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Exercise of professional autonomy of intensive care nurses in the pandemic scenario

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Exercício da autonomia profissional de enfermeiros intensivistas no cenário pandêmico

Ejercicio de la autonomía profesional de los enfermeros intensivistas en el escenario de pandemia

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ABSTRACT

Objective: To analyze the exercise of professional autonomy of intensive care nurses during times of the new coronavirus pandemic.
Method: A descriptive, qualitative study, conducted with 19 nurses from Intensive Care Units of two public hospitals and one private hospital. The information was produced from October 2020 to January 2021, through semi-structured interviews, using content analysis in thematic modality, guided by Eliot Freidson's Sociology of Professions.
Results: Nursesargued that it was difficult, amidst the pandemic, to act with all the prerogatives assigned to them by their social mandate, for various reasons, such as limited knowledge about the disease, fragile teamwork communication, and scarcity of material and human resources.
Conclusion: The exercise of professional autonomy is shaped by the confrontation of multiple factors that impact the performance of intensive care nurses, especially in a context of pandemic crisis.
Descriptors: Professional autonomy. Nurses. Ethics in nursing. Pandemics. Intensive care units. Sociology.

RESUMO

Objetivo: Analisar o exercício da autonomia profissional de enfermeiros intensivistas em tempos de pandemia do novo coronavírus.
Método: Estudo descritivo, de natureza qualitativa, realizado com 19 enfermeiros de Unidades de Terapia Intensiva de dois hospitais públicos e um privado. As informações foram produzidas de outubro de 2020 a janeiro de 2021, mediante entrevistas semiestruturadas, utilizando a análise de conteúdo na modalidade temática, à luz da Sociologia das Profissões de Eliot Freidson.
Resultados: Os enfermeiros argumentaram que houve dificuldade, em meio à pandemia, de atuarem com todas as prerrogativas que seu mandato social lhes atribui, devido a várias causas,tais como: o conhecimento limitado acerca da doença, a comunicação frágil no trabalho em equipe e a escassez de recursos materiais e humanos.
Conclusão: O exercício da autonomia profissional se configura a partir do enfrentamento de múltiplos fatores que impactam a atuação dos enfermeiros intensivistas, sobretudo numa conjuntura de crise pandêmica.
Descritores: Autonomia profissional. Enfermeiras e enfermeiros. Ética em enfermagem. Pandemias. Unidades de terapia intensiva. Sociologia.

RESUMEN

Objetivo: Analizar el ejercicio de la autonomía profesional de los enfermeros de cuidados intensivos en tiempos de la pandemia del nuevo coronavirus.
Método: Estudio descriptivo, cualitativo, realizado con 19 enfermeros de Unidades de Cuidados Intensivos de dos hospitales públicos y un hospital privado. La información fue producida de octubre de 2020 a enero de 2021, a través de entrevistas semiestructuradas, utilizando análisis de contenido en la modalidad temática, a la luz de la Sociología de las Profesiones de Eliot Freidson.
Resultados: Los enfermeros argumentaron que hubo dificultad, en medio de la pandemia, para actuar con todas las prerrogativas que les atribuye su mandato social, por diversas causas, como conocimiento limitado sobre la enfermedad, comunicación frágil en el trabajo en equipo y escasez de recursos materiales y humanos.
Conclusión: El ejercicio de la autonomía profesional se configura a partir del enfrentamiento de múltiples factores que impactan la actuación de los enfermeros de cuidados intensivos, especialmente en un contexto de crisis pandémica.
Descriptores: Autonomía profesional. Enfermeras y enfermeros. Ética en enfermería. Pandemias. Unidades de cuidados intensivos. Sociología.

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INTRODUCTION

The work environment in an Intensive Care Unit (ICU) is permeated by critical situations, ethical dilemmas and important decision-making challenges that healthcare professionals face on a daily basis. With the advancement of the Covid-19 (Coronavirus Disease) pandemic in 2020, this scenario became even more complex when there was a quick expansion of many ICUs in response to the significant admission of patients, causing work overload for intensive care teams[1]. Beyond that, there were constant questions in the workplace about which populations were the most vulnerable, how Covid-19 was evolving and, above all, how Nursing could qualify its assistance together with the multiprofessional team to avoid the worst of outcomes: patient death[2].

In situations of global health crisis, nurses assume the leading role in patient care, coordination and management of teams and services with excellence[3]. However, historical issues in Nursing emerged in the face of the Covid-19 pandemic, such as precarious working conditions, exhausting working hours, understaffing and low social recognition of the professional class[4].

Furthermore, frontline nurses presented a high risk of exposure to the new coronavirus (SARS-CoV-2), as they spent more time with their clients, especially during ventilatory assistance for patients at potential risk of death in the ICU[5,6]. In this scenario, Nursing sought to strengthen as a science and renew its fight for technical, scientific, financial and social recognition[7], showing resilience and ethical commitment and striving to conquer its space of professional autonomy[8].

From the perspective of the Sociology of Professions, whose approach will ground the present study, professional autonomy is defined as the freedom that a profession has in relation to others to control an area of knowledge and perform the work in the way it finds most convenient, having the monopoly over the field, without depending on other professions for their practice. It is from this type of autonomy that professional power is extracted, and it is necessary to be articulated with other aspects that guarantee its preservation and effectiveness[9,10].

Professional autonomy is considered a vital element for healthcare professionals and an important aspect of a healthy and positive work environment for nurses[11]. Understanding that all professional practice is set through the mastery of a specific field of knowledge in the occupational spaces assigned for the construction of their professional identity and ethics, it is essential that nurses establish good clinical judgment and decision-making power to manage and conduct their daily activities with autonomy, wisdom and respect, translated into care that is free from harm to the human person.

Given the complexity of the Covid-19 pandemic in Brazil and considering that this problem represented an unprecedented challenge for the work of intensive care nurses, this study becomes relevant. Beyond that, the intensity of daily activities performed by nurses during the pandemic required research to address the experience of these professionals[12], since the development of an autonomous practice is mandatory in times where the role of nurses has not yet reached full recognition.

In light of the above, this study was guided by the following question: how do intensive care nurses exercise their professional autonomy while working on the frontline during the new coronavirus pandemic? To answer this question, the research objective is defined as: to analyze the exercise of professional autonomy of intensive care nurses in the pandemic scenario.

METHOD

This is a descriptive, qualitative study. For this research, the consolidated criteria for reporting qualitative studies present in the Consolidated Criteria for Reporting Qualitative Research (COREQ)[13] were used. The investigation was conducted in three large hospitals in Maceió – Alagoas, Brazil, one being a public teaching hospital, one a private hospital and a public reference hospital for urgent care and emergencies. The justification for choosing these scenarios was because the three hospitals played a crucial role in coping with the SARS-CoV-2 pandemic and were accredited in the Support Program for the Development of the Unified Health System (*Programa de ApoioaoDesenvolvimento do Sistema* Único *de Saúde* – PROADI-SUS), developed by the Ministry of Health in partnership with the *Hospital Alemão Oswaldo Cruz*, where they carry out projects aimed at quality of care, patient safety and strategic planning.

The sampling was by convenience, consisting of 19 nurses who provided direct care in the Intensive Care Units (ICUs) of each hospital. As an inclusion criterion, it was defined institutional experience in an ICU of at least six months, considered a reasonable time to adapt to the workplace. Nurses who were rotating through other sectors during the interview period were excluded.

To reach the 19 participants, we initially sought to verify which nurses met the eligibility criteria. With the list sent by hospital management, with the names and telephone

contacts of the nurses who worked in the ICUs, the researcher found that: from the nine nurses from a public teaching hospital, five were included to participate in the study; of eight nurses from a private hospital, five were included; and from the thirteen nurses from a public reference hospital for emergency care, nine were selected. Among the three hospitals, there was no proportionality regarding the total number of intensive care nurses.

Intensive care nurses were contacted by phone or by messaging applications to invitation and schedule interviews. Six nurses refused to participate in the study, citing lack of time and not feeling comfortable talking about the subject. There was no response to the invitation by only one nurse.

The information was produced from October 2020 to January 2021, through semi-structured online interviews, using the Zoom® and Google Meet® platforms. The statements were recorded on an electronic audio device, with previous authorization from each participant. Due to the pandemic, hospitals were not allowing researchers to enter the ICUs, which justified the choice of conducting interviews online. Participants were free to choose the best location to be interviewed, whether at workplace or at home, as long as it provided privacy and safety.

After each participant had received information about the study, read and signed the Informed Consent Form (ICF), data were collected to characterize the group of participants, regarding age, gender, place of birth, institution where they graduated, length of training, highest academic degree, type of employment in hospitals, number of jobs held. Additionally, participants were asked to inform whether their workplaces were all public or private, how their work schedules were and whether they were daily workers or shift workers.

Then, in-depth interviews were conducted. In the semi-structured script, the triggering questions about the object of study referred to the potentialities and difficulties during the exercise of professional autonomy, with an emphasis on coping with the Covid-19 pandemic, and on working conditions in the ICUs. After concluding the interviews, the researcher thanked them for their participation and informed the nurses that, when the interviews were fully transcribed by her, their contents would need to be validated by the participants. They were guaranteed anonymity using pseudonyms. The average duration of the interviews was approximately one hour.

It is worth mentioning that, during the development of the interviews, some limitations were present, namely: non-adherence with the use of the camera by eight nurses and temporary failures in the internet connection. However, the researcher was careful to wait for the participants' connection to be reestablished and always asked each one to repeat the last words and/or phrases that were not clear.

The saturation criterion was used to finalize the production of research information, which happens when available or sufficient information has been collected, considering the research goals or when ongoing collection does not bring new information. The following criteria were adopted to conclude the information search: analysis of the number of participants in similar studies[14,15] and the repetition of narratives that no longer added new elements to the data already collected[16].

After producing and organizing the information, it was analyzed using the content analysis method in the thematic modality, proposed by Maria Cecília de Souza Minayo, which consisted of revealing the meaning cores in the communication, whose presence or frequency had some meaning for the analytical objective, thus allowing to reach the most manifested level in the interviews[16].

During the analysis of the information, already organized through exhaustive reading, the participants' statements were synthesized. To achieve this, a rich and extensive schematic chart was manually constructed, where the statements were aligned with meaning cores to extract thematic categories capable of leading to the elucidation of the guiding question. Initially, 40 meaning cores were found. Then, those that had similarities between themselves and those that were contained in others were combined, building more density in each of them and reaching 20 meaning cores.

In order to guide the process of contextualization and interpretation of data, the framework of the eminent contemporary sociologist Eliot Lazarus Freidson (1923-2005) was chosen, in the light of the Sociology of Professions[9], as it offers a conceptual framework which can contribute to a broader understanding of Nursing as a profession and science. Although Freidson's theory appears to portray Nursing as a subordinate profession, meaning an occupation that operates submissively[9,10], it is opportune to discuss critically with Freidson's thinking, since his analyzes allow us to defend Nursing as a profession that has autonomy[17].

The ethical principles that guide the researcher's activity were followed throughout the entire process. The research project, registered on *Plataforma Brasil* under no. 26735019,8,0000,5013, was approved by the Research Ethics Committee (REC) of the *Universidade Federal de Alagoas* (UFAL), according to Opinion no.3,777,418.

RESULTS

In total, 19 intensive care nurses participated in the research. The group of participants represented a group of professionals who brought heterogeneity of vision, including women and men from various social backgrounds, guaranteeing the diversity of experiences that brought density to the explanatory categories of the phenomenon under study and allowing to understand the reality that every nurse faces.

Regarding sociodemographic data, most participants were female, and the age range varied from 27 to 57 years old. Regarding professional data, it was observed that a large part of the nurses graduated from private Higher Education Institutions, with training time varying from four to 31 years, the majority had specialization in Urgency and Emergency/ICU and the time institutional experience in the ICU ranged from six months to 25 years.

Although the training period shows different periods of experience, the fact that many nurses had two or more employment positions meant that they had different experiences of exercising professional autonomy, including considering the working hours and shifts in the three hospitals, which was mostly 30 hours a week distributed across day and night shifts.

From the speeches of intensive care nurses, two categories of analysis emerged: the first, "Requirements for the exercise of professional autonomy in the face of the Covid-19 pandemic"; and the second category, "Professional autonomy and working conditions in times of pandemic".

Requirements for the exercise of professional autonomy in the face of the Covid-19 pandemic

The participants in this study pointed out difficulties in exercising their autonomy, which were caused by disagreements in professional procedure when faced with suspected or confirmed cases of Covid-19 and added to the insecurity that existed on the part of intensive care teams when dealing with a new disease. The following statements support these ideas:

> [...] *we also had difficulty with one thing: because it was prohibited even doing non-invasive [mechanical ventilation]. Non-invasive and nebulization. And sometimes a patient would arrive with pulmonary congestion, who had another pathology. Like, we had one there who was a leukemia patient. And the patient is saturating, saturating. Then the doctor: Look, let's nebulize her. Doctor, nebulization is suspended, because it is aerosol... [nurse]. But I'm sure this patient is not Covid-19! [doctor]. When taking the exam: the patient had Covid[in a tone of lamentation]. So, at that moment it was more difficult. This issue of autonomy was a bit... [...]. So, there was a lot of difficulty, due to the insecurity of technical-scientific knowledge! Because neither physician had it nor Nursing had it! And then it created fear!* (NUR. 1)

> [...] *Even the nursing team spoke, questioned, tried to dress correctly, but ended up having many obstacles. As happened several times when patients came in here [in the ICU] and [said]: Oh, no. It's another pathology. And when inside they saw that it was Covid. And the nursing team is already signaling, signaling [...]. There were these little problems at the beginning. But then things started to adjust more, and we started to be able to have more of a voice.* (NUR. 2)

The possession of scientific knowledge was revealed as a fundamental requirement for the affirmation of professional autonomy in the intensive care setting, as it gives nurses the ability to develop solid arguments, with the aim of persuading the healthcare team, especially physicians, when there are divergences on knowledge and procedures in the care for critically ill patients.

> [...] *autonomy involves more the power to say "Do I do it or not do it?". If I don't do it, even if it's prescribed by another specialty, I must have a scientific basis to say "no" and I must have a scientific basis to say ["yes"], to do it and then answer for what I did.* (NUR.3)

> [...] *when you are a professional who knows how to ethically discuss all procedures, all procedures, then we have a certain respect. It's not that person who's going to do it because so-and-so told them to.* [...] *So, we gain this autonomy when we study daily! We cannot only link ourselves, for example, to college or postgraduate studies, as everything is very limited. You are the one who will seek your daily knowledge from the institutions.* (NUR. 16)

Scientific knowledge as a measure to strengthen the exercise of professional autonomy was also observed in moments when intensive care nurses needed to position themselves in the face of difficult situations experienced with other professionals in their daily work.

> [...] *if you don't have knowledge, if you don't have the courage to speak, then you really don't have any autonomy. Huh? That there are some people who won't have the courage to speak, won't want to expose themselves or who have some kind of... it's not an obstacle, some kind of favoritism. So, if I go head on, I'll be penalized, I'll lose something. I have a different situation: I am permanent. There are people who do not have a guaranteed bond, it is a fragile bond. So, if they expose themselves to somebody, who has a very large administrative political influence, they could lose. In this sense too, there are people who allow themselves to be carried away by low self-esteem and loss of autonomy because of these things, these issues. So, this interferes a lot. Let's not say that this doesn't exist because that would be a lie. Right?* (NUR. 17)

The existence of pre-established routines was a factor requested by the interviewees to enhance the exercise of their autonomy, with a view to delimiting the specific assignments of each profession and respecting the spaces for interprofessional action in the ICUs, as can be seen from the statements:

> [...] *I realize that what we also lack are pre-established routines and establishing what belongs to each person. What belongs to each one! The physical therapist is a more recent profession, but he has managed to establish himself more. So... For example: aspiration. Aspiration can be done by the nurse, it can be done by the physio, because they requested it. So, if I'm on duty and there's a physio, I call the physio. Why?! Because, if it's something he requested, let him do it! Huh? We can't lose the bandage, because if we mess up, soon the physio will be left with our complex bandages. So... it's something that we must be more united and technically discuss these issues.* (NUR. 7)

> [...] *that's what I always tell people: "We must have everything systematized". And that's what [work] processes are for, right? So that we can still maintain autonomy. And so, try to do things, innovate, so that we don't completely need other teams. And so, participate in the process. Because if we don't start participating, everyone wants to do a little bit of what Nursing does and then we end up being left out.* (NUR. 10)

An important element that emerged in the statements of the respondents was the need for intensive care nurses to participate more actively in discussions with other professional colleagues about their ethical-legal competencies and in the development of clinical guidelines that support the exercise of professional autonomy in ICUs. A crucial requirement pointed out by nurses that favors autonomous practice in the intensive care setting was the establishment of effective communication during teamwork. The following statements show this:

> [...] *So, I think this is missing a lot, this part of the medical issue of saying "Look, I want..." For example, let's suppose: "This patient from today onwards will begin to be treated in palliative care". But then he/she doesn't prescribe anything, nothing evolves. So, we are a bit tied up waiting for medical treatment!* (NUR. 5)

> *So, if you take a patient in the ICU without previous communication, your planning is already non-existent. So, you don't know if the patient came intubated, didn't come intubated, if they're going to need oxygen, if they're going to need central venous access... Then there's that screaming. Did you understand? Where is the intubation material? Where is the central venous access material? Then the nursing team runs around inside the ICU. But there is no urgency there! It was a lack of planning* [...]. *So, this is a pressure on our autonomy.* (NUR. 7)

The participants in this study highlighted that when communication was weak on the part of the healthcare team, especially physicians, this hindered planning and their work routines in the ICUs, delaying the provision of immediate care to critical patients.

Professional autonomy and working conditions in times of pandemic

The interviewees revealed that when their efforts to work on the front line were not recognized regarding fair remuneration, there was a loss in the exercise of their professional autonomy in the ICUs. One of the interviewees was emphatic in defending the importance of nurses demanding better salaries. This is what can be seen in the following statement:

> [...] *it was very strange because the staff did not receive a bonus. And the other hospitals received it! So, they felt devalued, because they were working with the same Covid-19 patients, exposing themselves, getting ill, taking them home, taking them to friends* [...]. *So, they felt smaller because of it. This also greatly influenced people's mind and motivation. They weren't recognized as frontline workers, right?* [...] *When I took on the leadership position,*

where there must be a process to receive the bonus, I didn't receive it for months. And when I said: "This month won't pass. If I don't receive it, the request for dismissal from my position is ready." Because I must have my autonomy, I need to be valued. "Ah, I'm going to stay here thinking it's beautiful to be the head of the ICU without earning." No! Because I spend, I come every day. So, it has to be in that sense! Put anyone else, because I didn't invest so much in my career to be another person who could get here and just sign papers. (NUR. 17)

The themes of work overload and lack of adequate supplies in ICUs were problems identified recurrently in the interviews, which intensified even further during the Covid-19 pandemic, compromising the good performance and, consequently, the professional autonomy of nurses in the frontline.

[...] *during the peak period of the pandemic, with the increase in the number of cases, our ICU started to receive Covid-19 patients. This changed an entire routine, an entire structure, ranging from emotional care to our attitudes here. Did you understand? And in many cases we were even caught by surprise here* [...]. (NUR. 4)

Another different thing was the issue of PPE, which sometimes we did not consider appropriate. There was a lot of controversy at the beginning. But then, because the nurse is the professional, let's say, who is more qualified in knowing what was and was not appropriate about Personal Protective Equipment, we at that time had the autonomy to clarify before the responsible sectors of the hospital, which would be better for the ICU, because at times poor quality materials arrived. (NUR. 13)

I think it's also important to consider the issue of supplies, the materials we need to work with. This makes it very difficult! Huh? We are living, constantly, improvising. I think this can be quite exhausting and even demotivating. (NUR. 14)

As a measure to legitimize the exercise of professional autonomy for intensive care nurses, the participants in this study revealed the need for a larger nursing staff in ICUs and for their actions to be supported by the hospital's nursing coordination. This would ensure a safe practice that is free from interference.

Even though we don't have enough nursing staff to provide care, we had to open beds! So, every day was a discussion. How many beds do we have today? Since the number of beds, we would need to have to be able to provide care had already been agreed with the units' nursing manager. Right? But every day there was pressure [...]. *It got to the point of saying: What is missing here for you to put this bed to work?! [imitating a dismissive tone] Then we say: Ah! A respirator is missing! [nurses] A respirator arrived from I don't know where! [head nurse]* [...] *But there is no staff to take care of these beds, just equipment.* [...] *What autonomy is this, that we are not heard?!* (NUR.6)

To strengthen the exercise of nurses' professional autonomy, there is a need for permanent dialogue between intensive care nurses and hospital nursing managers, especially regarding equitable distribution of human and material resources essential to the proper operation of ICUs and to the Nursing work process.

DISCUSSION

Throughout the interviews, intensive care nurses argued how difficult it was, amidst the Covid-19 pandemic, to exercise their profession with all the prerogatives that their social mandate (Law No.7,498, of June 25, 1986) gives them. The present study showed that this difficulty was multifactorial and resulted from the following factors: limited knowledge about the disease; disagreements in professional procedures regarding care for critically ill patients; weak communication within teamwork; lack of pre-established routines that support nurses' clinical practice; work overload; lack of material and human resources; lack of recognition of the importance of their work with low wages in hospitals; and lack of support from hospital nursing management in their decision-making and actions.

From the perspective of the Sociology of Professions, all professional groups seek autonomy. The greater the prestige of a profession, the more legitimized its autonomy becomes, which is deliberately organized and recognized, when one acquires the right to control their own work, including determining who can legally perform it and how it should be done. To achieve this, it is necessary to possess a complex body of knowledge, that is, expertise[9].

The acquisition and development of expertise were elements recurrently observed in the statements of the participants in this research, when asked about which factors enhance the exercise of autonomy in ICUs in times of pandemic. During the interviews, nurses were emphatic in

recognizing the need to constantly update their knowledge based on the best scientific evidence, aiming to strengthen their decision-making and increase their performance to ensure excellent quality care within healthcare organizations.

A study conducted in Jordan, which set out to examine the work difficulties of intensive care nurses, especially in an underdeveloped country during the pandemic, showed that expertise, whether present or absent, was a preponderant factor in the care offered to critically ill patients, since Many nurses did not know how to interpret an electrocardiogram, nor how to perform oxygen therapy procedures[18].

In addition to ensuring assertive work, expertise provides the professional with "extraordinary autonomy in controlling both the definition of the problems on which the expert works and the way in which he performs his work"[9], making him an expert in a given function and supporting them in their decision-making in daily work, including when dealing with a highly complex and challenging environment such as ICUs.

During the interviews, interviewees pointed out that it is through expertise that they acquire the respect and trust of healthcare teams in ICUs, as "activities can be judged by their fidelity to knowledge and the degree to which such practice is based on that knowledge"[9]. In this sense, the level of professional knowledge is positively related to the confidence attributed to the work of intensive care nurses. It should be noted that expertise is consolidated through training, qualifications and research[19].

Nurses contributed significantly to the safe management of healthcare in times of pandemic, however, there were obstacles for these professionals to expand their spaces of autonomy in the ICUs. The use of the expression by nurse 2 *"and we started to have more voice"* highlights the idea of an autonomy that needed time to be (re)affirmed in the workplace. This corroborates the Freidson's perspective, characterizing Nursing as "a combative occupation"[9].

The participants' statements corroborate the Freidsonian interpretation that the position that the nurses occupies in the team, their expertise and their experience provide them with support to negotiate and discuss cases with the medical team, in addition to being able to find a balance in conflicting forces, not being in a passive pole of submission[9].

The existence of pre-established routines, standardized clinical guidelines that support the specific duties of intensive care nurses, that enhance the development of their professional autonomy and that promote respect for interprofessional action spaces in ICUs, was a factor requested by the participants of this study. The ability to freely exercise their own rules or control over the performance of their members, that is, self-regulation, is considered a test of professional autonomy[9,10].

The issue of aspiration technique, a situation that emerged in the statement of nurse 7, brings the need for greater discussions involving the competent professional bodies, representative entities, and nurses, pointing out paths that best lead these professionals to strengthen their professional autonomy and for the construction of respectful relationships in the hospital environment. This corroborates the findings of a qualitative study conducted in Iran[14], which stated that hospitals that have clear guidelines on the activities that ICU nurses are responsible for, make these professionals to play an active role in decision-making, providing legitimacy in performing their occupational tasks, without restrictions on them, and a better quality of care provided, ensured with the exercise of professional autonomy.

During the fight against the Covid-19 pandemic, an aggravating factor for the exercise of professional autonomy by intensive care nurses was the weak communication on the part of physicians, which hindered the planning of nursing care in ICUs. A qualitative study conducted in an Intensive Care Center of a hospital in Belo Horizonte, Minas Gerais, also pointed out the failure in communication between nurses and physicians as the main cause of disconnected work, showing that situations like this occur when teams are not well aligned and clarified about the processes and routines of the work environment[20]. An Italian study also showed the importance of organizing the work environment and work practices for the well-being of intensive care nurses, with mutual support and communication within the healthcare team being fundamental, with a view to achieving common goals[21].

The Freidson's theory denotes that, in the hospital setting, nurses' dependence on physicians' orders and demands is evident, which determines the tasks that they should or should not perform[9]. Situations in which the work of intensive care nurses only achieves legitimacy through their relationship with medical practice, constitute a very delicate problem, which emerged in the speech of nurse 5, when she said *"we get a bit tied up waiting for medical conduct!"*. Italian research argued that the degree of professional autonomy achieved by intensive care nurses is strongly related to the quality of the relationships they are able to establish within the healthcare team, that is, in the construction of bonds of trust. For a good working relationship between nurses

and physicians, there must be collaboration, communication, recognition of each other's skills and autonomy, and training – both specific to each profession and as shared[22].

It is undeniable that nurses have been working for many years in a context of precarious work, which became even worse during the pandemic, with emphasis on low wages and little or no recognition that negatively impact mental health[23] and in encouraging these professionals to perform a good job, as seen in the statement presented by nurse 17. Regarding the recognition of a profession, the Sociology of Professions claims that if professional work has little relationship with the knowledge and values of society, its survival will be difficult. Besides, the privileged position of a profession, which is conferred by this same society, can be recognized and abolished by it[9,10].

A relevant issue that emerged in this research was that, unlike a worker with a permanent contract in a public hospital, working in the private environment sometimes makes it difficult for nurses to have the power to speak out to demand better working conditions and make use of their expertise to refute conflicting situations experienced with other professionals. These findings corroborate other studies, one of which revealed that nurses working in private hospitals had greater difficulties in exercising their professional autonomy, due to the low administrative and bureaucratic support of the institutions[24].Another study emphasized that employment relationships represented by temporary contracts can generate greater instability, insecurity and fear for professionals, related to job loss[25].Thus, it is clear that "the workplace has more influence on professional performance than formal knowledge and ethics"[9].

The ability to adapt to complex changes in ICUs, which were imposed by the pandemic scenario, was revealed in this research to be an unprecedented challenge faced by intensive care nurses, characterized by the scarcity of material and human resources, fear of contagion, physical and emotional distress, and the difficulty in communicating with hospital managers. The same was revealed by a study conducted in Spain[26].

The disorderly flow of suspected or confirmed Covid-19 patients, added to the lack of intensive beds and the undersized nursing staff, led to an exhausting working day for intensive care nurses. A Belgian research identified that Covid-19 patients required much more time and attention from ICU nurses in the care process than other types of patients, in activities such as monitoring, displacement and hygiene[27], causing work overload for these professionals during the pandemic. Moreover, a Polish study argued that one of the factors that limited the exercise of professional autonomy by intensive care nurses was the absence of staff in hospitals, which led to an increase in workload and reduced the freedom of action of these professionals[28].

Due to the overload of assignments, which made it impossible for intensive care nurses to take control over ICU admissions, the exercise of professional autonomy was compromised, and this propelled these frontline workers to adopt strategies to (re)organize the care process. However, in the absence of sufficient resources and the imposition of healthcare work, it is inevitable that professionals resort to shortcuts that resemble mechanical techniques and only minimally acceptable, putting the nature of the work itself at risk[9].

A very evident problem in the statements of the deponents was the shortage of material resources in the ICUs, caused by the negligence of hospital managers in not providing Personal Protective Equipment (PPE) in proper quantity and quality. This situation generated a lot of insecurity among intensive care nurses, due to the high risk of viral exposure in their workplaces, and generated demotivation to perform their activities with professional autonomy.

Even though this problem existed, this research showed with the statement of nurse 13 that professional autonomy was able to be affirmed from the moment she used her expertise to clarify to the responsible sectors which are the most appropriate PPE that should be directed to the ICU. Thus, it is understood that when a profession organizes itself to ensure a good job that serves the public interest, it justifies its claim about the conditions of its work[9].

The emphasis given by nurse 6, when questioning the legitimacy of professional autonomy upon the question *"what autonomy is this, that we are not heard?!"*, reveals that there was a lack of support from hospital nursing management to achieve a practical autonomous in the ICU. An Australian study stated that the willingness of ICU nurses to manage care is directly related to adequate communication by of managers, highlighting the importance of interpersonal relationships in the hospital setting[29]. This draws attention to the need to provide organizational spaces that allow intensive care nurses to problematize and express their difficulties faced in daily work, establishing a permanent dialogue with hospital managers that contributes to improvements in the work process developed in ICUs.

CONCLUSION

This research revealed that the exercise of professional autonomy during the Covid-19 pandemic constituted an unprecedented challenge for intensive care nurses, marked by the confrontation of multiple factors that directly impacted the work process in the daily lives of healthcare organizations. Although it is stipulated and regulated in normative provisions of the Nursing profession, the present study, supported by the Sociology of Professions, signaled that professional autonomy is not always a right made effective in practice by intensive care nurses, showing that, in many times, these professionals adopted various strategies to assert their autonomy during teamwork and recognized how fundamental it is to act with expertise and develop their self-regulation, with a view to achieving recognition, respect for spaces of professional activity and continuous improvement in the provision of care in ICUs.

There was mention of several requirements that favored autonomous practice by intensive care nurses in times of pandemic, namely: the possession and constant improvement of scientific knowledge, the existence of pre-established routines to better direct interprofessional practices in ICUs, satisfactory communication in the healthcare team and the support of head nurses in their decision-making and actions. On the other hand, the interviewees revealed that some factors made the exercise of their professional autonomy unfeasible, such as: limited knowledge about the disease, divergences of knowledge and procedures during care for critical patients, weak communication in teamwork, the absence pre-established protocols, lack of material and human resources, work overload and wages incompatible with the complexity of the work performed.

After the publication of this study, it is expected to encourage discussions about the professional autonomy of intensive care nurses, its constituent elements, and the limits and constraints to its consolidation. The emergence of new research on the topic in a post-pandemic scenario may shed light on which aspects of the issue of autonomy are inherent to the exercise of the Nursing profession and which were specific to the pandemic scenario. The aim is also to encourage class representative organizations, health institutions and educational entities to recognize and defend the professional autonomy of nurses as an essential element for the effective operation of healthcare services.

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