweating, headaches, diarrhea, crying. The consequences for mental health are presented by symptoms such as frustration, anxiety, anger, guilt and depression. Moral overload can have repercussions on the professional dimension, with the development of professional dissatisfaction, isolation, motivating a change of sector or job and abandonment of the profession, distancing from the patient, and the possibility of developing a clinical condition of Burnout Syndrome[3,4,10-12].

This study is part of a research project entitled "Nurses' moral suffering in a university hospital" under development, and is justified by deepening the issues that overload the practice of resident nurses, as well as the importance of knowledge about the intensity and frequency that nurses have residents are exposed to situations that generate MS. The term moral overload is also considered appropriate for the context in question, since the impacts will be perceived in several dimensions, including the psychic and physical, and the exposure can have consequences for the health of the professional, understood as MD.

Considering that nursing residents are routinely exposed to situations that can generate stress or moral overload, resulting in MD, it is inferred as a hypothesis that nursing residents are exposed in their work practice to MD situations and do not identify them.

Therefore, it aims to analyze the experience of moral distress by nursing residents of a university hospital in the city of Rio de Janeiro; to identify what generates moral distress in nursing residents of a university hospital in the city of Rio de Janeiro; and, to identify how nursing residents perceive the intensity and frequency of moral distress in the practice of a university hospital in the city of Rio de Janeiro.

Methodology

This is a study with a quantitative, descriptive and transversal approach. Conducted with 104 nursing residents who joined the university hospital between 2017 and 2020, in 11 programs, namely: Internal Medicine, Nephrology, Occupational Nursing, Psychiatry and Mental Health, Intensive Care, Cardiovascular, Surgical Clinic, Surgical Center, Adolescent Health, Pediatrics and Neonatology.

The nursing residency course lasts for two years on a full-time basis, with a weekly workload of 60 hours, distributed between practical (80%) and theoretical (20%) activities[13].

As an inclusion criterion, nursing residents were defined who were summoned in the contests held for the formation of the classes started in the years 2017 to 2020. And, as exclusion criteria residents who were on extended medical leave or who did not respond to the questionnaire after 3 attempts to contact.

Data collection for residents who joined in 2017 and 2018 was through a printed questionnaire applied during the Bioethics course, common to all programs. With regard to residents entering the course in the years 2019 and 2020, data were collected between March and September 2020, with participants being contacted by social media, such as WhatsApp©, e-mail, with the availability of a link for access to the questionnaire on the Google Forms© platform, allowing to reach a greater number of participating residents. On the platform, the questionnaire and the MD scale could only be accessed after accepting participation in

the research based on the Free and Informed Consent Term, available for printing if the participant so desired.

The questionnaire consisted of two parts, the first consisting of questions referring to sociodemographic characteristics and professional training. In addition, the second elaborated with open questions for the participant to describe their understanding of the theme, and what situations make them recognize themselves in MD in the activities of the residency course. Moreover, finally, the MD instrument, consisting of 39 items answered using a Likert-type scale from 0 to 6, related to the intensity and frequency of MD for each item.

For data analysis, responses were organized and grouped in a database, available in Microsoft Office Excel 2013 software. Data analysis was performed using simple descriptive statistics describing frequency and percentage. To calculate the MD intensity and frequency scores, the following correlation was assigned to qualify the data in score: none (0), low (1/2), moderate (3/4) and high (5/6).

The study was approved by the Research Ethics Committee of the University of the State of Rio de Janeiro (CEP/UERJ), under protocol No. 3,094,449/2018.

Results and Discussion

This study had the participation of 104 nursing residents, and the programs that had the most expressive participation were Internal Medicine 19.2% (20), Cardiovascular 14.4% (15), Nephrology 13.5% (14), Clinical Surgical 12.5% (13) and Intensive Care 10.6% (11), which is inferred to be correlated with the number of vacancies allocated to these programs in the residency course in question, namely: Internal Medicine 12 vacancies, Cardiovascular, Surgical Clinic and Intensive Care 8 vacancies each and Nephrology 6 vacancies[13]. The other programs have between 2 and 5 places.

Of the participants, the majority were female 82.7% (86); female gender 84.6% (88); white race 54.8% (57). In relation to sociodemographic characteristics, regarding sex and gender, the data corroborate with research carried out with nursing residents, who present a majority of female participants. On the other hand, they are opposed in the research carried out on the profile of nursing, which points to the masculinization of the profession since the 1990s[8,12,14-17].

Results related to the age of the participants, aged between 22 and 45 years, 75% (78) were aged between 22 and 29 years, with a mean age of 28.7 years. These data corroborate a study that traced the profile of Brazilian nursing, recording that 25.3% of the total are up to 30 years old. And yet the data are similar to studies developed with multiprofessional residents, aged between 22 and 29 years[8,15,17].

Regarding professional training, the year of training varied between 2000 and 2020, with 81.7% (85) graduated as a nurse between 2016 and 2020; only 25% (26) had worked as a nurse before the residency, and of these 46.2% (12) worked from 1 to 3 years, 27% (7) less than 1 year, 11.5% (3) from 7 to 9 years old, and 7.7% (2) from 13 to 15 years old.

The training results of the participants show that the group has a profile characterized by nurses trained for 3 to 4 years (48.1%), but with little previous experience in the profession, seeking specialization and improvement in the practice of care in the residency course.

A study developed relating age with lack of experience, little skill and practical experience, emphasizes that these issues can have important influences on their health, making residents even more insecure and vulnerable, which can generate stress. In this way, the residency course provides the resident nurse with improvement in work practice, technical and theoretical knowledge, experiences in the management of conflicts in the daily work and increase in professional confidence, being an experience with preparation for the job market[18,19].

Among the participants, 50% (52) claim to have a husband/wife, and 60.6% (63) live in the city of Rio de Janeiro. It can be seen that the intense rhythm of the course's 60-hour weekly workload and the different theoretical and research activities require more time at home, which causes some distance from family, friends and leisure activities[9,15,18].

The residency period is a professional qualification stage that requires a long workload, which has consequences such as sleep deprivation, fatigue, excessive care workload, excessive administrative activities and problems related to the quality of teaching and the educational environment, which lead to an overload and stress to this professional[9,20]. Emphasizing that the resident, in addition to developing work activities, accumulates academic activities, which can favor stress and physical and mental exhaustion[9,18].

When asked about the topic addressed in the research, 70.2% (73) reported having heard of the term moral distress, of which 73.9% (54) had the correct conceptual definition. Among the participants, 5.7% (6) associated MD with harassment in the work relationship. With the conceptual exposition of the term MD, 69.2% (72) recognized experiencing situations that can result in MD for practice at home.

When the residents were asked which situations lead them to recognize moral distress in practice, they pointed out issues related to the care of patients without treatment possibilities 1.9% (02); feeling of powerlessness and lack of autonomy in some situations 9.6% (10); institutional obstacles 10.6% (11); absence/lack of material resources and personnel 1.9% (02); disrespect in interpersonal relationships 9.6% (10); devaluation as a resident/professional 8.6% (09); lack of interest on the part of the head of the service 3.8% (04); neglect of some professionals with the patient's health 3.8% (04) and physical and emotional exhaustion 9.6% (10).

In the second part of the questionnaire after application of the MD scale, with the presentation of 39 situations related to the work practice of the health professional, assessing the perceptions of resident nurses regarding the intensity and frequency of MD. Thus, the total number of situations whose responses were considered was 35, as 4 questions were discarded because they addressed

dilemmas experienced by professionals who work in hospital units in the private network, since they were not part of the professional reality of the residents.

In the analysis of the responses to the 35 items of the MD scale, three categories emerged: (1) Lack of competence in the work team; (2) Disrespect for the patient's autonomy; (3) Denial of nursing as a patient's advocate[21].

Lack of competence in the work team

This category is related to issues arising from the routine of patient care and assistance, in which there is a lack of skill or technical competence that should exist when performing an action specific to the specific professional category[21].

Table 1 lists 14 questions in this category, regarding the intensity scores, 35.7% (5) have a moderate to high score (q03, q10, q13, q16, q32); 42.8% (6) ranging from low to high (q08, q33, q34, q35, q36, q38); and 21.4% (3) with a score from none to high (q09, q18, q24). Regarding the frequency scores 21.4% (3) ranging from low to moderate (q03, q08, q34); 71.4% (10) from none to below (q09, q10, q13, q16, q18, q32, q33, q35, q36, q38), and 1 7.1% (1) with a score of none (q24).

Table 1. Situations related to lack of competence in the work team. Rio de Janeiro, RJ, Brazil, 2020

Questions	Intensity				Frequency			
	0	1/2	3/4	5/6	0	1/2	3/4	5/6
	n/ %	n/ %	n/ %	n/ %	n/ %	n/ %	n/ %	n/ %
q03 - Carry out medical orders for unnecessary treatments and tests	12 11,5%	26 25%	35 33,7%	31 29,8%	11 10,6%	42 40,4%	39 37,5%	12 11,5%
q08 - Perform a work task for which you do not feel professionally suited	21 20,2%	24 23,1%	21 20,2%	38 36,5%	28 26,9%	39 37,5%	29 27,9%	8 7,7%
q09 - Avoid taking action when finding that a member of the nursing team applies the wrong medication and fails to report it	26 25%	22 21,2%	17 16,3%	39 37,5%	47 45,2%	41 39,4%	13 12,5%	3 2,9%
q10 - Allowing medical students to perform painful procedures on patients just to hone their skills	17 16,3%	23 22,1%	24 23,1%	40 38,5%	33 31,7%	31 29,8%	23 22,1%	17 16,4%
q13 - Working with nursing staff at a level they consider "unsafe"	17 16,3%	23 22,1%	25 24%	39 37,5%	32 30,8%	40 38,5%	20 19,2 %	12 11,5%
q16 - Observe, without taking action, when the nursing team does not respect the patient's privacy	19 18,3%	22 21,2%	28 26,9%	35 33,6%	35 33,6%	35 33,6%	27 26%	7 6,8%
q18 - Providing assistance to a physician who, in your opinion, is acting incompetently towards the patient	25 24%	22 21,2%	21 21,2%	36 34,6%	42 40,4%	43 41,4%	12 11,5%	7 6,8%
q24 – Giving intravenous medication during cardiac arrest without performing massage or intubation	44 42,3%	16 15,4%	13 12,5%	31 29,8%	83 79,8%	15 14,4%	5 4,8%	1 0,9%
q32 - Working with nurses who lack the necessary competence that the patient's condition requires	22 21,1%	20 19,2%	28 26,9%	34 32,7%	30 28,8%	36 34,6%	23 22,1%	15 14,4%
q33 - Working with nursing technicians/assistants who do not have the necessary competence that the patient's condition requires	20 19,2%	26 25%	25 24%	33 31,7%	30 28,8%	38 36,5%	24 23,1%	12 11,5%
q34 - Working with medical and nursing students who lack the necessary competence that the patient's condition requires	16 15,4%	27 26%	25 24%	36 34,6%	23 22,1%	36 34,6%	24 23,1%	21 20,2%
q35 - Working with physicians who lack the necessary competence that the patient's condition requires	15 14,4%	26 25%	23 22,1%	40 38,5%	26 25%	39 37,5%	19 18,3%	20 19,2%
q36 - Working with support services that lack the necessary competence that the patient's condition requires	24 23,1%	25 24%	24 23,1%	31 29,8%	33 31,7%	37 35,6%	21 20,2%	13 12,5%
q38 - Being asked to care for patients, not feeling prepared to care	22 21,2%	27 25,9%	24 23,1%	31 29,8%	35 33,6%	42 40,4%	18 17,3%	9 8,7%

In the related questions, all presented an intensity with a high score, which we can emphasize how much the absence of a prepared team and with professionals with technical skills to care for patients, can generate suffering in the professional within the team that can have repercussions on care. Although the frequency of these situations varies up to a moderate score, when the professional is exposed to a situation that brings him suffering at a high level of intensity, the occurrence of an event already puts him in a situation of overload.

Within these issues, the situation related to the professional hierarchy within the work environment is exposed (q3) that there is the institutionalization of a traditional model that privileges the medical category, in addition to bureaucracy as the responsibility of nursing and actions inflexible imposed by the institution, which negatively influences the experience of moral distress for nursing professionals[4,21].

Disrespect for patient autonomy

This category contains issues related to disrespect for privacy, individual choice and freedom of the patient's desire with their health process and care[21]. In Table 2 are presented 08 related questions of this category, regarding the intensity scores 12.5% (1) presented moderate to high (q12); 12.5% (1) ranging from low to high (q04); and 75% (6) with a score from none to high (q15, q17, q19, q25, q26, q30). Regarding the frequency scores 50% (4) ranging from none to low (q04, q12, q15, q17); 50% (4) with no score (q19, q25, q26, q30).

Table 2. Situations related to disrespect for the patient's autonomy. Rio de Janeiro, RJ, Brazil, 2020

Questions	Intensity				Frequency			
	0	1/2	3/4	5/6	0	1/2	3/4	5/6
	n/%	n/%	n/%	n/%	n/%	n/%	n/%	n/%
q04 - Providing assistance to a doctor who is performing a procedure on the patient, without the informed consent of the patient or family member	25 24%	28 26.9%	15 14,4%	36 34,6%	39 37,5%	43 41,4%	17 16,3%	5 4,8%
q12 – Carry out medical prescriptions to carry out unnecessary examinations and treatments for terminally ill patients	20 19,2%	20 19,2%	32 30,8%	32 30,8%	38 36,5%	34 32,7%	24 23,1%	8 7,7%
q15 – Continuing to take part in the care of a person with no chance of survival, who has been kept alive on a respirator, when no one makes the decision to "turn off the devices"	26 25%	25 24%	21 20,2%	32 30,8%	52 50%	22 21,2%	21 20,2%	9 8,6%
q17 - Obey the doctor's order not to tell the patient the truth, even when the patient asks for the truth	28 26,9%	18 17,3%	18 17,3%	40 38,5%	52 50%	27 26%	17 16,3%	8 7,7%
q19 – Preparing a severely insane, terminally ill elderly person for gastrostomy tube placement surgery (for food)	35 33,6%	24 23,1%	19 18,3%	26 25%	65 62,5%	26 25%	10 9,6%	3 2,9%
q25 - Comply with the doctor's request not to discuss resuscitation with the patient in case of cardiac arrest	35 33,6%	17 16,3%	17 16,3 %	35 33,6%	68 65,4%	23 22,1%	9 8,6%	4 3,9%
q26 - Comply with the doctor's request not to discuss the patient's resuscitation with the family in case of cardiac arrest, when the patient is deprived of discernment	37 35,6%	13 12,5%	19 18,3%	35 33,6%	70 67,3%	20 19,2%	10 9,6%	4 3,9%
q30 - Heed the doctor's request not to talk about death with a dying patient who asks him about dying	34 32,7%	15 14,4%	21 20,2%	34 32,7%	66 63,5%	23 22,1%	11 11,5%	4 3,8%

Of the situations that present a frequency of no score, they are related to the professional hierarchy and the disrespect for the patient's will, in which they are subjected to interventions without clarification or acceptance to perform the procedure; mainly to patients who are in the process of terminality, many times, their wishes are not respected.

It is noteworthy that ethical issues related to the patient's lack of autonomy are present in the nurse's routine, since within hospital units they can generate situations of conflicts and dilemmas for both the health team and the patient and family. Emphasizing the role of the nurse to clarify questions, and allowing the patient to be informed of their rights and their health situation[12].

Interpersonal relationships within the context of the hospitalization unit can generate conflicts and dilemmas, which involve the professional's autonomy, since the nursing work is complex and continuous, and by its nature, it can generate wear and suffering for these professionals; this is intensified when subjected to conflict situations[22].

Residents usually assume, most of the time, care activities during the shift or shift, they deal with situations such as unfamiliarity with the routine of the sector, the complexity of care that some patients demand, and they are

still faced with issues bureaucratic tasks they deal with on a daily basis. It is inferred that in this way, they feel more overloaded, and stress and suffering are generated in an attempt to face such situations.

Denial of nursing as a patient advocate

This category is related to issues arising from the routine of patient care and assistance, in which the potential of nursing to demand the rights of patients is not used or respected[21]. Table 3 shows 11 questions in this category, regarding the intensity scores, 9.1% (1) has a moderate to high score (q07); 9.1% (1) ranging from low to high (q05); 9.1% (1) ranging from low to moderate (q02); 18.2% (2) none to moderate (q11, q31); and 45.4% (5) with a score from none to high (q06, q20, q22, q23, q28, q29). Regarding the frequency scores, 54.5% (6) from none to low (q02, q05, q07, q22, q23, q31), and 45.5% (5) with no score (q06, q11, q20, q28, q29).

Table 3. Situations related to the denial of nursing as a patient advocate. Rio de Janeiro, RJ, Brazil, 2020

Questions	Intensity				Frequency			
	0	1/2	3/4	5/6	0	1/2	3/4	5/6
	n	n	n	n	n	n	n	n
q02 – Follow the family's wishes to maintain the patient's life, although this is not the best thing for him	20 19,2%	28 26.9%	34 32,7%	22 21,2%	33 31,7%	38 36,6%	20 19,2%	13 12,5%
q05 – Initiating intensive life-saving procedures when you believe they will only stave off death	13 12,5%	29 27,9%	25 24%	37 35,6%	25 24%	44 42,3%	22 21,2%	13 12,5%
q06 - Ignore situations where there is suspicion of patient maltreatment by caregivers	39 37,5%	10 9,6%	16 15,4%	39 37,5%	53 50,9%	34 32,7%	14 13,5%	3 2,9%
q07 - Ignore situations in which the patient was not given adequate information to ensure informed consent	22 21,2%	25 24%	26 25%	31 29,8%	33 31,7%	40 38,5%	23 22,1%	8 7,7%
q11 - Provide assistance to physicians who are performing procedures on patients after cardiorespiratory recovery has not been satisfactory	29 27,9%	23 22,1%	29 27,9%	23 22,1%	54 51,9%	32 30,8%	14 13,5%	4 3,8%
q20 - Discharge a patient when he/she has reached the maximum length of hospital stay related to the diagnosis, even though he/she has a great need for care	30 28,8%	18 17,3%	20 19,2 %	36 34,6%	54 51,9%	30 28,8%	11 28,8%	9 8,6%
q22 – Accomplishing the family's request not to talk about death with the dying patient, who asks him about his situation	26 25%	24 23,1%	24 23,1%	30 28,8%	47 45,2%	39 37,5%	15 14,4%	3 2,9%
q23 - Providing care that does not alleviate the patient's pain because the physician fears that increasing the analgesic dose will cause the patient's death	27 26%	21 20,2%	25 24%	31 29,8%	47 45,2%	35 33,6%	20 19,2%	2 1,9%
q28 – Increasing the dose of intravenous morphine prescribed for an unconscious patient when you believe it will hasten their death	37 35,6%	11 10,6%	21 20,2%	35 33,6%	66 63,5%	23 22,1%	9 8,6%	6 5,8%
q29 – Responding to a patient's request to help him or her commit suicide when the patient has a poor prognosis	41 39,4%	12 11,5%	12 11,5%	39 37,5%	87 83,6%	13 12,5%	3 2,9%	1 0,9%
q31 - Execute prescriptions for the application of analgesics even if the prescribed medication does not control the pain	28 26,9%	19 18,3%	31 29,8%	26 25%	44 42,3%	33 31,7%	19 18,3%	8 7,7%

This category brings together the issues in which nurses, as the professional who is closest to the patient, do not play their role of advocate, related to the absence of actions such as protecting the patient against interventions that are not their desire; let the patient choose whether or not he wants to undergo any treatment that is unnecessary for his recovery; make him/her able to make his/her choices and decisions regarding his/her care and treatment.

In the training of nurses, the advancement and academic discussion of the professional in relation to the ethical issues that permeate the nurse's assistance to the patient in the health-disease process is highlighted, which are used as tools for guidance and health education, and the practice of effectively communication with patients, measures that allow the exercise of the advocacy role, making the right to health exercise not only by the patient, but by the entire multiprofessional team[23].

It is noteworthy that the patient is the responsibility of the entire multidisciplinary team, however, nursing, due to the characteristics of the profession of being closer and responsible for a large part of patient care procedures, ends up playing the role of advocacy and guidance and rights, and increasingly this advocacy role has become more specific to nursing[24].

In view of the resident's activities, the study points out the issues of role conflict, in which the actions are interposed by the dilemma between the professional resident and the resident in the position of student, in this situation there may be a loss of professional autonomy, negatively influencing the decision to be taken and for the practical exercise of patient advocate[4,25,26].

Questions q06, q07 and q23 exemplify situations of denial of the nurse as an advocate for the patient, despite having a frequency of no score, but a significant portion indicate no score of intensity, a fact that concerns in which we can suggest that there is a moral disengagement by the resident, characterized by distance from the problem in question, which reduces the possibility of generating MD. However, this practice of moral disengagement generates repercussions for professional life and can form a professional nurse practitioner, distancing himself from issues related to the promotion and protection of patients' rights[23,24].

Understanding that there are issues that generate conflicts, which can affect the personal and professional life of the resident, requiring the use of strategies to reduce and face the problem. Faced with the issue related to patient advocacy by nursing, it is highlighted the possibility that residents are developing, in their professional practice, moral disengagement, in which there is a detachment from the problem and this, consequently, reduces the possibility of generating MD[24].

As the residency is a period in which nurses will reinforce skills and deepen knowledge necessary for their performance, experiencing situations in which the displacement of reality allows for moral disengagement, is a concern. Since it is in this period of professional qualification that everyday practices are strengthened, learned and incorporated.

Conclusion

The study achieved the proposed objectives to analyze and identify, in terms of intensity and frequency, the experience of moral distress in the practice of nursing residents in a university hospital in Rio de Janeiro. Most nursing residents reported experiencing overload situations that can generate MD, especially issues related to impotence and lack of autonomy in some situations, such as institutional obstacles; disrespect in interpersonal relationships between members of the multidisciplinary team; devaluation as a resident/professional; physical and emotional exhaustion.

Situations related to the patient's lack of autonomy were the questions that presented the highest frequency of MD with a high score (5/6), a fact that worries and makes us rethink strategies within the institution to review the qualification of health professionals and that, in the context of the qualification process, exercise their moral role, promoting assistance to the patient that seeks respect for their will in decision-making in the health-disease process. In general, in terms of intensity and frequency, residents identified score 3 (moderate) of experiencing moral distress.

The term MD is still not widespread within nursing, even if the group of participants had a correct concept of the term; they made associations relating issues and moral conflicts. The study brought the residents closer to the theme, making them recognize which situations, within the activities developed in the hospital units, make them experience the MD. Moral disengagement by nursing residents was observed in the results as a possible strategy for coping with MD, due to distancing from situations and conflicts in work practice. The issues of disengagement and coping strategies by residents deserve attention for future studies and deepening of this theme in the context of professional training in public hospitals.

The difficulties encountered in carrying out this study occurred with the beginning of the Coronavirus pandemic, when there was a reduction in the scale among nursing residents, making communication with the study participants difficult, since it was a period in which there were several departures from course residents. due to contamination by the Coronavirus, making contact impossible to participate in the research.

Thus, this study is an advance for the debate on issues related to the experience of MD among nursing residents, insofar as it offers subsidies for discussions with residents and with the coordination of the course about coping strategies, at the individual and institutional levels, of situations that generate moral distress and improvements in the quality of the resident's work process. The situations that generate MD need to be discussed in the search for resolutions, including analyzing their temporality, due to their impact on the physical and mental health of residents, influencing the quality of patient care.

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