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RESEARCH

WORK EXPERIENCES OF NURSES IN GENERAL INTENSIVE CARE UNIT AND COVID INTENSIVE CARE UNIT

VIVÊNCIAS NO TRABALHO DE ENFERMEIROS DE UNIDADE DE TERAPIA INTENSIVA GERAL E UNIDADE DE TERAPIA INTENSIVA COVID

EXPERIENCIAS LABORALES DE ENFERMEROS EN LA UNIDAD DE CUIDADOS INTENSIVOS GENERAL Y UNIDAD DE CUIDADOS INTENSIVOS COVID

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ABSTRACT

Objective: to analyze the work experiences of nurses who worked in the general Intensive Care Unit and COVID Intensive Care Unit during the pandemic period and their relationship with moral distress. **Method**: qualitative, exploratory-descriptive study, carried out in a university hospital in the southern region of Brazil. Data collection took place from August to October 2021, online, through interviews on an electronic platform, following a semi-structured script. Discursive textual analysis was used. **Results**: a total of seven nurses participated in the research. From the perspective of the participants, experiences involving the lack of material and human resources, precarious infrastructure, conflicts between professionals and their decision-making processes, weaknesses in care, medical hegemony, and unilateral decision-making were reported. **Conclusion**: experiences at the organizational and relational levels were recognized that can lead to the development of moral distress in the work process of nurses in both intensive care units.

Keywords: Nursing; Ethic; Psychological Distress; Intensive Care Units; COVID-19.

RESUMO

Objetivo: *analisar as vivências no trabalho de enfermeiros que atuavam na Unidade de Terapia Intensiva geral e Unidade de Terapia Intensiva COVID no período pandêmico e sua relação com o sofrimento moral.* ***Método***: *estudo qualitativo, exploratório-descritivo, realizado em um hospital universitário da Região Sul do Brasil. A coleta de dados ocorreu de agosto a outubro de 2021, de forma online, mediante entrevistas em plataforma eletrônica, seguindo um roteiro semiestruturado. Empregou-se análise textual discursiva.* ***Resultados***: *no total, sete enfermeiros participaram da pesquisa. Na perspectiva dos participantes, relataram-se vivências envolvendo a falta de recursos materiais e humanos, precariedade na infraestrutura, conflitos entre profissionais e seus processos de decisões, fragilidades no cuidado, hegemonia médica e tomada de decisão unilateral.* ***Conclusão***: *foram reconhecidas vivências em nível organizacional e relacional que podem propiciar o desenvolvimento de sofrimento moral no processo de trabalho dos enfermeiros de ambas as unidades de terapia intensiva.*

Palavras-chave: *Enfermagem; Ética; Angústia Psicológica; Unidades de Terapia Intensiva; COVID-19.*

RESUMEN

Objetivo: *analizar las experiencias laborales de los enfermeros que trabajaban en la Unidad de Cuidados Intensivos general y en la Unidad de Cuidados Intensivos COVID durante el período pandémico y su relación con el sufrimiento moral.* ***Método***: *estudio cualitativo, exploratorio-descriptivo, realizado en un hospital universitario de la Región Sur de Brasil. La recolección de datos se llevó a cabo de agosto a octubre de 2021, de forma online, mediante entrevistas en una plataforma electrónica, siguiendo un guion semiestructurado. Se empleó análisis textual discursivo.* ***Resultados***: *en total, siete enfermeros participaron en la investigación. Desde la perspectiva de los participantes, se reportaron experiencias que involucraban la falta de recursos materiales y humanos, precariedad en la infraestructura, conflictos entre profesionales y sus procesos de decisiones, fragilidades en el cuidado, hegemonía médica y toma de decisiones unilateral.* ***Conclusión***: *se reconocieron experiencias a nivel organizacional y relacional que pueden propiciar el desarrollo de sufrimiento moral en el proceso de trabajo de los enfermeros de ambas unidades de cuidados intensivos.*

Palabras clave: *Enfermería; Ética; Distrés Psicológico; Unidades de Cuidados Intensivos; COVID-19.*

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INTRODUCTION

Nursing professionals face constant ethical conflicts and moral dilemmas in their work routine, often characterized as moral problems. Specifically in Intensive Care Units (ICUs), they are repeatedly exposed to stressful situations arising from the work process, since their practice demands a high technical-scientific level, agility in clinical reasoning and complex interventions. This context, combined with the high risk of morbidity and mortality among patients, can lead to feelings of powerlessness and dissatisfaction[1].

Furthermore, stress in these environments can be attributed to their characteristics as closed sectors, marked by accelerated work rhythms, extensive workloads, and feelings of sadness, suffering and unpredictability in the face of clinical and organizational situations[2], which can lead to moral problems.

During the COVID 19 pandemic, some ICUs were adapted and others created to meet this demand, presenting professionals with new challenges and a wide range of stressful elements. COVID 19, caused by the SARS-CoV-2 coronavirus, is a highly contagious respiratory disease, with symptoms ranging from mild, such as fever and cough, to severe, such as pneumonia, respiratory failure, and death[3,4].

The pandemic, declared by the World Health Organization (WHO) in March 2020[3], generated a health crisis, overloading healthcare systems and exacerbating social and economic inequalities, leading to changes at all levels of health care, with significant impacts on ICUs. The high number of hospitalizations due to the rapid spread of the virus, especially in the first year of the pandemic, placed professionals facing unprecedented challenges[5].

In this context, research has shown an escalation of moral problems among healthcare professionals. Specifically, nurses have had to improve their skills and have faced situations of extreme exhaustion. The pressure to make quick decisions, often life-or-death, the overload of critically ill patients, the high mortality rate, the lack of essential resources and equipment, the increase in working hours, the constant risk of infection for themselves and their families, the loss of colleagues and the fear of the unknown aspects of the disease are examples of this exhaustion. As a result, there has been an increase in psychological distress, fostering symptoms of anxiety, isolation, exhaustion and, consequently, moral distress (MD)[3,6,7-10].

MD is an emerging problem in the health context, as its occurrence impairs the deliberative process necessary for autonomous professional practice and compromises the moral integrity of individuals. Experiencing MD can have profound impacts on the mental health and well-being of professionals, affecting the care provided and personal satisfaction at work[11].

MD manifests itself in the face of institutional barriers such as lack of resources, restrictive policies, work overload, rigid hierarchical structures and limited autonomy[12]. It arises from a significant internal conflict caused by the inconsistency between the subject's actions and convictions[13], characterized as an experience in which the professional knows what is the morally correct action to be performed, but, due to these obstacles and limitations in the work routine, becomes unable to act in accordance with his/her ideals and ethical-moral precepts[12,13].

International studies show that levels of MD among professionals that work in ICU vary from low[14,15], moderate[15,16] to high[17], depending on the context and working conditions. High levels of MD among nurses were observed in ICUs with a negative ethical climate assessment, low access to palliative care teams and lack of autonomy, negatively impacting both the quality of care provided to patients and the mental health and well-being of these workers[17].

Although articles related to the work of healthcare professionals in ICUs during the pandemic have already been published, there are still significant gaps in the understanding of how work circumstances during the pandemic impacted the experiences of MD of nurses in the care of critically ill patients. This study therefore aims to analyze the work experiences of nurses who worked in general ICUs and COVID ICUs during the pandemic and their relationship with moral distress.

METHOD

This is a qualitative, exploratory-descriptive study carried out in a university hospital in the southern region of Brazil, a regional reference for medium and high complexity care. The general ICU and COVID ICU sectors participated in the research. At the beginning of the pandemic, the general ICU was located on the fifth floor of the institution and the COVID ICU was on the ground floor, adjacent to the Emergency Room. During the pandemic, in early 2021, the ICUs Center was inaugurated, which had been under construction since 2012. During the study period, both ICUs were in the middle of this space, the first with 14 beds and the second with 20 beds.

The study population included 34 nurses working in general and COVID ICUs. The number of nurses was not differentiated by unit, since some worked in both. The inclusion criterion was to be a nurse working in the

mentioned sectors. The exclusion criterion was to be away from care practice during data collection.

Nurses were invited to participate in the research through a digital flyer, which informed the title, objective, form of participation and contact details of the researchers. The invitation flyer was sent by email, posted on the research group's Instagram and shared in the units' WhatsApp groups, after authorization from the managers, thus ensuring that everyone had the opportunity to participate. Once interest was expressed, the interviews were scheduled according to each nurse's availability. The interaction, from the expression of interest to the scheduling of the interviews, occurred through the social networks as mentioned above. Data collection was carried out from August to October 2021, by two master's students trained by the lead researcher.

Due to restrictions from the COVID - 19 pandemic, data collection and dissemination were carried out entirely online, through electronic platforms, reducing health risks and preserving the integrity of participants and researchers, in accordance with the guidelines of the National Research Ethics Commission (CONEP)[18].

The interviews, which lasted an average of 34 minutes, were conducted via Google Meet, with audiovisual recording, allowing for the analysis of facial expressions and body language, contributing to accurate transcriptions and a detailed understanding of participants' experiences and feelings. Visual interaction strengthened empathic connection and trust.

After acceptance, the link to the Informed Consent Form (ICF) was sent via Google Meet chat to be read and signed electronically. The signed ICFs and the interview files are archived in an external hard drive, under the custody of the researcher in charge, following ethical and legal protocols to protect the privacy and integrity of the information.

The number of participants was not established a priori; the sample size sought to follow methodological coherence to obtain satisfactory answers to the research question and meet the proposed objectives. Thus, data collection was completed when it was found that there was a lack of new information relevant to the study and that elements previously identified were repeated[19].

The interviews followed a semi-structured script, addressing closed questions (age, time since graduation, years of experience in the sector and presence of postgraduate studies) and open questions ('What are the ethical or moral conflicts perceived in this sector? How do they occur? How are they dealt with?', 'Do you believe that conflicts or the way of dealing with situations in the work environment affect your health? And the care provided to the patient?', 'How do you recognize moral distress in your work routine?', 'If you feel comfortable, report situations in which you experienced/experience moral distress', 'How do you perceive the moral atmosphere in your work environment? Do you think this interferes with your health?', 'How do you evaluate the actions in your unit for the safety and quality of care?').

Data analysis was performed using discursive textual analysis, a methodology that understands the phenomena and discourses of participants through the production of meanings in a self-organized process divided into three sequential phases: unitarization, categorization, and communication. Unitarization consisted of reading the data to identify the units of meaning relevant to the research. Categorization involved organizing these units into thematic categories, grouping them according to their similarities and differences to facilitate interpretation. In the communication phase, the results were synthesized and presented in a coherent narrative that expresses the emerging meanings of the participants' statements[20].

This study was elaborated according to the Consolidated Criteria for Reporting Qualitative Research (COREQ), aiming to ensure its quality, cohesion, and credibility. The ethical precepts of Resolution 466/12 were considered. The study was approved by the local Research Ethics Committee, with Opinion number 4.847.212 on July 14, 2021. The nurses' statements were identified by the codename 'Enf', followed by a sequential number (Enf1 to Enf7), according to the order of the interviews. The codenames Enf1 to Enf3 refer to professionals working in the general ICU; Enf4 to Enf7, to those working in the COVID ICU.

RESULTS

Seven nurses participated in the study, six of them were female and one male. Their ages ranged from 26 to 49 years old, and six had some type of postgraduate degree. The length of time working in their current sectors ranged from six months to six years. Furthermore, regarding the units where they worked, three worked in the general ICU and four in the COVID ICU. The analysis process resulted in the categorization of two thematic units on work experiences and their relationship with moral distress: work organization and interpersonal relationships.

Work organization

In this category, it was found that professionals experienced concerns related to the organizational structure

of the institution, especially regarding material resources, infrastructure and human resources. Professionals working in the general ICU reported a shortage of material resources, ranging from a lack of equipment for medications to insufficient parts for respirators, in addition to highlighting the precarious conditions of the infrastructure. The following are statements that demonstrate this scenario.

> *We had a horrible physical infrastructure, in need of renovations and with little space to work. We had difficulties with equipment, and there were times when some patients did not have an oximeter.* (ENF1)

> *It's also a question of lack of materials, as I've already said, and resources. Sometimes, we must do things, try alternative ways with other things that sometimes wouldn't be the right thing to do, they're missing... For example, we were short of equipment for amino acids, which we call free intravenous infusion set, because the drip is better. So, in this case, we would put a needle, which isn't the right thing to do, but we would cover the needle because of contamination. So, we would think, "Wow! But that's not right", and then we would go after it, trying everything we could to get the right infusion set. So, this is something we didn't want to happen, but we had to do it.* [...] *the patient was in serious condition, and we didn't have the resources. There were missing parts of the respirator, there wasn't another respirator.* [...] *Thus, in our day-to-day shifts, you end up not realizing that, sometimes, you are in moral distress because of all these things that are missing, there's a lack of resources, both materials and personnel.* (ENF3)

In contrast, in the COVID ICU sector, it was found that professionals had favorable conditions in relation to the organizational model of the work environment. In this sense, participants reported having the infrastructure and material resources adequate to the needs of the work routine, both guaranteeing the individual protection of the professional and to ensure good care performance.

> *The working conditions were excellent!* [...] *as soon as I started, I was given shoes to work in. I picked up my clothes daily from the laundry; when I needed to change them, I just had to ask a staff member. The aprons were always available for all the beds as well. The N95 mask was provided daily. There was a face shield, goggles and gloves. I don't think there was any shortage of PPE-related materials.* (ENF4).

> *In the hospital, there is no shortage of materials, there are plenty of people to work, to help each other. Everything works, everyone helps each other* (ENF5).

> *We have a range of equipment, PPEs, technological equipment, everything at our disposal* (ENF6).

> *Very good ward structure, rooms with four beds, independent rooms, where you have a very good tranquility to work* (ENF7).

During the pandemic, the physical space of the adult ICU was transitioned to the ICU Center, which was under construction. Subsequently, with improvements in infrastructure and gains in material resources, the change brought benefits to the work process in this sector.

> *We moved to a completely new infrastructure, received new monitors, new respirators, all the beds have supporters/devices, we even received an external pacemaker generator last week* (ENF1).

> *Before, we had a very poor physical structure. A very small space, the conditions were very bad for work* (ENF3).

Furthermore, in the general ICU, due to absenteeism caused by the high number of medical certificates in the first year of the pandemic, a lack of human resources was identified. In this situation, the insufficient number of professionals made it impossible to meet the daily demands of the sector.

> *When there were a very significant number of sick leaves and the hospital did not have Nursing technicians to take over, the nurses ended up taking over. Many did not want to play this role of providing comprehensive care to the patient* (ENF1).

> *The lack of professionals ends up having an impact on the patient, there is a lot of demand and few professionals. The quality of the service gets worse* (ENF3).

In the COVID ICU, on the other hand, in addition to the human resources being appropriate for the sector's routine, the existence of cohesive teamwork among Nursing professionals and well-integrated into the multidisciplinary team was identified.

> *A team that worked together, no one had more experience than anyone else. We created a relationship of partnership, of help, of humility, of teamwork, of nurses and Nursing technicians talking about the cases, of doctors also requiring a lot of us as nurses. The multidisciplinary team involved* (ENF4).

> *You don't need to worry about other things, worrying about the pharmacy, worrying about service logistics.* [...] *Everything is easier to get, an exam, getting a specialty. And, as I say, the*

workforce there is... we don't get squeezed, there are plenty of people (ENF5).

The team works very synchronously, everyone talks and discusses the cases. We have discussion rounds, but not all the nurses can always participate. There is no imposition of anything. The management and conduct are discussed together (ENF6).

Interpersonal relationships

In this category, it was observed that professionals demonstrated dissatisfaction with certain particularities in interactions within the work environment. Participants in the general ICU, for example, highlighted the existence of conflicting interpersonal relationships in the sector, especially involving issues of lack of respect, embarrassment in the face of the establishment of power relations and gossip. Below, some statements that prove this context are highlighted.

People must have a professional attitude and know how to respect other professionals. I see more Nursing technicians attacking nurses than nurses attacking Nursing technicians. Or doctors, often, think they are superior to the other professionals on the team, and they use harsh, aggressive words (ENF1).

One or another doctor approaches you to speak badly of someone, with an ulterior motive. This is something that is unethical. The person is even embarrassed to be listening (ENF2).

Dissatisfaction with the organization of work relations, shift routines and the presence of unilateral decision-making was identified. This situation, due to the lack of communication between the multidisciplinary team and the consequent deviation in the work process, became a source of moral suffering.

There are decisions that will be made by Nursing, and there are decisions that will be made by doctors. Multidisciplinary work only adds value to the patient, but it is something that does not exist. That is why it sometimes creates an unfavorable climate, because the team does not agree on certain things (ENF1).

Sometimes the doctor asks you to do something, and you know it's complicated to do, and the doctor insists a lot, so you end up doing it. Of course, you involve other professionals, there's a physiotherapist... But sometimes, it's not that you put the patient at risk, but the situations are very close to risk. For example, sitting down a patient who is on mechanical ventilation, who is in a very complicated situation. The doctor insists on wanting to put the patient in a sitting down position. There's not much you can do, if I say no, it gets complicated. And then, sometimes, you end up not wanting to stress yourself out, you talk to the physiotherapist, and then you end up doing it (ENF2).

Look, we always end up getting stressed, getting anxious about things, we end up feeling helpless, we can't solve things right away. And since I work night shifts, everything must be solved during the day, and then you end up like this: "Oh, I wanted to try to solve it now", what can be solved we solve, but if not, we must wait until the day shift. Then, you must tell the day shift staff that something is missing, they must do this, they must do that, and then it seems like a bad situation. [...] *there have been times when the doctor said something like: "you can turn off the respirator". An ethical issue that we wouldn't do that. And he/she (the doctor) ends up delegating: "Nursing technician, go there". He says: "turn off the respirator, you can turn it off, you can turn off the medications". After he/she (the doctor) has already certified the death* (ENF3).

Many doctors from other departments were reassigned there. So, I felt that it was a team, for the most part, that didn't want to be there. So, this caused moral suffering for us, because, many times, we knew what the patient needed and it wasn't done, because there was no medical request. [...] *no patient is intubated on the night shift, no patient receives a central venous catheter, MAP, or goes for a CT scan on the night shift, because the medical team doesn't take responsibility for this with us. And it caused me to suffer, because as soon as I took over the morning shift, this patient would go to the tube. And this ended up damaging their health, you know? Sometimes, many things were needed that we couldn't do, of course, due to the organization of our profession. So, it did cause me suffering, and it still does* (ENF4).

Furthermore, weaknesses in care were observed in both the general ICU and the COVID ICU sectors. These weaknesses were mainly due to the lack of communication between the multidisciplinary team and the lack of time, due to the complexity of the patients, which compromised the quality of care, making it fragmented.

As a weakness, rounds started to occur now, towards the end of the pandemic, because they were always serious patients, we were never able to discuss as a multidisciplinary team. It was practically impossible to pass twenty patients on to a multidisciplinary team (ENF4).

I thought there was a lack of psychological support for the patients. I thought that was very poor! Sometimes, the nurse had to be there, often having to help the family and the patient as well. And, sometimes, we ourselves would need to have the strength to be

> *there facing that, because there were some cases of great suffering. So, we had to support the family and be strong ther* (ENF5).

> *We have some limitations when it comes to accessing the results of imaging tests and blood tests. This makes our work a little more difficult, it is a weakness* (ENF6).

Consequently, significant medical hegemony was identified in both sectors, especially due to the predominance of a biomedical and vertical model. In the general ICU sector, medical hegemony occurred mainly due to the lack of multidisciplinary communication, with medical decisions prevailing over others. In the COVID ICU sector, this hegemony occurred mainly due to the difficulty of accessing medical leadership.

> *And many patients enter palliative care; the team, in some way, does not agree, but it is not our decision. So, I think that this ends, not that it interferes with the quality of care, you know? But I think there is ethical interference, e.g., for the team. Because you are taking care of that patient and you do not agree with that, you know?* [...] *It is a biomedical model; it is what the doctor decides, and the rest of the team accepts. It is not multidisciplinary work, where everyone participates in the decisions.* (ENF1).

> *The medical head was also not an easy person to deal with.* [...] *A nurse had already worked there and ended up being fired, precisely for questioning the medical head. This class struggle (between nurses and doctors) was quite annoying* (ENF4).

DISCUSSION

It was observed that the work experiences of nurses in general and COVID ICUs are mainly related to the axes of work organization and interpersonal relationships, which may be associated with the development of moral distress or even be precursors of it, since different moral problems become evident in this work context. However, these problems are often neglected by the institution and even by the professionals themselves.

Among the elements of work organization, the lack of material and human resources and the weaknesses of the infrastructure stand out. Regarding interpersonal relationships, issues such as lack of respect, embarrassment in the face of power relations, inadequate organization of work relations, unilateral decisions, lack of communication, fragmentation of care and medical hegemony were identified.

The functional and structural complexity of ICUs, combined with the negative repercussions of a pandemic, change these sectors into places with high levels of occupational stress. Occupational stress facilitates the occurrence of MD, since by altering organizational dynamics, it intensifies ethical and moral conflicts and, consequently, affects the physical and psychological condition of professionals[21].

When exploring the perception of general ICU nurses, an apparent feeling of frustration was found, characteristic of the MD, due to obstacles related to structural and interpersonal vulnerabilities, such as insufficient material and human resources and precarious infrastructure, especially before the change in physical space. The fight against COVID 19 exacerbated existing problems in ICUs, subjecting nurses to emotional overload due to the combination of workplace stressors and personal fears. The detrimental impacts on the mental health of these professionals, added to the perception of scarce institutional support, point to an increase in levels of stress, anxiety, depression, and signs of exhaustion[21,22].

In the general ICU, precarious conditions related to material resources and infrastructure, prior to the transition to a new physical environment, as well as insufficient human resources, hindered the work process. Elements of work organization, such as an inadequate environment and shortage of supplies, including Personal Protective Equipment (PPE), contribute to the psychophysical suffering of professionals[23]. In addition, the number of nurses infected with coronavirus and away from their duties resulted in a significant reduction in staff in the general ICU, and this absenteeism has been shown to be a factor that causes work overload and physical and mental exhaustion of professionals[22,24].

On the other hand, in the COVID ICU sector and in the general ICU, after the change in infrastructure, professionals were satisfied with their working conditions and reported making satisfactory use of the resources available in the unit. The lack of material and infrastructural resources leads to greater psychological overload[24]; however, it is inferred that the existence of working conditions favorable to the needs of the sector increases the feeling of satisfaction among professionals and reduces the rates of mental illness, corroborating the premise of the inverse relationship between job satisfaction and MD in Nursing[25]. In addition, it is observed that efficient human resource management and inclusive and collaborative teamwork correspond with greater job satisfaction and better professional performance, representing potential reducers of MD[26].

Regarding the elements of interpersonal relationships, in the general ICU, the remark of conflicts between professionals who were part of the sector team stands out,

negatively interfering in problem-solving. Although conflicts are intrinsic to the routine of nurses, regardless of their place of work, it is understood that disrespectful interpersonal relationships hinder the performance of collaborative practice[27]. In this same context, unilateral decision-making was another element mentioned by the participants. It is understood that, when they feel overlooked in the deliberations of their work process, feelings of powerlessness, inadequacy and insecurity are manifested in relation to care, making them more susceptible to experiencing MD[28].

The weaknesses in care that emerged in both ICUs are also noteworthy. It is believed that the lack of communication and time, especially due to the complexity of the demands in ICUs, compromises the quality of care provided, making comprehensive care unrealistic and, as a result, causing suffering for team members[27]. In addition, the significant medical hegemony displayed by nurses in both sectors is highlighted. The persistence of a biomedical model perpetuates a structure of hierarchical relationships, in which ethical decisions often occur in a verticalized manner and under medical dominance. Therefore, the limitation of the exercise of autonomy and collaborative practice among the team increases the feeling of invisibility, frustration and anguish, leading to higher levels of MD[11].

To reduce damage and prevent the lasting harm to the psychosocial well-being of professionals, it is important to create or enhance strategies to deal with problematic situations and even MD. In this sense, international literature points to some strategies, such as debriefing, which helps in effective communication between teams[29], the implementation of programs for moral empowerment, which reduces MD rates[30], and also providing spaces that offer active, reflective and structured support in the work environment[31]. The institutional responsibility for implementing interventions and establishing collaborative practice among the team is highlighted, contributing to the promotion of a healthy work environment[32].

It is worth highlighting the impossibility of generalizing the results, since this is a qualitative study, carried out on a specific sample of nurses from two ICUs of the same institution. Further research should be conducted, since a deeper understanding of the topic becomes essential for further clarification of professional experiences in ICUs.

CONCLUSION

This study allowed us to identify experiences in the work process of nurses in two ICUs, one general and one COVID , and their relationship with MD. In the general ICU, insufficient material resources, personnel, and inadequate infrastructure were noted. In both ICUs, conflicts were detected between team professionals in their decision-making processes. It was also observed that in both the general ICU and the COVID ICU, weaknesses in care were evidenced by the lack of communication between the multidisciplinary team and among colleagues, in addition to the lack of time due to the complexity of the patients, reflecting in the fragmentation and disqualification of care.

Furthermore, both ICUs reported significant medical hegemony, which, given the vertical biomedical model and the inaccessibility of medical managers, made effective communication among the team even more difficult. Therefore, it is believed that greater investment in occupational health promotion actions and more effective methods are needed to overcome ethical dilemmas and interprofessional conflicts, including, for example, the creation of collective spaces for discussions and joint decisions, minimizing possible experiences of MD.

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