






NURSE'S IDENTITY CONSTRUCTION IN THE FACE OF THE MORAL DISTRESS PROCESS IN AN INTENSIVE CARE UNIT*

CONSTRUÇÃO IDENTITÁRIA DO ENFERMEIRO DIANTE DO PROCESSO DE DISTRESSE MORAL EM UM CENTRO DE TERAPIA INTENSIVA*

CONSTRUCCIÓN IDENTITARIA DEL ENFERMERO ANTEEL PROCESO DE ANGUSTIAMORAL EN UN CENTRO DE CUIDADOS INTENSIVOS*

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ABSTRACT

Objective: to understand nurses' identity construction in the face of the moral distress process, from the perspective of intensive care nurses. **Methods:** qualitative, descriptive, interpretive and analytical study, developed in 2016 in an intensive care center of a university hospital. Twelve nurses from the day shift participated in the research. Data collection took place through interviews guided by a semi-structured script and the data were submitted to thematic content analysis. **Results:** from the nurses' perspective, the relationship between the identity configuration and moral distress occurred through experiences of situations in the daily work at the ICU that prevent them from exercising the practice as they believe it is the correct way, such as: the model of care of work organization; the development of technical-assistance activities to the detriment of care management; work more mechanically than intellectually; not belonging to the health team; and organizational aspects such as intense work schedules, the relationship with coordination and difficulties in implementing improvements in the work process. **Final considerations:** it was concluded that the nurse's work is permeated by experiences of moral problems that influence the construction of identity and their ethical commitment to provide the care that they deem appropriate for critical patients. This is because identity is built from the perception of oneself and one's work and is influenced by interpersonal relationships, the organization of work and their daily experiences. **Keywords:** Nursing; Social Identification; Morale; Ethics, Nursing; Intensive Care Units.

RESUMO

Objetivo: compreender a construção identitária do enfermeiro diante do processo de distresse moral, na perspectiva de enfermeiros intensivistas. **Métodos:** estudo qualitativo, descritivo, interpretativo e analítico, desenvolvido em 2016 em um centro de terapia intensiva de um hospital universitário. Participaram da pesquisa 12 enfermeiros do turno diurno. A coleta de dados se deu por meio de entrevistas orientadas por roteiro semiestruturado e os dados foram submetidos à análise temática de conteúdo. **Resultados:** na perspectiva dos enfermeiros, a relação entre a configuração identitária e o distresse moral se deu mediante vivências de situações no cotidiano do trabalho no CTI que os impedem de exercer a prática conforme acreditam ser o modo correto, tais como: o modelo assistencial de organização do trabalho; o desenvolvimento de atividades técnico-assistenciais em detrimento da gestão do cuidado; o trabalho mais mecânico do que intelectual; o não pertencimento à equipe de saúde; e aspectos organizacionais como as escalas de trabalho intensas, o relacionamento com a coordenação e as dificuldades em implantação de melhorias no processo de trabalho. **Considerações finais:** concluiu-se

que o trabalho do enfermeiro é permeado por vivências de problemas morais que influenciam na construção identitária e no seu compromisso ético em prestar o cuidado que julga ser o adequado ao paciente crítico. Isso porque a identidade constrói-se a partir da percepção de si e do seu trabalho e é influenciada pelos relacionamentos interpessoais, pela organização do trabalho e suas vivências no cotidiano.

Palavras-chave: Enfermagem; Identificação Social; Moral; Ética em Enfermagem; Unidades de Terapia Intensiva.

RESUMEN

Objetivo: comprender la construcción identitaria del enfermero ante el proceso de angustia moral, desde la perspectiva del enfermero de cuidados intensivos. *Método:* estudio cualitativo, descriptivo, interpretativo y analítico, llevado a cabo en 2016 en el centro de cuidados intensivos de un hospital universitario. En la investigación participaron 12 enfermeros del turno diurno. La recogida de datos se realizó mediante entrevistas semiestructuradas; los datos fueron sometidos a análisis de contenido temático. *Resultados:* desde la perspectiva de los enfermeros, la relación entre la configuración identitaria y la angustia moral se dio a través de vivencias de situaciones en el día a día de trabajo en la UCI pues sienten que no pueden ejercer la práctica de la forma que consideran ser más correcta, tales como: el modelo asistencial de organización del trabajo; el desarrollo de actividades técnicas y asistenciales en vez de gestión del cuidado; trabajo más mecánico que intelectual; no pertenecer al equipo de salud; y aspectos organizativos como horarios de trabajo intensos, la relación con la coordinación y las dificultades para implementar mejoras en el proceso de trabajo. *Conclusión:* el trabajo del enfermero está impregnado de vivencias de problemas morales que inciden en la construcción identitaria y en su compromiso ético para brindar los cuidados que estiman oportunos para el paciente crítico. Esto se debe a que la identidad se construye a partir de la percepción de uno mismo y de su trabajo y está influenciada por las relaciones interpersonales, la organización del trabajo y sus vivencias diarias.

Palabras clave: Enfermería; Identificación Social; Moral; Ética en Enfermería; Unidades de Cuidados Intensivos.

INTRODUCTION

Identity construction results from socialization processes that are added during the whole human development process. During these processes, work plays a central role by which man reconstructs himself,¹ due to experiences, challenges and established relationships.

Work is configured as a means of "being" and "being with" the other, resulting in a complex of experiences, which can lead to facing ethical problems. In this sense, experiences in the work context can redefine the perception of oneself and, consequently, influence the construction of professional identity.

Regarding the work of nurses in Intensive Care Unit (ICU), there is a performance marked by particularities expressed, among other aspects, by the rigidity of the processes, the emotional tension and the constant decision making.² Therefore, the work at ICU does not happen in a linear way, being built every day, alive in action and integrated with the use of various technologies.³

The aforementioned aspects associated with the proximity of relationships between professionals, patients and family members, inherent to the ICU, favor the occurrence of experiences of moral problems.^{2,4} Thus, in order to support the process of moral deliberation, the nurse needs to judge the problems that present themselves, in line with their technical-scientific knowledge and their ethical-moral conception.

Acting and deliberating permeate the movement of reflection on oneself and on the problem situation, choosing the most appropriate resolution behavior, which is not always consistent with previously established "recipes".⁵ In this sense, the experiences of moral problems by nurses involve reflection about himself/herself, influencing the professional's identity construction.⁶

Therefore, it is apprehended that in the process of constructing the identity of nurses, in addition to the professional training resulting from graduation, the experiences in different contexts and spaces of socialization also participate, here also encompassing work, in which beliefs, attitudes, norms are externalized and values that will make up the identity framework.⁷ This process is not restricted to the transmission of norms, conducts, individual values or ways of acting, but comprises a complex field of representations that involve the identification and belonging relationships of the subject.⁶ In this field, the experiences of ethical problems integrate the process of identity and ethical construction of the subject.

However, at work, the nurse has found obstacles to act in line with his/her judgment, whether for institutional and/or relational issues, preventing him/her from acting,^{4,8} then characterizing the process of moral suffering.

Moral suffering is triggered by the recognition of an ethical-moral problem experienced by the individual, which requires judgment. However, the judgment itself does not always lead to the desired action, given that barriers can stand in the deliberative process, preventing the individual from exercising it in accordance with his/her moral judgment. In this case, the individual's experience of moral suffering is triggered, with consequences such as: anguish, isolation, dissatisfaction and, in more severe cases, illness and removal from work.⁵

The marks left by the experiences of moral suffering are capable of promoting the disruption of the subject's moral integrity.^{5,9} For nurses, acting or not in accordance with ethical-moral conceptions has an individual impact on the construction of their identity and collectively in the organizational space, because the expression of their moral conception and practice is presented in deliberation. In addition, nurses' experiences promote identity ruptures, which hurt

their values, causing suffering, insecurity and loss of protagonism, in addition to the development of a negative image of themselves.⁴

Considering that socialization takes place in the professional's relationships with himself/herself, with the other and in the expectations and realities related to the activities performed,⁶ a question emerges: how does the nurse's identity construction take place in the face of the moral distress process?

The aim of this article was to understand the nurse's identity construction in the face of the process of moral distress, from the perspective of intensive care nurses.

METHODS

Qualitative, descriptive, interpretative and analytical research developed in an intensive care center of a university hospital located in the state of *Minas Gerais*, Brazil.

The intentional choice of the scenario considered that important changes in the organizational scope promoted new arrangements in the nurse's work, highlighting hospital management by the Brazilian Hospital Services Company (*Empresa Brasileira de Serviços Hospitalares - EBSEH*), which instituted the public entrance exam as a way of admission and adoption of the global model of care as a Nursing model of care. Through this model, the nurse started to assume full assistance to the patient, assisted by the Nursing technician, developing care "at the bedside". Organizational changes and work arrangements have great potential to promote identity reconstructions, which is why the choice of this scenario suited the objects of the study on screen.

The choice of participants was intentional and considered that there are singularities between the organization of day and night shift in the hospital, thus defining the participation of nurses who worked only during the day shift at the ICU as an inclusion criterion. In this way, the total sample of 20 nurses who worked during the day in the sector was established. Twelve nurses participated in the present study, who freely and spontaneously agreed. It is noteworthy that, among the non-participants, two nurses were taking regular holidays at the time of data collection and six refused to participate.

Data were collected in February 2016 through an interview guided by a semi-structured script, being held at the hospital itself, in a restricted location, at a previously scheduled time. The interviews were recorded on an electronic device and lasted, on average, 30 minutes. They were conducted by a previously trained researcher, who introduced himself to the interviewee and clarified the objectives and ethical aspects, collecting the interviewee's consent. After the interview, the respondent was able to listen to it in its fullness, so that, it could be modify, delete or add some information if it were considered necessary.

The interviews were transcribed in full and the data were submitted to thematic content analysis, according to the chronological poles of the pre-analysis of the material, the exploration

of the material and treatment of the results and the inference and interpretation. The pre-analysis phase was based on the organization and floating reading of the material, with the delineation of the central themes. The exploration of the material and the treatment of the results allowed to make them meaningful and valid through the analysis of two thematic categories: the nurse's identity and the experience of moral distress. The last step consisted of inference and interpretation of the data, in which the two initial thematic categories were related and presented as a synthesis of them.¹⁰

The research was carried out in accordance with the ethical principles expressed in the Declaration of Helsinki and in the Resolution of the Brazilian National Health Council Nr. 466 of 2012. It was submitted to ethical review and approved by the Research Ethics Committee of the *Universidade Federal de Minas Gerais* under the Opinion Nr. 1,237,831, on September 21, 2015. All participants signed an Informed Consent Form, expressing their agreement to participate in the study and attesting to the discomfort, risks and benefits of the research. In order to guarantee anonymity, the statements were coded as Nurse, followed by the number of the respective interview.

RESULTS

The identity construction goes through the subject's understanding of himself/herself and the expectations and experiences he/she has in relation to work. In the nurses' perspective, the relationship between the identity configuration and moral distress occurred through experiences of situations in the daily work at the ICU that prevent them from performing the practice as they believe it to be the correct way, disfiguring the profession.

Nurse 8 emphasizes Nursing as a pillar to support her identity configuration in the personal and professional scope.

For me, being a nurse means support, one of the personal structures that is the profession. Being a nurse is a pillar of my life (Nurse 8).

Nurse 9 and Nurse 1 highlight the importance of work organization in the construction of identity. In this regard, the participants referred to the model of care adopted at the ICU, called "nurse at the bedside", which prioritizes activities aimed at direct patient care, causing strangeness regarding management activities being demoted to the background. Such strangeness is the trigger for nurses to experience the process of moral distress.

Here at ICU we are assistant nurses. So, it is a little different! It diverges well from that practice of other services, in which we were managers, supervisors, we supervised the technician's service. Here we do a technical service, more direct care, which is also very noble (Nurse 9).

Here was our first experience as an assistant nurse, even though I consider the name wrong for what I do, I think that every nurse is assistant and I even think that the name, the terminology, ends up making the assistant nurse as if he/she were smaller than another nurse, for example, the manager (Nurse 1).

According to Nurse 1, the exclusive development of technical-assistance activities limits the practice directed to private nurses' actions, linked to care management. In this sense, the nurse recognizes that this practice does not match what he/she believes to be the correct one, expressing dissatisfaction with the disorganized work and the impossibility of applying Nursing scales and indicators that they consider to be their responsibility in the management of care.

The nurse could be a care manager, I do not think the nurse here manages care and this is a problem. Then, it shows, once again, a disorganization of Nursing, because in an ICU we have 12 nurses for 16, 14 patients per day, 12 nurses plus 5 technicians, there is no Nursing Activities Score scale applied. There is no Therapeutic Intervention Scoring System applied, I have no evaluation of pressure ulcer indicators nor of an indicator of bloodstream infection, there is no indicator at all (Nurse 1).

Regarding not carrying out the practice consistent with what they believe, Nurse 12 and Nurse 1 refer that they perform a mechanical rather than intellectual work, feeling like replacements for Nursing technicians, which generates ruptures in the construction of identities and moral distress.

I think the work I should be doing is much bigger, but less tedious. Today my job is a heavy job, a heavy load. And I will talk to you, I use my mind just a little. I think it is more about a technical work, it is a work of heavier performance, more manual and less reflective (Nurse 12).

We came, in our mind, to qualify the care and here they made a bit of a point of putting us in the technician's place (Nurse 1).

Another aspect that interferes with the construction of professional identity and generates moral distress in nurses is related to belonging to the health team. In this regard, Nurse 2 reflects on the challenge to carry out care as he thinks it is correct due to the lack of sharing information between team members, making clinical assessment and proper conduct by nurses unfeasible. Nurse 11, on the other hand, mentions that the lack of autonomy and integration among the other members of the multidisciplinary team limits the

nurses' actions in their field of knowledge, preventing them from acting according to their practice.

When you are going to make a diagnosis of the patient you will write down "risk of bleeding", but how am I going to write down a risk of bleeding if I don't know the patient's prothrombin time, if I don't know the patient's activated prothrombin time? So, when we can get this and, depending on who is on duty, he/she goes over it in a correct way. But we cannot do it because there are professionals who do not share the data, so I cannot work properly (Nurse 2).

A good scale does not help if the team is closed for nurses to act. It must be a joint work with the other professionals to give space to the nurse and then we can work in the right way. Here there is a status problem, so, as long as there is no horizontal assistance from a multiprofessional team, instead of a medical team and the nurse working for the doctor, we are not going to make any improvement here (Nurse 11).

Another obstruction in the nurses' ways of acting in line with their intentionality concerns the organizational aspects represented by situations such as intense work schedules, the difficulty in relating to coordination and the difficulties in implementing improvements in the work process.

We have a shortage of professionals, making our work more difficult. I do not have enough professionals to meet the demand. The schedule is extremely aggressive, perhaps not even human. The professional who works in intensive care has a Saturday and a Sunday off in 30 days of work, it is extraordinarily not enough! (Nurse 6).

So you are exposed to the suffering of the other, to this closed, cold, stress-filled place, of professionals, with all the anxieties that we experience from this model of care that has changed and we cannot do things properly. It is complex. So, people are really getting emotionally sick here, there is no time for family, time off (Nurse 1).

In view of all the situations presented above that generate discontent inherent in the fact that they do not act as they would like, nurses experience moral suffering and demonstrate that such experiences have a negative impact on their identity constructions. Nurse 10 and Nurse 9 express this situation with statements that question the choice of the profession and the motivation to perform it.

I think it is a lot of wear, I like what I do, but if I were to choose, I do not know if I would do it again, understand?! It is exhausting, it is stressful (Nurse 10).

You must like Nursing, there is no other way. Because we are not valued, there is no value for the medical team, there is no financial value, nor for the institution. So, to be here with the patient, taking care of the other, giving the nurses' time, knowledge, care, affection for another person without being a nurse as they should, you really have to like it, because otherwise we would not do (Nurse 9).

DISCUSSION

The findings of the present study point to the complexity of the nurses' work in the ICU and to the fact that the construction of their identity occurs in the articulation of the triad between the perception of the self (being), the influences of the work environment and interpersonal relationships. The meaning of "being a nurse" characterizes the identity assumed by the participants, being fundamental for the exercise of professional practice while the organizational and team configuration are decisive for their recognition, considering their professional expectation. It is in this relationship that the experiences in the daily work at the ICU prevent nurses from exercising the practice as they believe it is the correct way can generate ruptures in identity and moral distress.

It is important to consider that the identities of individuals are built through work, which becomes important for social and personal recognition. Under this prism, the nurse's identity is constructed, in part, by the professional identity,^{6,11} established during graduation, in a professional socialization process⁸ in which the profession is formally presented to the individual and he attributes meaning to the information received, subjectifying him/her and applying them in daily work. As shown in the results, Nursing is considered part of the subject's identity in his/her personal and professional scope.

Professional socialization is a component part of the construction of identity, since it is through it that the individual experiences, accumulates new information and, while reflecting, he/she builds himself/herself as a subject. In analogous thinking, it is through the moral experiences of socialization that reflection and acting on moral grounds are developed in the individual, in a movement to construct the ethical subject.¹² It is noticed that the same process that configures the individual's identity also constructs him/her through the experiences in the recognition of moral problems in the work environment, being a process in constant transformation. Thus, it was noticed by the results of the present study that the situations that nurses experience while building and strengthening identity are also sources of moral suffering for them, corroborating the findings of other studies.^{12,13}

The nurse, as an ethical subject, expresses him/her ethical-moral conceptions regarding the care he/she must offer to the patient through daily deliberations¹³, in the way of caring was marked as an identifier of the nurse's work in this scenario. However,

in the findings of this study there are notes made by nurses that they are unable to provide care in the way they believe to be appropriate and based on technical-scientific conceptions in the field of Nursing knowledge. The obstacles that prevent them from deliberating according to the morally correct action refer to organizational aspects such as intense work schedules, relationship with coordination and difficulties in implementing improvements in the work process, assistance model of work organization, development technical-assistance activities to the detriment of care management, work with a more mechanical than intellectual focus and not belonging to the health team.

Regarding organizational limitations, it was noticed that they are an obstacle for the professional to perform his/her activities according to what he/she believes to be consistent with his/her ethical-moral values. In this regard, studies reveal that ethical-moral situations that impact on the non-execution of care in accordance with what the professional believes to be adequate enhance the experience of moral suffering at work.^{4,5,14-16} This experience is highly related to the ways of organizing the work of nurses,¹⁷ which follow as barriers to the realization of professional deliberations.

In this field, work organization, such as the model of care, the excess of technical activities, the scales of reduced days off and the impossibility of applying scales and Nursing indicators that they consider to be their responsibility in the management of care enhance the distance between the care provided in practice and care understood as appropriate to the patient. This reality has a direct impact on the quality of the work performed⁴ and on the concept of "being a nurse"¹³, that is, on the nurses' identity configuration and on experiences of moral distress. In this sense, a similar result was identified in a study that found that situations typical of the organization's daily life and the accumulation of tasks made it impossible to develop specific duties for nurses, compromising patient care,¹⁷ generating dissatisfaction and suffering in the professional. It is noteworthy that conflicting situations of daily work, which translate into experiences of contradictory feelings, frustration and demotivation for work, are triggering processes of moral distress.^{14,16,18}

The performance of technical-assistance activities to the detriment of care management refers to the contradiction related to the performance of managerial and assistance activities, especially when these are polarized, and in fact, they are substantiated by complementarity.¹⁹ In view of this polarization made explicit in the nurses' statement, negative feelings emerged related to the lack of recognition and differentiated appreciation of work among supervisory and care nurses. This is because the nurse is unable to deliberate in accordance with what he/she deems morally appropriate regarding care management, which weakens the perception of himself/herself as a nurse and characterizes experiences of moral distress.²⁰

As for the question related to the nurse's belonging to the health team, the findings reveal the nurses' difficulties in exercising their practice within the team, whether due to lack of recognition, due to the hegemonic medical culture that imputes the subordination of their practice to the medical work or for lacking a collaborative practice between members. With these relational barriers, the nurse is unable to carry out his/her action, given that he/she understands that his/her practice needs to be joint and collaborative with the other members of the multidisciplinary team. When he/she does not find resonance to perform it according to his/her judgment, his/her practice is impaired regarding actions aimed at the needs of patients. Thus, one perceives the restriction of professional autonomy, already described by researchers as also generating moral distress.^{13,21}

Moral suffering generates identity impacts when the professional is unable to deal with the initial suffering, triggering the experience of reactive suffering, which is capable of providing a break with the individual's moral integrity.⁵ There is, in moral integrity, the inseparable relationship between the personal and professional spheres, thus inferring that the rupture of moral integrity, influenced by nurses' experience of moral distress, is related to their identity configuration.¹⁸

The moral suffering experienced by nurses has contributed to the occurrence of identity crises, manifested mainly in the fragility of the perception of themselves and their work. This corroborates researchers who defined it as invisibility of the self, that is, the invisibility that nurses have of themselves when they do not perceive themselves as such in their daily lives and question themselves and their work.¹³

The present study allowed us to understand that the identity configuration is changeable and procedural, as well as the moral experience, which are permeated by institutional, relational issues, knowledge and practices. Nevertheless, the experience of moral distress is productive in the sense of maintaining the nurses' reflection on the involvement of moral issues in their daily work.^{5,18}

It is important to highlight the limitation of the study regarding its performance in a single hospital, assuming that some particularities are inherent to the scenario. Still, it is important to reflect on the implications of choosing the conceptual framework for the analysis of moral distress, which the researchers needed to adhere to. This framework requires special attention to the complexity that involves the moral problem, and the possible outcomes of the analysis of this problem are specific, including moral distress.

CONCLUSION

It was apprehended by the study that the nurse's work at the ICU is permeated by moral problems that influence his/her identity construction and his/her ethical commitment to provide the care he/she deems appropriate to the critical patient, which may culminate in experiences of moral distress.

In this commitment, it is up to the nurse to deliberate on the daily problems, considering the ethical-moral precepts constructed throughout life as the guiding principle for deliberation, based on family formation, socialization, norms and professional training. However, the deliberative process is not always carried out, culminating in experiences of moral suffering and ruptures in identity, often fostered by issues that relate to institutional organization and interpersonal relationships in the context of work.

It is important to highlight the adherence to the methodology adopted to carry out this investigation, which allowed us to understand the experience of the moral distress process and its interference in the identity construction of the ICU nurse.

Still, it is necessary to promote studies and expose these results to health services, allowing reflections on the part of nurses and organizations on the construction of professional identity and the ethical subject and their relationship with moral conduct in face of ethical-moral problems that they involve and demand their positioning, strengthening deliberative processes in order to minimize moral distress at work and its consequences.

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