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ORIGINAL ARTICLE

MORAL SUFFERING OF NURSES, IN END-OF-LIFE SITUATIONS, IN INTENSIVE THERAPY UNITS

SOFRIMENTO MORAL DOS ENFERMEIROS, EM SITUAÇÕES DE FINAL DE VIDA, EM UNIDADES DE TERAPIA INTENSIVA

SUFRIMIENTO MORAL DE LOS ENFERMEROS, EN SITUACIONES DE FINAL DE VIDA, EN UNIDADES DE TERAPIA INTENSIVA

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ABSTRACT

Objective: to understand the practices practiced by nurses, in the Intensive Care Unit (ICU), in end-of-life situations, and to relate them to moral suffering. ***Method:*** qualitative study, of descriptive type. Eleven nurses from a hospital were interviewed. Data were analyzed using the Content Analysis technique. ***Results:*** data were grouped into three categories: 'End-of-life experiences', 'End-of-life decisions' and 'Situations generating moral distress'. ***Conclusion:*** the data showed a series of difficulties to be faced by nurses in these situations: professional inexperience, dealing with patient and family suffering, lack of collaborative work among the team and, mainly, the nurses' involvement in decision making at the end of life. ***Descriptors*:** Nursing; Professional Practice; Stress, Psychological; Burnout e Professional.

RESUMO

Objetivo: compreender as práticas exercidas pelos enfermeiros, na Unidade de Terapia Intensiva (UTI), em situações de final de vida, e relacioná-las ao sofrimento moral. ***Método:*** estudo qualitativo, do tipo descritivo. Foram entrevistados onze enfermeiros de uma instituição hospitalar. Os dados foram analisados pela técnica de Análise de Conteúdo. ***Resultados:*** os dados foram agrupados em três categorias <<Experiências de final de vida>>, <<Decisões de final de vida>> e <<Situações geradoras de sofrimento moral>>. ***Conclusão:*** os dados evidenciaram uma série de dificuldades a serem enfrentadas pelos enfermeiros nessas situações: inexperiência profissional, lidar com o sofrimento do paciente e da família, falta de trabalho colaborativo entre a equipe e, principalmente, o não envolvimento dos enfermeiros nas tomadas de decisão no final de vida. ***Descritores:*** Enfermagem; Prática profissional; Estresse psicológico e Esgotamento Profissional.

RESUMEN

Objetivo: comprender las prácticas ejercidas por los enfermeros, en la Unidad de Terapia Intensiva (UTI), en situaciones de final de vida, y relacionarlas al sufrimiento moral. ***Método:*** estudio cualitativo, tipo descriptivo. Fueron entrevistados once enfermeros de una institución hospitalaria. Los datos han sido analizados en la técnica de análisis de contenido. ***Resultados:*** los datos se agruparon en tres categorías << Experiencias de final de vida >>, << Decisiones de final de vida >> y << Situaciones generadoras de sufrimiento moral >>. ***Conclusión:*** los datos evidenciaron una serie de dificultades a que necesitan ser enfrentadas por los enfermeros en esas situaciones: inexperiencia profesional, lidiar con el sufrimiento del paciente y de la familia, falta de trabajo colaborativo entre el equipo y, principalmente, el no involucramiento de los enfermeros en las tomas de decisiones en el final de vida. ***Descriptores*:** Enfermería; Práctica Profesional; Estrés Psicológico e Agotamiento Profesional.

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INTRODUCTION

Illness and death reside in the hospital, failing to occur in the home. This has become a reality because of the changes that occurred in the mid-twentieth century, when modern intensive therapies emerged, with the primary goals of treatment formulated through sophisticated therapeutic resources that included qualification, quantification and control of a wide variety of biological phenomena.[1] Thus, with the support of technological devices and modern therapies, most of the deaths occur in hospitals and, more specifically, in Intensive Care Units (ICUs).

Intensivism is an environment in which patients in end-of-life situations remain dependent on follow-up and decision of professionals. The constant apprehension about changing the clinical picture of the patient is determinant to generate an atmosphere of stress, as well as requires the nurse's judgment and action on conflicting and dilemmatic situations.[2]

Most of the time, end-of-life and death situations are preceded by medical decisions regarding the suspension of medications and therapeutic procedures. This is due to the growing power of medical intervention.

Nursing, with its care practices, requires the exercise of the profession in a responsible manner and seeks to provide competent skills so that professionals can face the day-to-day, permeated by problems generating ethical conflicts, moral dilemmas and moral suffering, since nurses , in the workplace, coexist with different professionals, patients and their families. Among the various situations that occur in the day-to-day work of these professionals, some relate to the professional unpreparedness to deal with loss, pain and suffering. This lack of preparation is caused by exhaustive and stressful routines, lack of dialogue among the team, disinterest with the patient's dying process, bureaucracy, among others. Thus, it can be inferred that such occurrences are related to the moral suffering of the professionals involved in these situations.[3]

Jameton introduced the concept of moral suffering in the Nursing context. The author implanted the term in his book on Nursing ethics, published in 1984, in order to distinguish two types of situations: those involving moral conflict and those involving moral restraint. For him, situations involving moral restraint could potentially give rise to what he called moral suffering.[4]

Moral suffering was first described in the 1980s, and is expressed as the consternation arising from the incoherence between people's actions and their convictions, that is, one knows what is right to be done, but recognizes that it is impossible to undertake this action , either by errors of judgment, personal failings, weaknesses of character or even by circumstances beyond personal control. [4] However, the term moral suffering is at permanent risk of conceptual confusion due to the variability of the definitions of the concept in the literature and the absence of conceptual clarity.[5]

In the work of Nursing, specifically, moral suffering can be defined as the psychological imbalance caused by painful feelings that occur when nurses can not perform morally appropriate situations according to their consciences or knowledge.[6-7] It can be defined, response when, after a decision with ethical conflict, they recognize a personal action hampered by individual, institutional or social barriers. Feelings of anger and sadness are the most cited in the literature as psychosomatic effects resulting from this type of suffering. Introspection is also one of the manifestations presented by Nursing workers who receive little or no support during the confrontation of moral conflicts. These feelings, related to moral suffering, can lead to emotional responses in the individual, such as discontent with work, reluctance to go to work or even abandonment of the profession.[7]

Faced with the realization of the implications of moral suffering for nurses' lives in the personal and professional dimensions, it is essential to carry out studies that focus on the development of moral suffering. In addition, it is necessary to implement strategies that strengthen the ethical organizational environment, valorization and recognition of the work of the nurse in the institution. Such actions contribute to the well-being and adequate provision of care to the users of the health services, as well as to the expansion of the collaborative dialogue with other professionals of the health team, in order to ensure the continuity of the Nursing identity as a profession whose essence is care.

In this way, it is justified the need to explore and analyze the moral suffering of nurses, since there is a small number of national studies in the area, besides considering the specificities of Nursing in its organizational daily life.

OBJECTIVE

- To understand the practices carried out by nurses, in the Intensive Care Unit (ICU), in

end-of-life situations, and to relate them to moral suffering.

METHOD

A qualitative study[8], a descriptive type, performed through the analysis of 11 semi-structured interviews, collected from nurses working in an ICU of a hospital institution in the Mid-West region of Minas Gerais. The average time of professional training was eight years, ranging from five to eleven years. In addition, the interviewees had an average of six years of ICU work.

The following guiding questions, were used, in the interviews: Tell me about your experience with end-of-life situations in the ICU; How are end-of-life decisions made, ie when the patient no longer responds to curative treatment?; Who participates in these decisions ?; How do you perceive your participation in decision-making in end-of-life situations ?; What is your feeling when the decision making goes against your opinion or against your values ?.

Data were collected from July 2014 to January 2015. The research project was submitted to the Research Ethics Committee of the Federal University of São João del-Rei, with a favorable opinion (CAAE: 31706314.1.0000.5545), complying with Resolution 466/12 of the National Health Council, of the Ministry of Health, which provides guidelines and norms regulating research involving human beings. The nurses' participation in the study was voluntary and, prior to each interview, the purpose of the study was made explicit. Next, the nurse was asked to read the Informed Consent Form (ICT).

The analysis of the material was done by means of the Content Analysis technique, in the Thematic Analysis modality, which consists in discovering the nuclei of meaning that make up a communication, whose presence or frequency has some meaning for the analytical objective. Operationally, the thematic analysis unfolds in four stages: Pre-analysis; Exploitation of material; Treatment of results and Interpretation.[9]

The pre-analysis consists in the choice of the material to be analyzed, the resumption of the hypotheses and the initial objectives of the research, reformulating them against the collected material, and in the elaboration of indicators that guide the final interpretation. The exploitation of the material is the moment of codification, in which raw data are processed in an organized way and aggregated into units, which allow a description of the characteristics relevant to the content. For that, the classification and aggregation of the data were chosen, choosing the categories that commanded the specification of the themes. The categorization allows to gather more information at the expense of a schematization and, thus, to correlate classes of events to order them. The stages of Treatment of results and Interpretation consists in the organization of the raw data, in order to constitute the themes, which can be defined as units that are released naturally from the text analyzed.[9]

RESULTS AND DISCUSSION

From the narratives, it was possible to understand the practices exercised by nurses in the ICU, in end-of-life situations, and to relate them to moral suffering.

Three categories were constructed, which are presented below: end-of-life experiences; end-of-life decisions; and situations that generate moral suffering.

♦ End-of-life experiences

It was observed that the end-of-life experiences, experienced by the nurses are, in their totality, very difficult at the beginning of the profession, because the professionals are not yet habituated and matured to deal with such circumstances. However, over the years of the profession, it is possible to notice that the way of dealing with these experiences becomes more calm, due to the great diversity of situations experienced.

In addition, the nurses interviewed report some personal maturation to deal with end-of-life situations. In this way, it is verified that, as the nurse acquires a certain experience in the assistance to patients in situations of end of life, it increases its maturity to understand that, in some cases, it is possible to obtain improvement for the patient in relation to the prognosis and in others this is beyond the therapeutic possibilities of healing related to patient care.

> *You learn to work and you know that your job within the unit is to be helping the patients, and there are things that are about to get done and things that are beyond our reach, right? (Nurse 4)*

> *At the beginning of the profession, I found it complicated because you end up taking everything home and day to day. (Nurse 6*)

Even with professional time and personal maturation, nurses report that they are still faced with situations that make them sensitive, moving, sad and frustrating, especially, in the case of young patients, who are expected to have a front.

> *Everything has already been done and it does not really show improvement, we end up accepting it, because it is even for the patient's own good, to rest, and not to suffer in life. But I'm still very sensitive, you know? I sensitized myself to the family, I was still very sensitive. (Nurse 3)*
>
> *If you are a young patient and I see you have a lifetime ahead of you, I feel frustrated. (Nurse 6*)

Another reported situation was the establishment of the bond between the nurse and the family and/or the patient. In this situation, especially when the patient is out of therapeutic healing possibilities, dealing with the family becomes a great difficulty, even though understanding that working with this adversity is of paramount importance. The paradigm shift from healing to relieving suffering is a slow process that depends on the initiative of nurses. However, most feel unprepared to offer this care and stress experience in acting as key to making a difference in patient and family care. Many nurses remember their own losses and end up putting themselves in the place of families.

> *The team, willing or not, ends up creating a bond with the family, creating a bond with this patient [...] and we have to adapt to that. (Nurse 11)*
>
> *The farewell of the family, the non-acceptance, especially, of those young patients in which the family does not yet have an emotional preparation to accept the loss, I believe this is the greatest difficulty that culls the Nursing. (Nurse 9)*
>
> *I stand as a patient, as if in his situation. (Nurse 10*)

The most frequently mentioned experience by nurses was the use of all available resources in an attempt to rehabilitate or prolong the life of ICU patients, and when there was no response to the curative treatment, seek to relieve pain with basic care, such as change of position and continuous analgesia.

> *Because, here, they go to the limit of the limit. (Nurse 5)*
>
> *We give comfort to this patient, with changes of decubitus and frequent analgesia to reduce the pain, allowing a good death. (Nurse 4*)

When all available therapeutic resources are invested and the patient does not respond to the treatment, it is noted that acceptance of the patient's loss occurs more smoothly, because nurses believe that all possibilities of curative treatment have been invested, and this causes suffering and no longer offers a favorable prognosis. This acceptance is greater, especially, when elderly patients, because the professionals consider that the elderly has gone through all the stages of life.

> *We've invested for so long, already invested several months, already did everything and it really does not show improvement, we ended up accepting. (Nurse 3)*
>
> *That elderly patient who has gone through the entire aging process and comes an hour that the body no longer responds, I feel comforted. (Nurse 8*)

The nurses report that a difficult aspect, related to end-of-life experiences, is, firstly, associated with the patient's daily suffering without favorable prognosis. The involvement of the Nursing team with the patient, being daily at the edge of the bed and experiencing all the care and treatment with him, makes possible the establishment of a relationship of mutual trust.

Another aspect, pointed out by the interviewees, concerns empathy, established between the nurse and the patient, being of great importance in the treatment performed, since it provokes therapeutic effect. In this sense, it is possible to observe the existence of a relationship of mutual respect, in a "I-you" relationship - being essential to put oneself in the place of the other.

> *You experience it by putting yourself in the patient's shoes, or if you do not put yourself in the position of some relative of the patient, thinking that that person could be someone in your family. (Nurse 2*)

In addition, an involvement is also established between the Nursing team and the relatives of these patients, who are there, daily, to visit their relatives. This bond with relatives is given in an attempt to listen to complaints, to dialogue and to provide detailed information about the patient's clinical picture. Nurses try to offer support or support to those involved by relating the patient's current situation to the religious and spiritual beliefs in which the family is embedded.

> *But we try to work, at least, with the way I work, I talk to them: 'Look, you have to give to God, you have to think that God is going to do what is best.' That's a way of trying to give comfort to the familiar, is not it? (Nurse 2*)

The nurses emphasize the importance of caring for the psychosocial aspect of the patient and family, either through the support of the professional psychologist or, even, in the improvement of the communication between the Nursing team and the relatives during the patient's stay in the ICU, help her in accepting the possibility of death and in preventing complicated mourning. Thus, the role of the nurse in the work with the entire

Nursing team is highlighted, so that they can find coping mechanisms that allow them to deal with these adversities, in a more relaxed way.

> *You have to prepare your team for the death of that patient, and, also, give a support to the relatives. [...] If you do not have a team prepared to deal with these adversities that happen, we can not do a good job and we can not provide adequate support for that patient. (Nurse 1*)

Nursing is directed at the importance of ethical practice focused on human care and must exert daily confrontation with ethical and moral problems in its work environment, that is, confronting moral uncertainty, moral dilemmas and moral coexistence of professionals, patients and their families.[3] Among the various situations that occur in the day-to-day work of these professionals, is the responsibility for the continuous care of patients and their families, especially, in end-of-life situations.

In the circumstances of diseases with reserved prognosis, in which the patient is considered out of therapeutic possibilities of cure, the nurse starts to offer palliative care and no longer curative care.[10] The change from the attempt of cure, to the relief of patient suffering and their families, is a slow and stressful process, which generates feelings of anxiety and anxiety in Nursing professionals.

Facing the end-of-life situations of young patients or even children is, in the nurses' conception, the most difficult circumstance experienced in the ICU, since these occurrences are unexpected and further disrupt the professional who is performing the care. Like most people, the nurse also shows regret at the loss of young patients and children. This is due to the fact that the nurse, first of all, has external feelings and references on various subjects, among them, death.[11]

Feeling sorry for the loss of young patients, as demonstrated by nurses, may also be the result of the idea that death should only happen in old age. From this perspective, all people are expected to go through all stages of the life cycle: birth, growth, aging and death.

Nurses have a certain difficulty in perceiving the irreversibility of the clinical picture, as well as the impediment in assuming the change of behavior towards the family members who accompany the treatment on a daily basis.[10] They point out in their narratives that there is no teamwork or discussions with professionals in the area on the implementation of the philosophy of palliative care and the psychosocial accompaniment of family members who experience this situation, choosing such aspects as difficulties and generators of greater suffering for the patient and the family.

Professional maturity and years of ICU experience seem to be fundamental factors that make a difference in care, in relieving patients' suffering and in coping with end-of-life experiences.[12] Respondents mentioned in several testimonies that they suffer with feelings of anguish, anxiety, incapacity and frustration for coping in their daily lives with end-of-life situations. However, have stated that they do not feel able to change this picture - even if the time spent in the ICU is extensive - and therefore they are still moved by the pain of the other.

♦ End-of-life decisions

According to the reports of the nurses interviewed, multiprofessional teams and coordination are very hopeful and opt to invest all possible treatment for the recovery of patients' health.

> *In this ICU, the coordination is very hopeful, so, here is always investing. (Nurse 5)*
>
> *In the ICU here, usually, one invests until almost the last drop that can invest with patient. (Nurse 5*)

End-of-life decisions, related to patients who no longer respond to curative treatment, occur together with the multiprofessional team, composed of the attending physician, the intensivist coordinator, the supervising nurse and the physiotherapist, through the so-called shift, when they are discussed the evolution of the patient's condition and the treatment to be performed.

> *When we are going to discuss any case of the patient, there is the intensivist coordinator, the attending physician, the nurse responsible and the physiotherapy. (Nurse 3)*
>
> *Decisions are taken inside a room designated for the duty shift. Physician, nurse, physiotherapist, that is: the whole team meets to make the decisions that will be made in each patient. (Nurse 7*)

However, some interviewees in this research, when asked about life experiences with end-of-life decisions, say that these decisions are exclusively for medical professionals, and there is no discussion or questioning with nurses on the evolution of the board of the patient and what they think should be done in the continuation of treatment.

> *Exclusively the doctors [...] We do what they designate. (Nurse 9)*
>
> *Here, in the ICU, we have the passages on duty that discuss the patients' cases. But whether you will decide to continue the treatment or not, these are medical decisions. (Nurse 10)*
>
> *Nursing has the participation in the day to day of the patient, but the decision is of the doctors. (Nurse 6*)

The nurses also report that they seek to dialogue with the doctors about some adversities encountered in the conviviality with the patients, in an attempt to adjust the curative and palliative care, however, they depend a lot on the staff of the caller to be heard.

> *Depending on the team, we even argue, argue that the patient is critical, asking to see the patient, about the ulcers and skin. (Nurse 3)*
>
> *There are those who do not accept opinions. (Nurse 6*)

ICU Nursing professionals cite feelings of anguish, suffocation, and professional frustration when decision making goes against their values and opinions. They argue that doctors are not on the bedside every day, following the evolution of the patient, and when they try to discuss the behaviors, in many situations they are not heard.

> *Feeling is anguish and suffocation. Because the doctors, they are not there on the edge of the bed, we are on the edge of the bed and, above all, the technicians. (Nurse 5)*
>
> *We got a bit frustrated professionally, why? You think like this: "no, I'm going to try hard, make the most of it here", and it does not happen. (Nurse 1*)

The decisions taken and reported by the nurses about the end-of-life patient, most of the times, are directed towards the relief of pain and suffering, such as analgesia and sedation, curative, release of visits and change of decubitus In several cases, nurses direct their decisions to provide the most frequent contact of the patient with their relatives. Therefore, release more visits in the ICU, in order to provide comfort to the patient outside therapeutic possibilities of cure. In addition, those interviewed in this study also report that physicians do not interfere with their behavior and have autonomy over Nursing care.

> *We define that we will let the family visit more often during the day, there one or two people. Only if the familiar is there on the side giving a word to this patient will comfort him, even if it is a patient who is sedated [...]. Here we have enough active voice. The diuresis of that patient there is not legal, I think it should be to take an examination of him, his auscultation is with a bit of snoring, a little wheezing ... then, in those clinical parameters, which is the part of the Nursing care, the doctors here quite respect our opinion. (Nurse 3*)

While some nurses report their participation in decision-making, others prefer not to commit and do not report their participation, they merely argue that the Nursing care provided to patients is delegated by physicians and that the decision on treatment is exclusively those professionals.

It is observed that the incipient involvement of the nurses in the end-of-life discussions, associated to the fact that they are not heard by the medical professionals regarding the behaviors to be taken, is one of the factors that contributes to avoid the moral suffering of the nurses. Based on this assumption, it is understood that, if there is no involvement, there is no internal conflict between professionals.

On the other hand, this lack of involvement can also be understood as a sign of moral suffering, since nurses may feel some discomfort associated with other emotional and ethical issues, especially, when they believe in a treatment that has not been proposed or taken in consideration by the multiprofessional team. Concomitantly, moral suffering can be aggravated when these professionals witness or participate in the moment when it is decided to suspend the life support in those patients without therapeutic possibilities of cure, against their moral and/or religious values.

> *We do what they (doctors) designate. So, he's going to know what kind of medication he's going to do, what care we'll take, if we can take care of ourselves, sometimes even shower, right? Change of decubitus is restricted depending on the patient's condition. Therefore, it is exclusively the doctor's decision [...]. I do what I am defined. I'd rather not say. (Nurse 4*)

Other nurses, in turn, report that their participation in decision-making is focused on day-to-day care. Thus, they are open to exposing their opinions to physicians regarding the best care to be given at that time to the patient in the end-of-life situation. In addition, nurses also participate in end-of-life decisions, presenting what they consider to be best for the treatment of the patient, as well as participating in the discussion groups with the multiprofessional team, even if the final decision on the patient's treatment is exclusive to the patients doctors.

> *We put our observations and see what we can do to the treatment of the patient and the conditions he is, but, suppose, decision*

> *making of medications, which medication will enter, it's all the doctors, is not it? Now, the issue of the care part, we interfere with the care, and we also contribute by telling the doctor what we have been observing about evolution. (Nurse 8)*
>
> *There are discussions, and Nursing participates in the discussions. Until I understand the medical situation, they want life. I think this is up to their ethical conduct, as long as you have treatment and have prognosis they are trying, so they do not want to know if the patient is in pain. (Nurse 5*)

In many situations, nurses are not effectively involved in end-of-life decision-making, with little active participation in this context.[13] Although it is evident from the data in this study that the nurses' performance on this occasion is timid, in the situations in which they could contribute effectively, defending the autonomy of the patient and the family, these same professionals fulfill the treatments with which, in most cases, they do not agree. In spite of this, it is possible to verify in the recent literature that nurses are more engaged with the function of being committed in favor of the patient and the family in the end-of-life processes, making the family more satisfied and able to advance their acceptances and decision-makers.[14] They want to help, but often, do not count on this opportunity.

Thus, it is observed that Nursing participates little in the decision of the behaviors to be taken. Only in some cases is there an opportunity to talk to the doctors and put your vision of the conduct. Therefore, it is noted that the interdisciplinary work between the teams is lacking, the decisions being almost exclusively centered on the figure of the medical professional.

- **Situations that generate moral suffering**

Among the several conflicting situations that are part of the routine of Nursing work, the most important are dealing with pain, illness and death, which are potentialized by the anxiety and anxiety of patients and their families. Another situation faced by nurses is the limitation of autonomy and the possible consequences of their professional practice. In addition, the problem of low remuneration regarding the level of training and the nature of the work performed, not to mention the still imprecise limits of their competencies, attributions and responsibilities, is verified. Thus, such situations can potentially be a source of moral distress for nurses, working in end-of-life situations, within an ICU.

> *It is a situation that if you do not have an emotional balance, a game of waistline, you can not get out, you get frustrated in the profession and we do not have to give in to frustration, we have to show our value. (Nurse 4*)

According to the interviewees, there are differences of opinion between the nurse and the doctor regarding the treatment that will be offered to the patient - and always prevails the medical opinion. This contradiction between power and fragility is related to the great experience of the Nursing professional in caring, either the lack of recognition or the frustrating feeling of being excluded from the decisions made.

When faced with the lack of active participation in decision-making about treatment and care in the end-of-life process, nurses find themselves without action since they can not modify or impose any therapy, due to the limitation of the profession. Respondents cite feelings of discouragement and impotence when faced with such situations.

> *It is sadness, discouragement, impotence, to see that years of experience in your profession sometimes serves you nothing. (Nurse 5)*
>
> *One feels, perhaps, less important. (Nurse 7*)

The time of profession is mentioned by the participants in this study as one of the reasons for divergence of opinions: the nurse feels devalued when a newly trained medical professional does not reflect on the aspects of the treatment that will be employed to the patient, suggested by the most Experient. Concomitantly, they report the feeling that they could have done more for the patient.

> *It's like on a shift that we have a newly trained doctor [...]. We know that the care and vision of him is different from the older professionals, [...] that an experienced doctor is different from a doctor who is not, and this brings a sense of impotence even, you know what has to be done and not can. That's the sad thing. (Nurse 8*)

There are reports that when the result of the treatment is not successful, the nurse experiences a feeling of sadness, since it is believed that the ICU is the place where all the resources necessary for patient recovery are offered and where seeks to invest all forms of treatment for the maintenance of life.

> *But as we always expect the ICU to be the last place, a place full of resources for the patient, but there comes a time that all the opportunities they have to be able to be helping this patient come. (Nurse 4*)

Despite this finding of suffering on the part of the nurses, some interviewees say that they have never experienced situations that generate moral suffering, since they do not discuss medical decisions and only obey what is established for both curative, and palliative care.

> *Look, I'd rather not say it. You know, I do not like it that way. So, I do what I am told. (Nurse 2)*)

In this way, the data found corroborate those of other authors, in the description of these dilemmas, as, for example, in situations of questionable professional practices; therapeutic obstinacy; inequality in the distribution of resources; work overload; and when there is disregard of their opinions in decision-making, since workers develop feelings of frustration and impotence because of the difficulty of influencing their working conditions.[15] This situation is conceived as generating moral suffering, that is, when nurses know the right thing to do, however, other health professionals are not in favor of their opinions.[16] This demonstrates that, for the most part, there is insufficient understanding of the Nursing professional's ability to exercise autonomy in their work environment, which may be revealed by omissions of your actual position in certain situations.

Another fact evidenced is the non-positioning of the interviewees before the end-of-life situation of the patient, allowing the physician to override his opinion and make the final decision. This non-involvement of the nurse can be interpreted as a coping mechanism involuntarily adopted by the professional, not to be affected by moral suffering or not to be judged by adversity of opinions.

The daily routine of exhaustive routines, stress, precariousness of Nursing care, lack of dialogue, banalization of death and bureaucracy, among others, accompanied by feelings of impotence in the face of apparent disregard for patients, influences the way of being and doing of Nursing workers. Such situations can cause them discomfort and suffering, without being, generally, identified as moral suffering.[12]

Moral suffering refers to those painful feelings and psychological imbalances that occur when nurses are aware of the morally correct conduct to be made, but are prevented from following this course of action4-5, whether by obstacles or lack of time, the reluctance of supervision, the centralization of medical power and institutional policies, or by legal aspects.17 Moral suffering seems to manifest itself more in situations and environments where meetings are not held between the work team, where there are few possibilities of dialogue with leaders and the institution, and also in places where there are no permanent education actions. In this way, the experience of moral suffering is associated mainly with the organization of the work environment, which does not privilege spaces for discussion, problematization, reflection and appreciation of situations experienced in the daily life of professionals and that may continually demand workers' confrontations.[18] Better work conditions, autonomy in the tasks of Nursing and greater renumerations can contribute to the confrontation of moral suffering, besides helping in their better understanding.[12]

CONCLUSION

The data evidenced a series of difficulties to be faced by nurses in these situations: professional inexperience, dealing with patient and family suffering, lack of collaborative work among the team and, mainly, the nurses' involvement in decision-making at the end of life. Such situations are related to the moral suffering, experienced by the nurses, in the situations of end of life.

Thus, it is necessary to overcome these difficulties in order for nurses to reach a more effective participation and with less stress in the care of the patient at the end of life, besides the actual confrontation of moral suffering.

As a limitation of the study, the impossibility of generalization of data is highlighted, considering that the research was performed only in one institution. Future studies on the subject should be conducted, for further clarification regarding moral suffering in end-of-life situations. Therefore, it is relevant to adopt strategies that seek to improve the work environment in the ICU, emphasizing the recognition and appreciation of nurses in this sector, in order to encourage them to participate in the decision-making process, especially in situations end of life. Finally, the importance of establishing effective channels of dialogue among nurses and other professionals of the health team is emphasized, so as to ensure that their identity and autonomy are preserved.

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