Healthcare Advocacy and Moral Distress in the Practice of Nurses

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Abstract

Background: By focusing in prioritizing patients and their rights, occasional limitations may arise and prevent nurses from doing their work according to their social and professional commitment. This may culminate in Moral Distress, resulting from the incoherence between the nurses' actions and their personal convictions.

Research question: Is there any relationship between healthcare advocacy and moral distress in the practice of nurses working in hospitals?

Objective: Analyzing the relation between healthcare advocacy and moral distress in the practice of nurses working in hospitals.

Research design: Quantitative, analytical cross-sectional study. The data collection instruments comprise the *Moral Distress Scale Revised* – Brazilian version and the *Protective Nursing Advocacy Scale* – Brazilian version. Data analysis was carried out with elements of descriptive statistics, Pearson's correlation and linear regression analysis.

Participants and research context: The participants comprised 157 nurses working in two hospitals located in a city in southern Brazil. One of the institutions is a public university hospital and the other is a philanthropic institution.

Ethical considerations: All the international directives for research with human beings were observed.

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Findings: The constructs *barriers to the advocacy practice* and *negative implications to the advocacy practice* were pointed out as predictors of moral distress.

Discussion: The situations approached in this study illustrate that certain organizational and cultural contexts have negative impacts on nurses, who are in constant contact with the necessity of promoting patient well being and increasing access to healthcare, especially under the perception of vulnerability in risk situations, or when the quality of the services provided decreases and patients are not given adequate assistance.

Conclusion: We hope that this study encourages the reflection about the relationship between patient advocacy and moral distress, and the search for resources that may contribute to the quality of the assistance provided by nurses.

Keywords

Healthcare Advocacy; Morals;
Nursing; Nursing Ethics;
Practice Patterns, Nurses.

Introduction

In healthcare environments, the nurse is responsible for coordinating the work of the other nursing professionals, planning and organizing healthcare activities in order to ensure adequate conditions for the assistance given to patients, as they are in constant need of the knowledge of healthcare professionals, the respect for their rights and the acknowledgement of their human condition. That responsibility reinforces the pressing commitment of the nurses working in hospitals [1].

It is important to note that the development of clinics and healthcare technologies towards socio-cultural, scientific and legal changes bring up implications for the promotion of more dynamic and versatile practices, whereas the solution of previously insoluble problems coexists with ethical dilemmas that are becoming more and more complex [2].

Among those dilemmas, especially noteworthy are those related to the inequality in the access to healthcare technology and resources, as well as negligence over patients' right to self-determination,

who demand more and more information about and control over their care [1, 3].

Background

Concerning nursing philosophy, nursing education and position in the health system, defending patient rights and interests is becoming more and more important as an integral part of the nurse's work. It has been described as an ethical and legal obligation, and more recently, as an ideal for the practice of the profession, which characterizes the term "advocacy in healthcare" [3].

Therefore, the political role performed by the nurses to healthcare users have been recognized as such, and has been considered one of the key concepts in nursing ethics. Advocacy has been discussed in the literature since 1973, when the International Council of Nurses (ICN) introduced the concept in the Code of Ethics of the profession [4].

The term comes from the Latin "advocatus", in English "advocate", and means the person who

defends or judges another person [2]. Advocacy is considered an important part in the guarantee of patient rights and safety, not only to achieve the results expected by the professionals, but also to act in favor of those who are not able to defend themselves [3].

Thus, advocacy in health care may help nurses become professionals that are confident and able to protect themselves, their profession and the patients under their care [5]. Although there is not only one concept of advocacy, it can be defined as a competence inherent to professional practice, and whose purpose is to help patients understand their rights and choices, to defend their rights and interests, preserving their safety, privacy and autonomy in decision making, ensuring quality health care and serving as a mediator between the patients and the healthcare environment [6].

Patient advocacy is also performed by other healthcare professionals. However, nurses stand out in that role precisely because of their close relationship with patients and the fact they spend more time in healthcare units. This facilitates a greater interaction in the therapeutic relationship and a deeper involvement in the patients' health, who in their majority need constant clarifications concerning their clinical state, needs and desires [7].

Also, when the nurses advocate for their patients, they may face a number of obstacles related to the institution, lack of support and ruptures in the multi-professional relationships within the healthcare environment. Several barriers may come up, and they weaken the nurse's confidence to approach the patients' rights, choices and assistance quality [8].

Such situations may cause moral distress, something common in the clinical practice. Verified especially among nurses [9], moral distress is the phenomenon in which the professional knows what the right action to be taken is, but feels hampered in their practice due to incompatibilities between their values and beliefs and the dominant needs and points of view in the working environment [9, 10].

Such phenomenon may threaten the integrity of those professionals and the quality of the assistance given, since the professionals believe that a certain action would be the best to be adopted, but perceive it as almost impossible, due to limitations in their practice, either because of internal factors, such as conflict of values, unawareness or fear, or because of external factors, such as administrative, legal and social constraints [10].

Moral distress occurs especially when the nurses feel they are prevented from acting according to their knowledge or what they consider ethically correct, and this situation causes a cognitive-emotional dissonance [9]. It may also be caused by situations related to the nature of the activities performed, disrespect for the patients or conflict in the working environment [10, 11].

Moral distress could also be defined as a painful feeling or psychological imbalance resulting from recognizing an ethically correct action that cannot be performed because of hindrances such as lack of time, reluctant supervisors or a power structure that may inhibit a moral action [9].

The necessity of identifying the relation between healthcare advocacy and moral distress experienced in the professional everyday routine of nurses working in hospitals justifies this study. Not exerting healthcare advocacy may culminate in the experience of moral distress, which may have an effect on the potentialities of these professionals, causing a decrease in the quality of assistance and even make them abandon the profession's ideals [12].

Based on the above considerations, we can see that the understanding of this phenomenon and its possible relation with the work routine is fundamental for reconsidering professional practices of nursing and adopting actions that may facilitate and prepare for the exercise of healthcare advocacy, thus favoring an ethical, autonomous, and humanized care.

Objective

Analyzing the relation between healthcare advocacy and moral distress in the practice of nurses working in hospitals.

Research design

Quantitative, analytical cross-sectional study.

Participants and setting

The study was conducted in hospitals, one of which characterized as a public university hospital and the other characterized as a philanthropic institution. Both hospitals are located in a city in southern Brazil. This city stands out because it is the biggest port complex in southern Brazil and because it has a great educational system that includes a federal university, a private university and a federal polytechnical school, attracting students from several places in Brazil. The population of the city is estimated at 200 thousand inhabitants.

The participants of the study were 157 nurses working in hospitals. The participants were selected through a convenience nonprobability sampling [13]. Thus, all the nurses that were present at the institutions mentioned above and that were working during the data collection period were invited to participate in the study, as long as they met the inclusion/exclusion criteria [14].

- The inclusion criteria were: being a nurse, working at one of the selected hospitals, having worked for over six months in that institution. We set the minimum limit of six months because we believe that is the time needed for adapting to the routine and organization.
- The exclusion criteria were: being absent from work at the moment of the data collection due to vacation leave, strike, sick leave or other kinds of leaves; being a temporarily hired professional.

In order to select the sample size, we adopted a specific formula to estimate the minimum sample size that would enable certain statistical procedures [15]. After learning that the two hospitals totaled

235 nurses, we applied that formula and got to the minimum number of 145 informants. Therefore, in an attempt to select the biggest possible number of participants in order to obtain a safety margin, we reached a total of 157 nurses.

Data collection and Instruments

Data collection was carried out between August and September 2015. For data collection we used two instruments operationalized in 5-point Likert-type scales. In order to analyze intensity and frequency of moral distress experienced by nurses in hospitals, we used the *Moral Distress Scale Revised*, cross-culturally adapted and validated for Brazilian nurses. In order to analyze actions and beliefs of nurses while performing patient advocacy, we used the *Protective Nursing Advocacy Scale* - Brazilian version [13], cross-culturally adapted and validated for the Brazilian context.

For the application of the data collection instruments, we visited the hospitals so that the nurses were invited to participate in the study at their working place and shift. After the procedures related to the ethical aspects of the study, the participants were given out the instruments in a kraft paper envelope, without any identification. Later, at a prearranged date, the envelopes with the filled out instruments were collected.

Data Analysis

For data analysis, two statistical tests were used to ensure the validity of the instruments: factorial analysis to summarize the data by identifying common factors among the questions, grouping them in constructs through the mean of the answers; and Cronbach's alpha to assess the level of reliability of the instruments by identifying characteristics in each group of questions, checking whether the questions in the questionnaire would be able to consistently measure the phenomena in question. Data normality was tested with Kolmogorov-Smirnov test.

In order to analyze the correlation between the quantitative variables, moral distress and advocacy, we used Pearson's linear correlation coefficient. This is a bivariate analysis method that analyzes two dependent variables simultaneously, measuring the intensity of the relation between them [16]. The second type of statistic analysis carried out was the multivariate linear regression, aiming to establish a relationship between moral distress intensity and frequency and patient advocacy, by analyzing a dependent variable with other independent ones. The statistical software SPSS (*Statistical Package for Social Sciences*) version 23.0 was used for data analysis.

Ethical considerations

All the ethical aspects of the study were respected, and the international directives for research with human beings were observed.

Findings

In relation to the sociodemographic data of the sample studied, we obtained a total of 157 nurses from the public university hospital (33.1%) and the philanthropic institution (65%). The majority of the participants were female (88.5%), with an average age of 31.9 years; the youngest was 22 years old while the oldest was 58 years old. The average time of professional education was five years (5.47) while the average work experience in the hospitals was four years (4.64). Most of the nurses (91.7%) are permanent employees.

Concerning the work units, the Adult Admission Unit had the biggest concentration of nurses (23.6%), as well as the highest weekly workload, 36 hours (49.7%). As for the modality of assistance in the work units, assistance through Sistema Único de Saúde (SUS) predominated. Bachelor's degree (Graduação) was identified as the most frequent highest qualification of the nurses (49.7%), followed by Lato Sensu graduate degree (Especialização) (39.5%).

In the scale of moral distress, with analysis of frequency and intensity, through question in the 157 questionnaires and through subsets of questionnaires in each hospital, the instrument showed a satisfactory internal consistency, with Cronbach's alpha at 0.88 for the instrument and between 0.94 and 0.76 for the hospitals. The twenty-one questions of the original instrument were maintained, and for determining the power of association between the questions of the instrument and moral distress, we adopted question q-22 "*In a general way, I experience situations of moral distress in my work routine*".

The Protective Nursing Advocacy Scale - Brazilian version was used for assessing the beliefs and actions of nurses' patient advocacy. It is composed of 20 items, arranged in five constructs: *negative implications of the advocacy practice, advocacy actions, facilitators to the advocacy practice, perceptions that favor advocacy practice, and barriers to the advocacy practice*. After analyzing the main components, question q10 was excluded from the instrument because it showed low factorial load, with a selfvalue lower than 0.500. The instrument's Cronbach's alpha showed a value of 0.78 while the coefficients of the five constructs were between 0.70 and 0.87, as shown in **Table 1**.

Table 1. Factorial analysis of the factors of Patient Advocacy Brazil, 2016

Constructs	Questions	Alfa (α)	Average
Facilitators to the advocacy practice	11, 12, 13, 14, 15	0. 817	3.06
Negative implications to the advocacy practice	1, 2, 3, 4, 5	0. 832	1.78
Advocacy actions	6, 7, 8, 9	0. 833	2.69
Barriers to the advocacy practice	18, 19, 20	0. 708	1.40
Perceptions that favor advocacy practice	16, 17	0. 701	2.94

The descriptive analysis enabled us to find that the construct *facilitators for the practice of advocacy* showed the highest average in the instrument (3.06), which evinces what characteristics and competences of the nurses favor the practice of advocacy, as well as commitment and bigger dedication to nursing.

The construct *Perceptions favoring the practice of advocacy* showed the second highest average (2.94). It is related to the nurses' perceptions concerning advocacy and the assistance given to patients, which may favor the nurses' actions as advocates, especially regarding the perception of vulnerability. Next, the construct *Advocacy actions* (2.69), which indicates multidimensional advocacy actions by nurses, such as acting and speaking on behalf of the patient, varying according to the clinical context.

The construct *Negative implications of the advocacy practice* showed an average of 1.78. It indicates that consequences of the practice of advocacy are relevant to the nurses, as they may culminate in job loss and even negative labeling by coworkers. On its turn, the construct *Barriers to the advocacy practice* obtained the lowest average (1.40), demonstrating that barriers that hamper or prevent nurses from practicing advocacy may not be perceived.

The Pearson's correlation coefficient enabled us to understand the relationship between patient advocacy and moral distress in the practice of nurses working in hospitals. It summarizes the intensity of association between the variables "Moral Distress" and "Patient Advocacy" by measuring the possibility that the variation in one of them may be associated to the variation in the other, with significance of 5%.

This way, we observed a correlation with moderate intensity between the variables "moral distress" and "Perceptions that favor advocacy practice" (0.455) and correlation with moderate, but defined intensity between the variables "moral distress" and "Negative implications of the advocacy practice" (0.202); "Advocacy actions" (0.294); "Facilitators to

the advocacy practice" (0.294) and "Barriers to the advocacy practice" (0.231), evincing the existence of a correlation between Moral Distress and Patient Advocacy (**Table 2**).

In the assessment of the effects of the five constructs in relation to patient advocacy, we used the regression model, with question q-22 "*In a general way, I experience situations of moral distress in my work routine*" as the dependent variable. The results showed significance relation at 5% in all the constructs. With the adjusted coefficient of determination, the test obtained the value of 0.84, representing 84% of explanation of Moral Distress obtained with the instrument used.

Table 2. Correlation between the constructs of patient advocacy and moral distress. Brazil, 2016.

Constructs	Low, but defined	Moderate
Negative implications to the advocacy practice	.202*	
Advocacy actions	.294**	
Facilitators to the advocacy practice	.294**	
Perceptions that favor advocacy practice		.455**
Barriers to the advocacy practice	.231**	

*:correlation at 95%; **: correlation at 99%.

Table 3. Regression analysis of variable q-22– with the constructs of patient advocacy. Brazil, 2016.

Variable	Beta (β)	Sigma (ρ)
Negative implications to the advocacy practice	.165	.039*
Advocacy actions	-.090	.278
Facilitators to the advocacy practice	.063	.500
Perceptions that favor advocacy practice	.126	.157
Barriers to the advocacy practice	.211	.008*

*: Significance level at 95%.

Table 3 shows the perception of Moral Distress referred to the five categories obtained, with question q-22 as the dependent variable.

The order of influence for moral distress was presented by Beta index, showing that the variable "Barriers to the advocacy practice" creates a greater impact in the perception of moral distress ($\beta = 0.211$), especially when the nurses experience moral distress, which is evinced by question a18 "*I am not an efficient advocate because I am suffering burnout and/or moral distress*", shown to be the greatest predictor of moral distress in this construct ($\beta = 0.236$ p 0.009).

The construct "Negative implications of the advocacy practice" ($\beta = 0.165$) was shown to be the situation with the second greatest impact on moral distress, especially highlighted in question a02 "Nurses that speak out on behalf of patients may face retribution from employers" ($\beta = 0.224$ p 0.034) and question a04 "Nurses that speak out on behalf of vulnerable patients may be labeled as disruptive by employers" ($\beta = 0.187$ p 0.048).

In order to determine the power of association between moral distress and the healthcare units where it occurs, we also used question q-22 "In a general way, I experience situations of moral distress in my work routine", which enabled us to verify that nurses working in the Emergency unit obtained the highest average in the instrument (6.83), followed by the management unit (6.10).

In order to identify the units that claimed to develop more advocacy actions in healthcare, the construct Advocacy Actions established was as the variable analyzed in those work units. The Emergency unit also showed the greatest average of advocacy actions in Healthcare (2.75), followed by the managing nurses. **Table 4** shows the intensity of moral distress and the advocacy actions found in the work units that composed the sample of this study:

In order to verify the existence of possible differences in the nurses' perception concerning the difficulties for patient advocacy practice, several va-

riance analyses were carried out, considering the constructs of advocacy and the following healthcare units: Emergency; Adult Admission Unit; Mother-child Admission Unit; Adult-Neonatal ICU; Surgical Ward; Management and Others. In the existence of

Table 4. Average of moral distress intensity and average of advocacy actions found in the work units. Brazil, 2016

Unit	Moral Distress	DP	Advocacy Actions	DP
Emergency	6.83	6.45	2.75	1.03
Adult Admission Unit	3.73	4.34	2.64	0.91
Mother-child Admission Unit	5.27	5.03	2.59	1.15
Adult ICU	3.67	5.00	2.61	0.79
Surgical ward	5.55	4.73	2.62	0.74
Management	6.10	4.79	2.65	0.82

Table 5. Comparison between the hospitals, concerning the constructs "Barriers to advocacy practice" and "Negative implications of the advocacy practice", Rio Grande, RS, Brazil, 2015.

Duncan alpha = .05	Barriers to the advocacy practice	Negative implications to the advocacy practice	Advocacy Actions	DP
Hospitals	1	2	1	2
Emergency	1.05*	-	1.61*	-
Adult Admission Unit	1.17*	-	-	-
Mother-child Admission Unit	-	-	-	2.30*
Adult/ Neonatal ICU	1.12*	-	1.57*	-
Surgical Ward	-	1.98*	-	-
Management	-	-	-	-
Other	-	-	1.42*	-

*: Significance level at 95%.

differences among perceptions at the level of 95%, Duncan test was performed among the subgroups in order to identify homogenous groups with each one of the variables, whose averages did not show significant statistical differences (**Table 5**).

The data in **Table 5** shows that, concerning the barriers to advocacy practice, the nurses that work in the surgical ward experience greater rates (1.98) and, therefore, form an isolated group from the other categories. As for the Negative implications of the advocacy practice, we can notice that the Mother-child Admission Unit shows greater rates (2.30) and thus distances itself from the perceptions evinced in the other healthcare units, which do not show significant differences among each other.

Discussion

According to the results presented, the construct *facilitators to the advocacy practice* obtained the highest average in the instrument, which evinces that personal values, characteristics and competences of the nurses are identified as the main sources of support to advocacy actions in healthcare. Therefore, the characteristics of the nurses may have an effect in aspects that influence patient advocacy practice, especially when the nurses are committed to provide quality assistance and safety to patients [15].

Commitment with the ideals of nursing potentiates the nurse's ability to act in favor of patients. This is similar to the results of a study about nursing care ethics, in which ethics is seen not as a set of rules and principles, but as a way of practical action that demands from nurses moral qualities related to attention, responsibilities, competence and responsiveness, which facilitate decision making through commitment and willingness to act on the patient's behalf [17].

Nurses that are more confident about their actions are able to overcome their personal fears and respond adequately to what a situation involving

moral problems demands, because they are willing to accept the moral commitment of advocating for patients and are properly prepared to help them by clarifying doubts and objectives of necessary treatments [17, 18].

This way, the professional competence based on theoretical and practical knowledge, along with the principles of the code of ethics governing the profession orient the practice and the provision of services necessary for society [18].

The construct *perceptions that favor advocacy practice* showed the second highest average in the instrument, similarly to a study with Brazilian hospital nurses that also highlighted this construct, especially concerning the perception of patient vulnerability [15].

Although not every patient is considered vulnerable, the combination of illness, hospitalization and negative prognosis may hamper a full expression of the patients' opinions and choice, so a mediator is necessary. In this context, the nurses see themselves as the professionals that are capable to defend patients, based on their beliefs and values [6].

It is important to note that situations of vulnerability and risk to patient health impel nurses to act as healthcare advocates, especially when the patients' needs do not seem to be satisfied, or when service quality decreases and when patients are not given adequate assistance [19].

The construct *perceptions that favor advocacy practice* showed moderate relationship with moral distress in situations where nurses cannot take their assistance actions. This corroborates the definition of moral distress [9] when it emphasizes that when the nurses cannot act as they should, according to their principles and values, moral distress is triggered and observed through feelings of powerlessness and incapability, especially in situations where patients cannot or are unable to represent and protect their own rights, desires and needs [15,16,19].

For the determination of power of association between the healthcare units and the instrument of

moral distress, we could verify that nurses working in the Emergency unit show great moral distress, followed by professionals working in administrative tasks.

The occurrence of moral distress in nurses has already been identified with greater emphasis in the emergency unit by another study with Brazilian nurses, highlighting that its origin was associated to the perception of flaws in the nurses' attributions in promoting quality assistance, usually due to overcrowding, lack of space and privacy for patients [20].

Also, it is noteworthy that nurses that have managing positions showed greater average of moral distress when compared to the other units. This is because they are constantly faced with changes in the policies governing healthcare, which may result in an increase in the number of juridical and institutional norms that are more and more complex, as well as several needs for clinical guidance, protocols, strong emphasis in accountability, insufficient number of workers, and constant work pressure. All of this is connected to the ever-increasing social demands that culminate in greater occurrence of moral distress [21].

It was possible to see that there is a correlation between *barriers to advocacy practice* and *moral distress*. This can be explained by the occurrence of conflicts experienced by nurses while performing their ethical practices, when they perceived themselves as being unable to perform certain actions or pressed to perform ethically incorrect actions, due to judgment errors, personal flaws, or even factors deriving from the working environment [22,23]. A similar finding was presented by a study about the organizational and relational restrictions in the healthcare environment, which showed the feeling of guilt and anxiety experienced by nurses when they felt constrained while defending their patients efficiently [7].

The inefficacy of the advocacy practice has been attributed to moral distress and professional

exhaustion issues, characterized in the literature as some of the main ethical problems affecting nurses in all health systems, and considered a threat to the professional integrity and the quality of the assistance provided. Studies indicate that the feeling of inefficacy, in which the nurse perceives that an action that would be the more correct to be adopted is not performed, has its origin in two sets of factors, one formed by internal factors, related to conflict of values, fear and lack of confidence, and the other formed by external factors, connected to administrative, juridical and social barriers [12, 22].

It was possible to identify that, concerning the barriers to the advocacy practice, the nurses working in the surgical ward experience a higher rate of moral distress related to this construct. A similar result was found in a study with American nurses, in which 87.8% of the nurses that worked full-time in the surgical ward pointed barriers to advocacy practice related to powerlessness when facing organizational issues and professional identity issues, and highlighted bureaucracy, increased workload, difficulties to deal with management structures, and the medical hierarchy [6].

Working in a Surgical Ward is considered a challenge, for it poses different working characteristics from the other units, as the nurse gives assistance to the surgical patient as well as support to the other team members. Situations of suffering may be related to the working environment itself, which is characterized as a closed sector with work overload in inadequate proportion, rotational shiftwork, biological risk connected to the handling of perioperative patients and physical risk inherent to the use of X-rays in operation rooms [24].

The complexity of human and working relationships, professional autonomy, high degree of demand regarding competences and abilities, high responsibility and planning of human and material resources cause, over the years, physical, emotional and mental exhaustion [24].

With regard to the particularities of the surgical ward, moral distress was identified in situations with inadequate assistance given by coworkers, late treatments, prolonged hospitalization, disrespect to the choices of patients and incomplete or imprecise information given by the medical team. Besides, the quantity of bureaucratic elements involved in the working environment caused an imbalance in the prioritization of administrative tasks about the defense of patient rights, since lack of time hampers the providing of efficient clinical care [6,8].

Another important relationship between moral distress and advocacy in health relates to the *negative implications of advocacy practice*, evinced more intensely in nurses working in the mother-child admission unit. This finding may be attributed to the necessity perceived by nurses of advocating for patients considered dependent and vulnerable and, at the same time, facing the risk of suffering negative consequences of the advocacy practice [15].

Under this perspective, studies point out that advocacy actions often fail to occur because they are associated with their negative consequences, such as the possible refusal by the other professionals to work as a team with the advocating professional, negative reputation/labeling, situations of moral embarrassment, lack of support from the institution, retribution from employers and even job loss.

In an attempt to change this situation, we highlight that nurses need to develop moral courage to overcome the fear of possible punitive risks related to the adversities of the health systems, so that other nurses can be influenced to exert patient advocacy [18,19]. Nurses that are committed to their professional practice, and supported by the ethical principles of their profession, feel more confident to act autonomously, and this reflects on a better management of conflicting issues that may come up in the working environment [23, 25].

Limitations

This study was carried out with a sample of nurses working in hospitals of a city in Brazil. Although it is significant in the context of the population surveyed, we cannot generalize the results for other contexts and cultures.

Conclusion

The situations approached in this study enable the reflection about the practice of nurses as patient advocates and elucidate the fact that the barriers to advocacy practice and their respective negative implications are predictors of moral distress, considering the complexity of peculiar situations in every hospital. In view of this, advocacy practice in nursing involves constant ethical judgments, professional commitment, continuous assessment and respect to the needs of patients as individuals by valuing every patient's subjectivity.

Although nurses should commit themselves to develop continuously their capabilities to cope with moral distress, healthcare organizations and professional associations also need to develop initiatives to prevent and resolve moral distress, in view of its complexity and the fact that nurses need to develop patient advocacy as a central part in their profession.

The Author(s) declare(s) that there is no conflict of interest.

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