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RESEARCH PAPER (ORIGINAL)

Suffering in primary care nurses

Sofrimento nos enfermeiros em cuidados de saúde primários

Sufrimiento de los enfermeros de atención primaria de la salud

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Abstract

Background: Suffering in nurses is associated with the delivery of care to patients in suffering and factors related to the working conditions. It is a multidimensional experience that occurs in situations of loss, damage, or threat to human integrity.

Objective: To compare the mean scores in the dimensions of suffering (Emotional Pain, Relational Loss, and Avoidance) based on the sociodemographic and professional variables of nurses.

Methodology: A descriptive and cross-sectional study with a quantitative approach was conducted with a sample of 100 nurses. A self-administered questionnaire was applied, as well as the Caregiver Grief Scale for assessing suffering.

Results: Women with children, with a partner, without specialization in nursing, and with more years of service had higher mean scores of suffering. In men, the highest mean scores were found in nurses without children, without a partner, with specialization in nursing, and with more years of service.

Conclusion: Nurses showed higher mean scores of suffering in the dimension of Emotional Pain, followed by Relational Loss, and Avoidance, and suffering was higher among women.

Keywords: mental suffering; nurses; primary health care

Resumo

Enquadramento: O sofrimento nos enfermeiros advém da prestação de cuidados ao doente em sofrimento e de fatores relacionados com as condições de trabalho. É uma experiência multidimensional que ocorre em situações de perda, dano ou ameaça à integridade da pessoa.

Objetivo: Comparar as médias das dimensões do sofrimento (Dor Emocional, Perda Relacional e Evitamento) em função das variáveis sociodemográficas e profissionais dos enfermeiros.

Metodologia: Estudo descritivo e transversal de natureza quantitativa. Amostra constituída por 100 enfermeiros. Foi aplicado um questionário de autopreenchimento e para avaliação do sofrimento a *Caregiver Grief Scale*.

Resultados: O sexo feminino com filhos, com companheiro, sem especialização em enfermagem e com mais tempo de serviço apresentou médias mais elevadas de sofrimento. No sexo masculino, as médias mais elevadas verificaram-se nos enfermeiros sem filhos, sem companheiro, com especialização em enfermagem e com mais tempo de serviço.

Conclusão: Os enfermeiros apresentaram médias mais elevadas de sofrimento na dimensão Dor Emocional, seguida da Perda Relacional e do Evitamento, sendo maior a expressão do sofrimento no sexo feminino.

Palavras-chave: sofrimento psíquico; enfermeiros; cuidados de saúde primários

Resumen

Marco contextual: El sufrimiento de los enfermeros proviene de la prestación de cuidados al paciente que sufre y de factores relacionados con las condiciones de trabajo. Es una experiencia multidimensional que se produce en situaciones de pérdida, daño o amenaza a la integridad de la persona.

Objetivo: Comparar las medias de las dimensiones del sufrimiento (Dolor Emocional, Pérdida Relacional y Evitación), según las variables sociodemográficas y profesionales de los enfermeros.

Metodología: Estudio descriptivo y transversal de naturaleza cuantitativa. La muestra constó de 100 enfermeros. Se aplicó un cuestionario de autocumplimentado y, para evaluar el sufrimiento, se utilizó la Caregiver Grief Scale.

Resultados: El sexo femenino con hijos, con pareja, sin especialización de enfermería y con más tiempo de servicio presentó medias más elevadas de sufrimiento. En el sexo masculino, las medias más altas se encontraron en los enfermeros sin hijos, sin pareja, con una especialización en enfermería y con más tiempo de servicio.

Conclusión: Los enfermeros presentaron medias más altas de sufrimiento en la dimensión Dolor Emocional, seguido de Pérdida Relacional y Evitación, y la expresión del sufrimiento fue mayor en el sexo femenino.

Palabras clave: estrés psicológico; enfermeras; atención primaria de salud

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Introduction

Community and public health nursing focuses on the health of every individual in a community, that is, primary care nurses care for individuals, families, and groups in a healthcare center, at home, or in community organizations, accompanying them throughout their life cycle, listening to their anxieties and problems. These nurses are also responsible for several health promotion and disease prevention activities in a given geographical area, as well as for the identification of needs and the coordination of care with other health professionals and institutions with a view to the continuity and complementarity of care (Regulamento nº 128/2011, de 18 de fevereiro).

The nursing profession is based on ethical values and the nurses' commitment to care for their patients, being characterized by the complexity of continuous care and the close relationship with the patient, family, and other members of the health team (Barlem & Ramos, 2015). It is a stressful profession and nurses must work at a very intense pace, which involves interacting daily with people who are suffering or in pain, other professionals and institutions, as well as performing the planned tasks with initiative, quickly, and without errors. Alienation, the inability to act with creativity in the relationship established with the patient, and the limits imposed by the work organization to the use of their knowledge are often triggering factors of suffering and burnout. Due to overload and stress, the quality of this relationship can be compromised and interfere with the quality of care delivery (Schaefer, 2017). Several studies have found physical, emotional, and behavioral symptoms, such as migraines, fatigue, depression, muscle pain, insomnia, absenteeism, self-medication, stress, and burnout in health professionals (Adwan, 2014), particularly in nurses. In caring for their patients, nurses promote their physical, psychological, and social well-being, while having to adopt an attitude that goes beyond their technical skills, that is, they have to help their patients to overcome their suffering. The act of caring requires an emotional investment from the caregiver. Hence it is natural for nurses to suffer when their patients are in pain. In this naturally interactive process, as regards the valuation of the performance of these professionals, it is important to understand the effects of the repeated exposure to the suffering of others on the nurses' health and psychological well-being. The quality of life and the biopsychosocial consequences of caring for others have been widely discussed in the literature. The majority of studies have examined this phenomenon in patients or informal caregivers (Ramos, Barth, Schneider, Cabral, & Reinaldo, 2016), and only a few studies have focused on the health professionals who are faced with the suffering and death of their patients on a daily basis. Due to the nature of the care they provide and the close therapeutic relationship with the patient/family, nurses are confronted with the suffering of their patients and with their own suffering every day. Therefore, it seems to be generally agreed that studies must be developed to understand this phenomenon in nursing professionals, with a view to preventing and mitigating its impact and raising the awareness of health institutions about the implementation of measures or policies to reduce suffering and overload (Barlem & Ramos, 2015; McCarthy & Gastmans, 2015; Ramos et al., 2016). Thus, the objective of this study is to compare the mean scores in the dimensions of suffering (Emotional Pain, Relational Loss, and Avoidance) based on the sociodemographic and professional variables of these nurses.

Background

The act of caring is the essence of nursing practice because it is through caring that nurses understand the patient's and the family's suffering in its biopsychosocial and spiritual dimension, without neglecting that caring is an act that requires knowledge, responsibility, and affection between those who care and those who are cared for (Coelho & Ferreira, 2015). According to Feneli, Gonçalves, and Azevedo dos Santos, "pain and suffering are unique, personal, non-transferable, difficult experiences that hurt deeply; they can be considered unpleasant experiences" (2006, p. 3). With regrad to nurses' professional practice, they place their knowledge and skills at the service of patients to restore their health. From frustrated hope comes suffering. However, it is important to remember that suffering is mediated by variables that affect the professionals' day-to-day life, namely the socio-cultural and economic aspects, the family obligations, the professional's past experiences with the causes of suffering, as well as other psychological and spiritual aspects (Feneli et al., 2006).

According to Viana (2014), suffering is a complex and challenging phenomenon to express in words. It is subjective, individual, untouchable, invisible, non-transferable, and inherent in the psychological dimension of the human being. Krikorian, Limonero, Román, Vargas, and Palacio (2014) speak of suffering as a multidimensional and dynamic experience of severe stress that occurs when there is a threat to the whole person and can lead to exhaustion. It results from personal experience and can be experienced in various situations where there is loss, damage, or threat to human integrity. It is not possible to live a life without suffering because, in one way or another, with greater or lesser intensity, all people experience it. Thus, it is a universal, biopsychosocial, and spiritual phenomenon that is present in all contexts associated with the disease (Viana, 2014) and has an impact on health professionals. It is accompanied by intense emotions such as sadness, anguish, fear, abandonment, and despair (Adwan, 2014). Its intensity "varies according to the culture, the values, the affective and social world, the feelings of belonging, the ideas, and the choices of the individual" (Coelho & Ferreira, 2015, p. 347).

The factors that trigger suffering can be associated with the working environments in healthcare and how they are organized (Caçador, Ramos, & Brito, 2017), with clinical situations, namely end-of-life and pain management treatments, difficult working conditions, limited resources, structural conditions, moral sources, rigid

schedules, poor staffing, and, consequently, excessive workload (McCarthy & Gastmans, 2015). Nurses' lack of preparation to deal with suffering and death creates feelings that promote suffering (Viana, 2014). Suffering or moral distress is a serious problem that affects nurses in different work contexts and "can generate feelings of dissatisfaction, physical and emotional symptoms, fatigue, staff turnover, and even abandonment of the profession, with a potentially significant impact on the quality of health care" (Schaefer & Vieira, 2015, p. 564). According to these authors, even experienced nurses continue to suffer, which demonstrates the need to strengthen these professionals' ability to cope with loss or suffering in a positive way. Nurses require support and psychological help to cope with human suffering, as well as with their patients' emotions and their own emotions, with the purpose of managing them and preserving their emotional balance, while providing high-quality nursing care (Coelho, Brito, & Barbosa, 2017).

Research question

What is the association between the dimensions of suffering (Emotional Pain, Relational Loss, and Avoidance) and the sociodemographic and professional variables of nurses?

Methodology

A descriptive and cross-sectional study was conducted with a quantitative approach. The target population was composed of all primary care nurses who worked at a Cluster of Healthcare Centers (ACeS) in the interior North of Portugal, in a total of 111 nurses according to information from the Executive Director of this cluster. The Executive Director requested via e-mail the participation of all professionals in this study. Eleven nurses did not return the questionnaire within the stipulated time, which was interpreted as a refusal to participate. The questionnaires were delivered in an open envelope to the nurse responsible for each functional unit who distributed them to the nurses of these units and then collected them and place them in a sealed envelope. Participants completed the questionnaire during work or rest periods, at the most appropriate time for them. The researcher was not present during data collection and had no contact with the participants. A total of 100 nurses participated in this study, which corresponds to 90.09% of the population.

Data were collected using a structured questionnaire divided into two parts: the first part was the sociodemographic and professional characterization of the sample and the second part was the Caregiver Grief Scale (CGS) for assessing nurses' suffering. This scale was adapted and validated for Portuguese primary care nurses by Vasconcelos-Raposo, Pires, Teixeira, & Monteiro (in press). This 11-item scale assesses three dimensions of the caregiver's suffering: Emotional Pain (items 1 to 3), Relational Loss (items 4 to 8), and Avoidance (items 9 to 11). The dimension of Emotional Pain (EP) concerns the current experiences of suffering and other unpleasant emotions related to the loss of someone. The dimension of Relational Loss (RL) refers to losses in the relationship and experiences shared with the patient when he or she was still healthy. The dimension of Avoidance (AV) refers to the person's behavior of protecting themselves from psychological pain, such as the emotions developed in the psychosocial contexts and relationships, which, for nurses, is directly associated with their emotional involvement with the patients. The answers to the items in each dimension are rated on a Likert-type scale where 1 - *totally disagree;* 2 - *disagree*; 3 - *moderately agree*; 4 - *agree*; and 5 - *totally agree* (Meichsner, Schinköthe, & Wilz, 2016). The dependent variable is suffering in different dimensions (EP, RL, and AV), and the independent variables are the sociodemographic and professional characteristics. Data were collected between February and March 2018, entered into a database, and analyzed using IBM SPSS Statistics, version 24.0, based on a matrix of previously encoded data to allow for statistical analysis. Descriptive statistics were used, and no inferential analysis was used because this was a representative sample of the population under study (90.09%). In descriptive statistics, absolute frequencies and relative frequencies were calculated for all variables, as well as the means for each dimension of suffering (EP, RL, and AV). The study obtained a favorable opinion of the Ethics Health Committee of the Regional Health Administration - North and the Executive Director of the cluster, with opinion No. 2/2018 about study T840. The fundamental rights defined in the Declaration of Helsinki and the Nuremberg Code of Ethics were respectd.

Results

The characterization of the sample shows that the minimum age was 33 years and the maximum age was 63 years, with an average of 43.9 years (standard deviation of 7.45). Women were predominant, which is in line with the reality of the nursing profession. The remaining characteristics of the sample are shown in Table 1.

Table 1
Sociodemographic and professional characterization of participants

		N (100)	% (100)
Gender	Male	10	10.0
	Female	90	90.0
Marital status	With a partner	81	81.0
	Without a partner	19	19.0
Existence of children	Yes	81	81.0
	No	19	19.0
Specialization in nursing	Yes	47	47.0
	No	53	53.0
Length of service	< 11 years	20	20.0
	11 - 17 years	50	50.0
	> 17 years	30	30.0
Functional Care Unit	UCC	37	37.0
	USF	35	35.0
	UCSP	28	28.0
Type of schedule	Continuous schedule	88	88.0
	Rigid schedule	8	8.0
	Flexible schedule	4	4.0
Weekly workload	35 hours	98	98.0
	40 hours	2	2.0
Frequency of continuous schedule with fewer members than initially planned	Never	5	5.0
	Rarely	27	27.0
	Sometimes	46	46.0
	Often	18	18.0
	Very often	4	4.0
Frequency of delivery of palliative and hospice care	Never	7	7.0
	Rarely	28	28.0
	Sometimes	38	38.0
	Often	24	24.0
	Very often	3	3.0
Frequency of contact with emergency situations	Never	4	4.0
	Rarely	45	45.0
	Sometimes	41	41.0
	Often	10	10.0
	Very often	0	0.0
Frequency of care delivery to people in suffering	Never	3	3.0
	Rarely	11	11.0
	Sometimes	27	27.0
	Often	47	47.0
	Very often	12	12.0
Frequency of contact with the death of patients	Never	6	6.0
	Rarely	23	23.0
	Sometimes	36	36.0
	Often	32	32.0
	Very often	3	3.0
Frequency of communication of the death of a patient to the family/caregiver	Never	52	52.0
	Rarely	39	39.0
	Sometimes	6	6.0
	Often	3	3.0
	Very often	0	0.0
Informal caregiver	Yes	36	36.0
	No	64	64.0
Reason for being an informal caregiver	Personal choice	22	61.1
	Family decision	11	30.56
	Monetary compensation	0	0.0
	Personal satisfaction/Solidarity	3	8.33

Note. UCC = Community Care Unit; USF = Family Health Unit; UCSP = Personalized Health Care Unit.

Female nurses had higher mean scores of suffering in almost all dimensions of suffering when compared to male professionals. Women with children had higher mean scores in all dimensions of suffering when compared to female nurses without children. In relation to marital status, male nurses without a partner had higher mean scores in the dimensions of EP and RL, while female nurses without a partner had higher mean scores only in the dimension of EP (Table 2).

Table 2
Comparison of the mean scores in the dimensions of suffering based on the sociodemographic variables (gender, marital status, and existence of children)

	Dimensions of suffering		Emotional pain	Relational loss	Avoidance
Sociodemographic variables	Male gender	With children	7.57	12.14	6.57
		Without children	8.33	14.33	6.00
		With a partner	7.44	12.33	6.44
		Without a partner	11.00	17.00	6.00
	Female gender	With children	9.82	15.36	7.94
		Without children	9.56	13.81	7.31
		With a partner	9.68	15.19	7.90
		Without a partner	10.16	14.66	7.55

Male nurses with a specialization in nursing had higher mean scores in all dimensions of suffering. On the contrary, female nurses with a specialization in nursing had lower mean scores in all dimensions of suffering. In relation to length of service, female professionals with more years of service had higher mean scores in almost all dimensions of suffering (Table 3).

Table 3
Comparison of the mean scores in the dimensions of suffering based on the professional variables (specialization in nursing and length of service)

Dimensions of suffering			Emotional pain	Relational loss	Avoidance
Professional variables	Male gender	With specialization	8.25	13.12	7.00
		Without specialization	6.00	11.50	4.00
		Length of service:			
		Up to 11 years	9.00	16.00	5.50
		11-17 years	8.00	10.66	6.33
		>17 years	6.00	16.00	7.55
	Female gender	With specialization	9.23	14.07	7.56
		Without specialization	10.19	15.86	8.03
		Length of service:			
		Up to 11 years	8.77	15.66	7.11
		11-17 years	9.29	14.73	7.59
		>17 years	10.31	15.23	8.19

Nurses who work in a continuous schedule (without lunch break) very often or often with fewer members in the nursing team than initially planned and those who provide palliative and hospice care very often had higher mean scores in the dimensions of EP and RL, respectively. In contrast, those who never provide care in these situations had higher mean scores in the dimension of AV. Nurses who never have contact with emergency situations, with the delivery of care to people in suffering, and with the death of patients had higher mean scores in all dimensions of suffering. Nurses who often communicate the death of a patient to the family/caregiver had higher mean scores in all dimensions of suffering (Table 4).

Table 4
Comparison of the mean scores in the dimensions of suffering based on the professional variables (frequency of continuous schedule, delivery of palliative and hospice care, contact with emergency situations, contact with the death of a patient, and communication of the death of a patient)

	Dimensions of suffering		Emotional pain	Relational loss	Avoidance
Professional variables	Frequency of continuous schedule with fewer members than initially planned	Never	9.60	14.00	8.80
		Rarely	8.40	13.44	7.03
		Sometimes	9.97	15.17	7.56
		Often	10.05	16.94	8.44
		Very often	10.75	12.50	8.75
	Frequency of delivery of palliative and hospice care	Never	9.42	11.85	8.14
		Rarely	9.89	14.85	7.82
		Sometimes	9.92	15.21	8.07
		Often	8.54	14.95	7.12
		Very often	11.00	16.66	5.00
	Frequency of contact with emergency situations	Never	10.75	15.00	8.75
		Rarely	9.73	14.71	7.24
		Sometimes	9.26	15.02	8.02
		Often	9.70	14.80	7.90
		Very often	---	---	---
	Frequency of care delivery to people in suffering	Never	11.33	15.00	9.66
		Rarely	10.18	14.36	8.18
		Sometimes	9.37	14.14	7.37
		Often	9.46	15.27	7.80
		Very often	9.50	15.15	7.00
	Frequency of contact with the death of patient	Never	10.16	14.50	7.16
		Rarely	10.13	14.56	7.60
		Sometimes	9.36	14.72	7.13
		Often	9.28	15.25	8.53
		Very often	10.00	15.33	7.00
	Frequency of communication of the death of a patient to the family/caregiver	Never	9.76	14.98	7.48
		Rarely	9.10	14.76	7.41
		Sometimes	10.16	13.33	9.83
		Often	11.33	17.00	10.66
		Very often	---	---	---

The majority of primary care nurses (98%) has a weekly workload of 35 hours. These professionals with a rigid schedule and those who provide care in the Personalized Health Care Unit (UCSP) had higher mean scores in all dimensions of suffering. Nurses who were also informal family caregivers had higher mean scores in the dimensions of EP and RL. Similarly, nurses who played this role by personal choice had higher mean scores in the dimension of EP (Table 5).

Table 5
Comparison of the mean scores in the dimensions of suffering based on the professional variables (functional care unit, type of schedule, weekly workload, informal caregiver, and reason for being an informal caregiver)

	Dimensions of suffering		Emotional pain	Relational loss	Avoidance
Professional variables	Functional care unit	UCC	9.40	13.91	7.48
		USF	9.60	15.00	7.62
		UCSP	9.78	15.92	8.03
	Type of schedule	Continuous schedule	9.47	14.72	7.62
		Rigid schedule	10.75	16.37	8.37
		Flexible schedule	9.50	14.75	7.75
	Weekly workload	35 hours/week	9.61	14.91	7.72
		40 hours/week	8.00	12.00	6.00
	Informal caregiver	Yes	10.30	15.97	7.63
		No	9.17	14.23	7.71
	Reason for being an informal caregiver	Personal choice	10.50	15.54	7.50
		Family decision	10.09	16.63	7.90
		Personal satisfaction/ Solidarity	9.66	16.66	7.66

Note. UCC = Community Care Unit; USF = Family Health Unit; UCSP = Personalized Health Care Unit.

Discussion

The topic of suffering in nurses has gained prominence in recent years, both in national and international nursing. In this study, and in line with the literature (Schaefer, 2017), most of the participants are women (90%), as is the case in the nursing profession, which is justified by the socially established roles of men and women and the fact that the role of family caregiver has been traditionally assigned to women.

The literature discusses whether the profession of nursing is more predisposed to suffering because it is mostly composed of women. Some studies reveal higher levels of suffering in women (Trautmann, Epstein, Rovnyak, & Snyder, 2015), and others in men, but the majority of studies found no significant differences between men and women (Woods, Rodgers, Towers, & Grow, 2015; Xiaoyan, Yufang, Lifeng, & Congcong, 2016). In this study, women had higher mean scores in all dimensions of suffering, except for women without children in the dimension of RL and women without a partner in the dimensions of EP and RL. According to Rodrigues and Silva (2016), fragility is a peculiar characteristic of women that suggests femininity because there is still a predominance of the culture of *machismo* in which work dignifies the man and men are potentially sexed, strong, and hardworking, taking on the family provider role.

In relation to marital status, women with a partner have higher mean scores of suffering in the dimensions of RL and AV. Women without a partner had higher mean scores in the dimension of EP, which may reflect the lack of spaces for sharing. The understanding of the experience of suffering in women, more specifically in the dimensions of RL and AV, can be explained by the need to protect the relationship with the partner, that is, they do not let the situations of suffering affect the marital relationship, preventing it from wearing out.

Despite the gradual changes in women's social role, women continue to perform the tasks that contribute to the family's well-being and stability, protecting it from emotional exhaustion. Although there is no evidence on the nurses' levels of suffering based on whether or not they have children, it was clear in this study that women with children had slightly higher mean scores in all dimensions of suffering. Nursing is a predominantly female profession enhanced by a cultural matrix that emphasizes the mothers' predisposition to caring for others. Thus, the results seem to indicate that women are more sensitive to and involved in experiences of suffering. As regards male nurses with children, higher mean scores were found only in the dimension of AV, which can be justified by the need to protect themselves from psychological pain and not transfer it into the household.

As regards the professional variables, it is clear that nursing education, either to obtain an academic degree or a professional specialization, has been contributing to the acquisition of knowledge and skills for a specialized professional intervention. However, more effective strategies should be considered to ensure better management of suffering situations by male professionals. As regards the length of service, professionals with more years of service have higher mean scores of suffering in almost all dimensions. However, Schaefer (2017) found that nurses with fewer years of service had higher levels of suffering. With respect to these variables, there is no consensus in the literature, with some studies indicating a significant association between age and length of service (Woods et al., 2015) and other indicating no association (Lusignani, Gianni, Re, & Buffon, 2016).

The majority of studies about suffering has been perfor-

med in hospital settings, especially in intensive care and emergency settings (Trautmann et al., 2015). Nurses who work in these settings had higher levels of suffering than primary care nurses (Schaefer, 2017). In this study, nurses who never have contact with emergency situations or provide care to people in suffering had higher mean scores of suffering, which can be explained by factors related to the primary care reform, in which nurses have assumed greater participation, autonomy, as well as specific competencies and responsibilities that may be sources of suffering (Ramos et al., 2016). Nurses who often communicate the death of a patient to the family/caregiver have higher mean scores in all dimensions of suffering, which is in line with studies that found that nurses also suffer when confronted with suffering and death because they become aware of their own finitude and feel powerless in the face of death (Viana, 2014).

As regards the functional care unit, nurses who provide care in UCSP have higher mean scores in all dimensions of suffering than those who provide care often to more vulnerable people in suffering or terminally ill patients in UCC. In fact, the functioning of UCSP has not changed with the primary care reform and this is reflected in the working conditions, the allocation of human and logistical resources, professional enhancement, and job satisfaction (Viana, 2014).

Nurses who have a weekly workload of 35 hours, those with rigid schedules, and those who often work in a continuous schedule with fewer members than initially planned have higher mean scores in all dimensions of suffering, which is corroborated by studies reporting that rigid schedules and excessive workload promote suffering, leading to professional burnout and alienation (McCarthy & Gastmans, 2015). Nurses who also play the role of informal caregivers have higher mean scores of suffering in the dimensions of EP and RL, which may reflect their experience with situations of suffering of their families, fear of rupture in the relationship, and the experiences shared with the patient. In this study, the role of informal caregiver is performed only by women, which is corroborated by studies mentioning that the role of family caregiver is traditionally assigned to women (Coelho & Ferreira, 2015).

This study highlights the association between sociodemographic and professional variables in nurses' suffering. As such, health institutions should draw up strategies for preventing and coping with suffering in the work environments, such as the creation of spaces for sharing and reflecting on experiences with a view to increasing their personal and professional satisfaction, improving the quality of care provided to patients/families and community, and, consequently, increasing productivity and maximizing resources, which is also suggested in the literature (Barlem & Ramos, 2015; McCarthy & Gastmans, 2015; Schaefer & Vieira, 2015; Ramos et al., 2016; Caçador et al., 2017; Coelho et al., 2017). Future studies should also examine the impact of suffering on nurses' personal and professional lives, either due to the downgrading of care or even the abandonment of the profession (Ramos et al., 2016).

Conclusion

Primary care nurses have higher mean scores of suffering in the dimension of EP, followed by the dimension of RL and, finally, the dimension of AV. Only gender comparisons produced significant differences, with women suffering more than men.

Understanding suffering is essential for nursing practice and health institutions' managers, to the extent that they can be proactive in implementing strategies for improving the quality of life of these professionals and the quality and safety of care delivery, thus leading to health gains. In this study, the assessment of nurses' suffering focused on the relationship established with the patient/family using the CGS. Therefore, future studies should analyze other organizational factors to obtain a broader understanding of this phenomenon and monitor the consequences of suffering for nurses. The fact that this study only involves nurses from a cluster in the interior North of Portugal might have been a limitation. Thus, future studies should include other regions of Portugal.

Author contributions

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