

Ethical problems experienced by nurse managers in the pandemic of COVID-19 in a university hospital*


Problemas éticos vivenciados por enfermeiros gestores na pandemia da COVID-19 em um hospital universitário

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ABSTRACT

Objective: to understand the ethical problems experienced by nurse managers in the context of the COVID-19 pandemic. **Methods:** qualitative study, conducted with 19 nurse managers. The inclusion criteria were nurses who had held a management position for at least six months, and the exclusion criteria were those who held an assistance position. Data were collected through individual interviews with a semi-structured script and document analysis and analyzed using Content Analysis. **Results:** the ethical problems were related to duplicity and lack of information about norms and routines; lack of patient flow; routine changes without communication with the nurse coordinators; absenteeism and presenteeism of the nursing team; refusal of reassignment by technicians; nursing professionals who chose to work in the COVID-19 sector and earn additional unhealthy salary and those who did not choose due to fear of disease; and conflicts arising from the patient. **Conclusion:** the analysis revealed situations marked by ethical problems that compromise the dynamics of work and the quality of care. **Contributions to practice:** understanding ethical problems contributes to the promotion of improvements in planning, intervention, and preparation of professionals to deal with conflicting issues experienced in hospital management.

Descriptors: Nursing; Health Management; Ethics, Nursing; COVID-19; Coronavirus Infections.

RESUMO

Objetivo: compreender os problemas éticos vivenciados por enfermeiros gestores no contexto da pandemia da COVID-19. **Métodos:** estudo qualitativo, realizado com 19 enfermeiros gestores. Os critérios de inclusão foram enfermeiros que exerciam a função de gestão há, pelo menos, seis meses, e os de exclusão, os que ocupavam cargo assistencial. Coleta de dados realizada por meio de entrevistas individuais com roteiro semiestruturado e análise documental, e analisados por meio da Análise de Conteúdo. **Resultados:** os problemas éticos estão relacionados a: duplicidade e falta de informação sobre as normas e rotinas; ausência de fluxo dos pacientes; mudanças de rotina sem comunicação com os enfermeiros coordenadores; absenteísmo e presenteísmo da equipe de enfermagem; recusa de remanejamento por parte dos técnicos; profissionais da enfermagem que optaram por atuar no setor da COVID-19 e ganhar adicional de insalubridade e os que não optaram devido ao medo da doença; e conflitos provenientes do paciente. **Conclusão:** a análise revelou situações marcadas por problemas éticos que comprometem a dinâmica de trabalho e a qualidade do atendimento. **Contribuições para a prática:** a compreensão dos problemas éticos contribui para a promoção de melhorias no planejamento, intervenção e preparo dos profissionais para lidar com questões conflitantes vivenciadas na gestão hospitalar.

Descritores: Enfermagem; Gestão em Saúde; Ética em Enfermagem; COVID-19; Infecções por Coronavírus.

Introduction

The pandemic of the new coronavirus (COVID-19) provoked ruptures in the daily life of health care units and showed weaknesses, among them, the difficulty to guarantee personal dignity, equity, protection of the vulnerable, solidarity, transparency in information and in saving human lives⁽¹⁾.

These weaknesses have the capacity to cause ethical problems. Ethical problems are defined as issues of difficult conduct, influenced by values, beliefs, and professional relationships that impede or make care difficult. In this context, nurses are unable to put into practice the standardized or expected care through previous planning⁽²⁾.

The problems generated by COVID-19 required changes in management, including a leadership style that presented rapid adaptation to care concepts and techniques, implementation of physical barriers, monitoring of the environment, follow-up of patients' clinical management, and adjustments in the professional-patient relationship⁽³⁾.

The manager has the responsibility to conduct issues related to the work environment, ensuring the well-being and quality of care. Thus, the performance of managers requires the application of ethical principles and behaviors that support the standards and scope of practice, considering the complexity of the work and the engagement in the development of professionals⁽⁴⁾. In this view, the professional needs to act responsibly, identify and recognize the problems, encourage discussion in search of solutions, and define the best decision, the means to achieve it, and reflect on the effects, that is, whether they are adequate or not⁽⁵⁾.

To give theoretical support to the present study, the Ethics of Virtue, proposed in 1981 by Alasdair MacIntyre, was adopted as a theoretical reference. For the author, despite all the places being marked by conflicts, challenges, and dilemmas, everyone establishes his values and goods according to his experiences in the community, in the family, in the place of birth and

residence, in associations, in religion, among others. It is in these spaces that the moral identity will be established⁽⁶⁾.

In MacIntyrean moral theory, the human being needs to be understood beyond his individuality, considering the relationships, environment, traditions, narratives, and practices of the group or community. Moreover, the theory values rights and duties as well as the concern to work on common problems⁽⁶⁾. The adoption of virtue ethics in the present study favored reflection on the ethical problems generated in the pandemic of COVID-19, since this context requires strategies that favor shared practices, challenges that arise from living in society, besides the engagement of individuals and common responsibilities.

In view of the above, the question that guided the present study was: "How were ethical problems experienced by nurse managers in the context of the COVID-19 pandemic?" This study is justified due to the gap in the literature regarding the definition of what an ethical problem is for the nurse manager and how this professional act when faced with the problem. The understanding of the ethical problem contributes to signalize the situations that compromise the work dynamics and the quality of care. Furthermore, studies were found in the literature that bring ethical problems with an assistance focus, not a managerial one.

The objective was to understand the ethical problems experienced by nurse managers in the context of the COVID-19 pandemic.

Methods

This is a qualitative study in which the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ) were followed, which consists of a checklist of 32 items to guide article design and writing.

The study setting was the Clinics Hospital of the Federal University of Minas Gerais, located in Belo Horizonte, Minas Gerais, Brazil. It is a university hos-

pital with 504 beds and a reference in medium and high complexity care in the state. For the treatment of COVID-19 the hospital has 74 beds, being 30 adult ward beds, 14 adult intensive care beds, one pediatric intensive care bed, 20 emergency room beds, five pediatric and four neonatal beds.

Nineteen nurse managers participated in the study, among them three nursing supervisors, one technical manager, two deputy coordinators, and 13 nursing coordinators. There were no withdrawals or refusals by the participants.

To understand how nurse managers organize themselves and how communication flows occur, it is necessary to talk about the nursing organizational chart. The hospital of choice is based on the (prescribed) organizational chart defined by the Brazilian Company of Hospital Services (EBSEH-in Portuguese), in which there are two administrative positions for nursing, namely, head of the nursing division and support unit for the nursing division.

However, nursing professionals experience another (real) organization chart reality, in which there is at the top a nurse who is the head of the nursing division, right below is the nurse of the support unit to the nursing division, and, below him, there are 13 technical administrative nurse-coordinators (who coordinate, on average, 3 to 5 units). Right down the line there is the nursing collegiate manager (which is composed of representatives from all nursing in the institution) and below that there are 32 coordinators. There are seven vice-coordinators, that is, not all coordinators have this position in overlapping.

Below the coordinators in the line of command are the supervising nurses. In inpatient units, all nurses manage the unit, and this is a rotating function. Thus, they supervise the nursing technical team, manage the care and the private activities of nurses, and can assume both direct patient care and the management of the unit.

In short, nurse managers are responsible for directing, organizing, planning, coordinating, executing, and evaluating the work process of the 1,500

nursing professionals in the hospital; moreover, they represent the interests of the category and manage conflicts.

The inclusion criteria for study participants were nurses who had been employed for at least six months and held positions related to nursing coordination. It is believed that these criteria are necessary for nurses to know the organizational structure and the functioning of the service, enabling the collection of differentiated and reliable information. The exclusion criterion was being a nurse in the exercise of care functions.

Prior to the data collection with the participants, three pilot interviews were carried out with different nurses, chosen at random, who had already held or were holding the position of nursing coordination in other similar institutions. The purpose of the pilot interviews was to adapt the semi-structured interview script to contemplate the object of study. After the first and second interviews, the need to change the data collection instrument was identified. These interviews were not used for analysis purposes.

Of the 41 eligible managers (coordinators (n=32), vice-coordinators (n=7) and technical managers (n=2)), all met the inclusion criteria, thus being potential participants in the study. The invitation was made randomly to a nurse coordinator, who gave the first interview and, at the end, was asked to indicate another nurse who met the inclusion criteria. This technique is called "snowballing" and was used to choose the 19 participants who were contacted by phone, e-mail or in person.

The "snowball" technique is a form of non-probability sampling that uses reference networks⁽⁷⁾. In this way, it allowed some people already in the group to indicate informants with private descriptions and experiences about the ethical issues. The "snowballing" technique was used until data saturation was reached, totaling 19 nurse managers.

To determine the number of participants, saturation sampling was used. Thus, saturation occurred when the data obtained presented certain redundancy

or repetition and, thus, would not contribute significantly to the improvement of the theoretical reflection of the material already obtained⁽⁷⁾. Thus, 19 nurse managers participated in the interview.

Data collection occurred through individual interviews with semi structured script and document analysis between the months of August and October 2021 by a researcher duly trained to ensure the veracity of the data. The different data collection techniques allowed collecting different evidence on the historical and behavioral aspects related to the phenomenon, enabling a process of data triangulation and, consequently, the convergence of information⁽⁷⁾.

Specific questions were asked related to the profile (gender and age) and the trajectory of the participant (time of training, level of qualification, weekly working hours, length of service in the hospital and number of jobs), and then questions were asked to discuss the types of ethical problems experienced during the COVID-19 pandemic, such as: Did the COVID-19 pandemic generate ethical problems in your work? What ethical problems were generated? How did these ethical problems occur? How did you feel in front of these problems?

The interviews were audio-recorded, 17 (90%) were conducted face-to-face, and 2 (10%) were conducted online via Google Meet. When online, it was suggested that the participants stay in a private room of the house, while the face-to-face interviews were conducted in the work environment in a preserved room ensuring that there was only the participant and the researcher in the environment. This was done to preserve the participants' anonymity and confidentiality.

The interviews lasted an average of 27 minutes and were recorded and transcribed in their entirety. After the transcriptions, the interviews were sent to the participants' e-mail for comments and/or corrections; however, there were no returns.

The documentary analysis was based on the nursing administrative notebook. This notebook is also known as the occurrence book and is filled out by the nurse during the shift. It is noteworthy that in the

hospital where this study took place, the notebook is filled out by the head nurse and the administrative technical coordinators. In this document the memory of an occurrence is described, thus, it will contain what happened, how it happened, who was present, what the consequences were, and the decisions taken. The occurrences can be facts from patients, professionals, or the multi-professional team. Three administrative notebooks were analyzed.

The records that addressed issues related to COVID-19 were extracted (the effective date of the notebook, the narrative of the case, the repercussions, and decisions made), in addition to the researcher's perceptions of the data collected. To make this process systematized, a Microsoft Excel spreadsheet was used. The period of the notebooks analyzed was from January 2, 2020, to October 25, 2021. The time frame is justified by the fact that January 2020 was the period in which the World Health Organization declared COVID-19 a public health emergency of international importance⁽⁸⁾.

The administrative notebook was considered sufficient to achieve the purpose related to the documentary analysis. This step was performed independently of the interview.

The data analysis was conducted by means of Content Analysis in the thematic modality, with the objective of overcoming the uncertainties and deepening the meanings of the experiences present in the interviewees' speeches and in the documents. The content analysis was carried out in three chronological poles: pre-analysis that allowed performing the "floating" reading, choice of documents, formulation of hypotheses, development of indicators and preparation of the material; exploration of the material that allowed performing the coding through clipping, aggregation and enumeration of data, originating the units of record that subsequently gave rise to the units of context and categorization; and in the third phase occurred the treatment of results, inference and interpretation, happening the identification of the poles of analysis and inferences that enabled the interpreta-

tion of data, generating unexpected or already predicted results⁽⁹⁾.

The research was conducted according to the required ethical standards. To ensure the confidentiality of the research participants, comic book hero codenames were used, such as: Wonder Woman, Supergirl, Batgirl, Captain America, Storm, Black Lynx, Vampira, Captain Marvel, Sorceress, Jean Grey, Hulk Woman, Spider Woman, Invisible Woman, Ravenna, Powerful, Zatanna, Mera, Wasp, and Black Canary. This was because nurses were referred to as “heroes without a cape” during the pandemic⁽¹⁰⁾.

The research followed the resolutions n^o 466/2012 and n^o 580/2018 of the National Health Council and was approved by the Research Ethics Committee of the Federal University of Minas Gerais, under opinion n^o 4,807,325/2021 and n^o Certificate of Ethical Appreciation Submission: 46988021,4,0000,5149.

Results

The 19 nurse managers interviewed were between 33 and 57 years old, 18 (95%) were women, with a time of training between 9 and 39 years, and 13 (68%) had between 10 and 16 years of training. Regarding the participants' highest level of qualification, 17 (89%) had a specialization, 2 (10%) a residency, 6 (32%) a master's degree, and 1 (5%) a doctorate. Among the specializations held by the nurses, it can be highlighted: labor nursing, neonatology, infection control, obstetric nursing, surgical center, public health, elderly health, oncology, and intensive care. Regarding managerial training, only 5 (27%) of the professionals said they were qualified to work in a managerial position, they said they had specialization in the areas of quality management, human resources management, hospital management or health management.

Through the data analysis process, the thematic categories were organized: Ethical problems arising from duplication and lack of information; Ethical problems related to nursing staffing; and Ethical problems with a patient suspected or diagnosed with COVID-19.

Ethical problems arising from duplicity and lack of information

The nurse managers experienced ethical problems in the work process related to lack of information about standards and routines, lack of flow of patients with the diagnosis of COVID-19 and duplicity of information. The nursing coordinators reported that there were changes in routines recommended by higher nursing positions without prior communication, since they were not jointly elaborated: *There were many problems in relation to routines created because they were not passed on to us. If it was passed on, it was only for one part (of the employees). The other part of the employees questioned why it was being done that way. The information did not reach everybody! We were all the time arguing and having clashes* (Hulk Woman).

Through the nursing administrative notebook some flaws in the work process were identified, such as: lack of knowledge by some professionals about the technical work instructions related to patients with COVID-19; the lack of patient flow between sectors, especially in situations where procedures are performed outside the sector of origin; failure in the communication of the diagnosis of the patient with suspected COVID-19 between the medical and nursing staff, causing exposure of health professionals and other patients.

Ethical problems related to the nursing staff

Regarding the nursing staff, the ethical problems arose from absenteeism (which is the absence from the work environment that can be due to particular reasons, pathology, and work accident), presenteeism (which refers to being present in the work environment, even if one feels ill or below capacity), refusal of reassignment by the nursing technicians, and misunderstanding between the professional who wants to be in the COVID-19 sector to earn additional unhealthy salary, and the professional who does not want to be there due to fear of illness.

The ethical problems related to absenteeism in

the hospital preceded the pandemic and were accentuated during it. With the pandemic scenario, there was the need to remove some servers for remote work due to risk factors for the disease, this fact caused work overload as well as a progression of physical and emotional wear of the professionals who remained in the unit: *We lost in terms of dimensioning, the Human Resources was very fragile! Many professionals were laid off! So, we were left with a very lean scale! With shortages! The difficulty we had to adapt the work process to the HR we started to have been difficult, especially in the beginning. It was very fast, and we hadn't planned for that!* (Vampire). *In a scale of 8 employees to have 1 employee and we had to work with this!* (Spider Woman).

The nurse managers reported that there were cases of nursing professionals who had confirmed or suspected diagnosis of Covid-19 several times, generating leave of absence: *We had colleagues who went as far as to leave of absence during the pandemic period seven, eight, nine times due to suspicion of COVID-19, and each leave of absence lasted 10 days* (Captain America).

The nursing administrative notebook brought elements that reaffirmed the difficulty faced by nurse managers in the reassignment of nursing technicians due to the refusal of professionals and the lack of support for the reassignment by some supervising nurses of the sectors. This situation caused wear, conflicts, and even threats by the technician, and the team's resistance was intensified under arguments that were not always convincing: *A refusal (to be reassigned) by the professionals who work in the area (COVID-19) every time we had low occupancy rates in the COVID area. There is a refusal, a great difficulty for people to understand the need to allocate themselves to other sectors. It is something that happens in the institution as a whole! It is not that COVID brought this! This is disseminated in the institution, but the COVID team brings the discourse of suffering and, behind this suffering, they want to justify their posture of demanding a sector with several people (nursing staff) that is totally out of reality or above normal parameters. ...There was never a situation like the ones we saw on TV of people spending the whole day without being able to go home, without sleeping, this didn't happen here! And yet, the discourse of the people here is just like that!* (Wonder Woman).

It is interesting that there is an action plan to implement changes with the participation of all tho-

se affected and that would take into consideration the understanding of the reasons why there is a refusal to relocate.

If, on the one hand, some nurses had true panic of being in the care units of COVID-19, on the other hand, some workers used artifice/tricks to be in these units because of the possibility of increasing their income. Thus, the nurse manager was pressured and uncomfortable with the situation of deciding between the professionals who would or would not make up the team of the COVID-19 sector: *For some, the desire was to leave a Covid-19 area and for others, it was the opportunity to earn 40% of unhealthy salary over the base salary, that is, to earn 3 to 4 thousand reais of salary increase due to working in a COVID reference area. Sometimes there was some abuse from the assistance teams that pressured their coordinators to be in these areas and earn the additional salary* (Wonder Woman).

The separation of the team between those who remained in the COVID-19 sector or not generated stress due to some people feeling unfairly treated for not being in the sector and not receiving health hazard premiums. However, the coordinating nurses saw themselves as having the duty to zeal for institutional economy: *We left an exclusive team for the COVID sector and this generated a little stress with the teams, because some people felt unfairly treated because in the COVID-19 sector they receive a higher health risk premium. And that led to phrases like: so-and-so gets (higher health risk) and I don't.* (Scarlet Witch).

Ethical problems with patients suspected or diagnosed with COVID-19

In relation to the patient, some of the problems originated in the multidisciplinary team, going beyond nursing. In this way, in the view of some participants, negligence in the care occurred as in the cases in which medical professionals shirked patient care, as illustrated: *We had an isolated patient with COVID that the doctors didn't come in to examine so that they wouldn't have to dress and undress. So, they would sometimes stay outside (the room) asking the nursing staff (who were inside the room) how the patient's breathing and vitals were. They wouldn't put their hand on the patient!* (Batgirl).

The negligence in the care by the medical team was also reported by Mulher Hulk who says that a doctor did not evaluate a patient with suspected COVID-19 and discharged him: *We evaluate the patient downstairs (lower floor) and verify if he has a suspected diagnosis of COVID-19, if he has a diagnostic hypothesis, we take him to a specific room for patients with COVID-19. In this case, the doctors would have to go there to see the patient. This was a struggle because many doctors said: I won't go! But why isn't he (the patient) here (on the upper floor)? Why isn't the patient upstairs? I'm not going to see the patient! And the doctors did not attend and sent this patient away (Hulk Woman).*

Regarding the nursing team, there were reports that some were absent from the physical area of the COVID-19 sector and that, in the beginning, nursing technicians reduced their presence at the bedside: *The person stayed on that scale, it was the process, but she never approached the patient and stayed only in the hallways. Within a supervision process, for example, she would only stay in the hallway outside going to the pharmacy and talking to the unit head (Wonder Woman).*

In face of the pandemic, it was necessary to be stricter in relation to the protective clothing and confinement in the patient's room, companions, and relatives, however, some were resistant to follow the hospital norms and routines: *We were stricter in relation to the patients, if they were putting the mask on correctly. So, we had to keep an eye on that! And sometimes, depending on the woman, she didn't like to be called to attention (to put on the mask). That created a little bit of discomfort (Storm).*

Discussion

The data obtained through the interviews and the documents consulted led us to the empirical categories already mentioned, which will be discussed in this topic. In this perspective, we mention the question regarding information about clinical manifestations, diagnoses, treatment, and transmission, which underwent successive and rapid changes during the pandemic of COVID-19. In the management of services, managers dealt with numerous information, not always precise and definitive, facing great challenges to prepare the team in relation to technical and cli-

nical aspects of care⁽⁴⁾. It is worth noting the uncertainties arising from the new virus that emerged and challenged science and professionals in the search for effective solutions.

Thus, nurse managers reported a lack of information, resulting in a lack of consensus, security, and transparency in the organization of work and in the process of care. In this regard, a survey conducted with health professionals pointed out that, during the first months of the COVID-19 pandemic, some managers made decisions based on emotions and perceptions because it was a new virus that was unknown until then. For such decisions, they used religious and personal values that generate family, community, and financial responsibility as determinants⁽¹¹⁾.

Through the document analysis, it was observed that each professional health category received information from the coordinators in a specific and distinct way, characterizing different strategies to reach this information with different results for the teams, thus generating conflicting situations and doubts regarding the work to be performed. From this perspective, the lack or distortion of information affected the care and management actions, constituting a source of stress and generating anxiety and insecurity. Thus, when nurses perceived that the sources of information were unreliable or that such information was limited, they had doubts about what to do (if they were being fair and equitable) and the quality of work was compromised⁽¹²⁻¹³⁾.

Transparent and consistent information is needed to identify potential risks, exchange information and opinions among experts, and enable an alignment of work processes with utilitarian principles⁽¹¹⁾. The provision of information is essential during a pandemic, as professionals experience uncertainty. This need exists not only in national health institutions, but also in the international arena. Therefore, institutional protocols should be objective and with measures applicable to all professionals, minimizing improvisation, arbitrary decisions, and contributing to ethical decisions on a case-by-case basis. Furthermore, stan-

standardized, and reliable information channels should be encouraged to provide better results⁽¹⁴⁾.

Another factor that generated ethical problems experienced by managers was the understaffing of the nursing team. In India, nurses experienced a significant increase in workload, which was exponential as patients were admitted. A contributing factor was the obligation to perform quarantine after the work shift to reduce risks to the professional at the expense of decreasing the proportion of nurses in relation to patients, causing an imbalance between service supply and demand⁽¹⁵⁾.

In Brazil, some professionals who had one or more comorbidities related to COVID-19 worsening, such as: disease related to diabetes, heart problems, respiratory problems, and immunodepression. They were forced to continue their care activities, even at a higher risk of becoming ill, as exemplified by the 572 complaints forwarded to the Public Ministry of Rio de Janeiro by physicians and nurses who reported having to work even with symptoms of COVID-19⁽¹⁶⁾. The Brazilian labor legislation establishes that it is the worker's right to work in a place where the risks inherent to the work are minimized; however, when it is not possible to guarantee adequate conditions, the legislation provides for the payment of additional salary⁽¹⁷⁾.

This trend is toward monetization, not toward reduction or elimination of risks. This fact has stimulated risky behaviors, i.e., the higher the value of the additional allowances the greater the demand for hazardous or unhealthy activities in favor of a higher salary. The monetary alternative is a way to reward the worker since he/she is exposed to an unhealthy work environment⁽¹⁷⁾. In this context, working in an unhealthy place for a higher salary is part of the constitution of the "I", because the individual's biography is inserted in the stories of the community where he will constitute his identity, social roles, and actions⁽⁶⁾.

The individual establishes a moral identity, because the human being is part of a social context, in which he performs several actions, which are in-

terconnected and have an impact on the subject that performs them as well as on the community where he lives. Thus, it is necessary to understand that, when interpreting a human action, one must consider the context, that is, a set of narratives that make up the individual's history and that are, in turn, interconnected with the lives of other people. Add to this morality, which is a web of relationships in which everyone is a coadjutant in other people's stories, thus there are no losers in the choice between right and wrong, because the loss generated by moral error is collective⁽⁶⁾.

Due to the pandemic of COVID-19, there was absenteeism related to the risk of viral transmission by workers who presented one or more symptoms suggestive of the disease or for presenting risk factors for contamination. The suspicion, confirmation or possible contagion implied the need to leave the worker⁽¹⁸⁾. Besides absenteeism, presenteeism was also observed, which generated a decrease in productivity and work quality, in addition to damages to the physical, emotional, and labor life of the professionals⁽¹⁹⁾. Both absenteeism and presenteeism can result in exhaustion, work overload, dissatisfaction, and Burnout. For the patients, it can compromise care and safety, and can cause an increase in adverse events, mortality, and hospital stay⁽¹⁸⁻¹⁹⁾.

Specifically, presenteeism can lead professionals to make questionable bioethical decisions⁽¹⁸⁻¹⁹⁾. For MacIntyre, virtues are exercised in the practical activities of each subject. When nurses face in their daily work an unfavorable environment with bad working conditions, overload, intense pace, long hours, physical and psychological wear, and interpersonal conflicts, this determines how nurses understand and interpret the practices, the nature of the relationships between subjects, and prevents the reach to the internal goods of daily practices^(6,12,20).

The pandemic of COVID-19 provided greater media exposure (nationally and internationally) for the vulnerability, the advancement of the disease among professionals and the precarious working conditions of nursing, but it also reaffirmed the political

and professional protagonist of Brazilian nursing. This happened because nursing constitutes more than half of the health workers⁽²¹⁾. It is worth mentioning the discussions about the main demands of the professional category, such as the national nursing wage floor and the establishment of a 30-hour workweek that gained visibility in the media⁽²²⁾.

Nurse managers also experienced ethical dilemmas between physicians and the nursing staff during the COVID-19 pandemic. Such dilemmas are related to the issue of putting themselves at risk of health and safety for the ethical commitment to treat patients or not putting their own lives and families at risk; the importance of the oath and the ethical commitment to care that they assumed upon graduation or experiencing fear of the virus. When facing the pandemic, fear arose, as the nurse assumed greater responsibility, and insecurity when acting in a new and unfamiliar situation.

Exposure to the biological agent and the risk of acquiring the disease can have repercussions on the feeling of impotence, dissatisfaction, and professional demotivation⁽²³⁾. About these repercussions for the worker, it is noteworthy that they experience a greater predisposition to moral suffering and stress because they face unpredictable situations and assume a greater degree of responsibility⁽²⁴⁾. Fear can generate anxiety and affect professional results. This feeling, together with the lack of knowledge and information about the disease, leads nurses to change their approach, acting with extreme caution. Thus, nurses started to produce their own rules, such as not touching the patient and not entering the room without some security⁽²⁵⁻²⁶⁾.

However, in Macintyrian moral theory, the human being needs to be understood beyond his individuality, considering the relationships, environment, traditions, narratives and practices of the group or community. The individual is only able to have an independent moral action when he/she recognizes the dependence on the other⁽⁶⁾. Thus, fear can be reduced through support from supervisors who must unders-

tand the factors that contribute to this state, support from colleagues and family members, and sharing of experiences and training⁽²⁵⁻²⁶⁾. Since any well-established and coherent cooperative human activity generates internal assets and can achieve standards of excellence⁽⁶⁾.

Professionals must guarantee care guided by patients' values, goals, and preferences, and have the moral duty to protect and respect people's autonomy and decision. However, when faced with attitudes that go against the world care recommendations, they must maintain an open and transparent dialogue with individuals, prioritizing the health and safety of individuals. The society must have clear, direct, and timely information, so that it can understand the need for protection⁽²⁷⁾. The sharing of experiences, desires and fears among family members, patients and health professionals can contribute to provide better attitudes, reduce pain and suffering and prepare family members in case of possible death⁽²⁸⁾.

The nurse manager is faced with a unique moment due to work overload and the specificity of the disease, generating an imbalance in the work process. In face of this, he/she needs to make difficult decisions, find strategies to promote a safer environment, identify exposed professionals, maintain an adequate team, prioritize critical situations, maximize the benefits that can be produced, and create transparent guidelines and scientific protocols to assist the teams in making decisions. It is suggested that the institution reaffirms the nursing leadership positions, since they play a key role in directing, productivity, and planning in the face of a pandemic.

Study limitations

The limitation of the results of this study is because the ethical problems generated in COVID-19 were analyzed only from the perspective of the nurse managers without considering the approach of other professionals in the nursing team.

Contributions to practice

The results translate into contributions to nursing management, as they exhibit the difficulties faced, reflect on the ethical issues experienced, bring the potential of management during the COVID-19 pandemic, and expose the importance of valuing leadership in nursing.

Conclusion

The pandemic of COVID-19 exposed nurse managers to ethical problems related to the absence of information, especially regarding protocols and routines, duplication of data, absenteeism and presenteeism of the nursing team, the intensification of refusal of reassignment by nursing technicians as well as the duality experienced by professionals between being in the COVID-19 sector and not wanting it due to fear of the virus. It is important to highlight the importance of providing spaces for ethical debate, aiming to deal with problems that may arise in the future and in delicate and conflicting situations.

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Authors' contribution

Conception and design or analysis and interpretation

of data; writing of the article or relevant critical review of the intellectual content; final approval of the version to be published; agreement to be responsible for all aspects of the manuscript related to the accuracy or completeness of any part of the work that can be adequately investigated and resolved: Cunha SGS, Brito MJM.

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