



RESEARCH ARTICLE

When Work Loses Its Meaning: Suffering Among Nurses in a Brazilian University Hospital

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ABSTRACT

Objective: To analyze manifestations of work-related suffering among hospital nurses and their association with work organization.

Materials and Methods: A single holistic, descriptive case study with a qualitative approach was conducted at the University Hospital of the Federal University of Pelotas, Brazil, with 32 nurses. Data were collected in April and May 2023, in three sequential stages, through vignettes and in-depth individual interviews, subjected to Thematic Analysis. The Psychodynamics of Work by Christophe Dejours was adopted as the theoretical framework.

Results: Six themes were defined and revealed the main perceptions of suffering among nurses: physical and psychological suffering, resulting from excessive workload, discomfort of patients and family members, inadequate organization, and also due to fragile relationships in the work environment.

Conclusions: Suffering arises from the moment the worker is unable to adjust the task according to their needs and desires. Thus, it is suggested that hospital managers pay attention to how the organization of nursing work is established. In this way, it would be possible to provide conditions for the psychic structuring of professionals, as well as to offer opportunities for pleasurable experiences in the performance of their activities. This includes, among other factors, attention to the work rhythms imposed on teams and the performance demands of employees, so that it is still possible for them to adjust the task according to their needs and the work does not become inflexible or lose its meaning for those who perform it.

Keywords: Nurse. Suffering. Hospital. Nursing. Qualitative Research.

Introduction

Nurses can perform all nursing activities; however, some responsibilities are exclusive to this professional, such as: directing, planning, organizing, coordinating, executing, and evaluating nursing care services; consulting, auditing, and issuing opinions; nursing consultations; prescribing nursing care; providing direct nursing care to critically ill patients at risk of death; and providing nursing care of greater technical complexity that requires scientific knowledge and the ability to make immediate decisions¹.

In the hospital setting, therefore, the work of a nurse, unlike that of technicians and other healthcare professionals, involves the coordination and organization of the nursing team's work, the transition of care between the beginning, during, and end of work shifts, characterized by an intense work rhythm with numerous demands/tasks that are exclusive to them, such as: nursing prescription, application of patient assessment scales (risk of pressure injury, risk of falls, complexity of care), in addition to responsibility for the most complex technical procedures^{1,2}.

In this work context, nursing professionals deal daily with precarious conditions due to a lack of material resources, inadequate staffing levels, a fragmented work process, an increased level of patient complexity causing worker overload, as well as fragile employment relationships, long working hours, and salaries that do not reflect the level of responsibility and relevance of their work activities²⁻⁴. Furthermore, in this environment, interpersonal relationships with the multidisciplinary team are not integrated. There is a lack of recognition, autonomy, and appreciation for the profession, and there are situations of power struggles, with high performance demands on nursing teams and concerns about patient safety. Additionally, there is daily exposure to patient suffering and death, among other factors intrinsic to the profession^{3,5}.

Similarly, a cross-sectional study conducted in six European countries corroborates the precariousness of the work environment and professional burnout in a continental context⁶. It was found that professional burnout, mental health problems, job dissatisfaction, and concerns about the quality of patient care are prevalent among physicians and nurses; this study also highlighted that clinicians

themselves prioritize organizational interventions (such as reducing bureaucracy) over mental health interventions, considering that better work environments and adequate staffing levels are associated with lower burnout rates and greater job satisfaction⁶. This finding validates the Dejoursian perspective adopted here, that the genesis of suffering lies in the organization of work and not in individual psychic fragility.

Suffering at work is a subject addressed by Christophe Dejours, a french psychiatrist and psychoanalyst, whose research involves topics in the field of psychopathology, with his object of study being psychic life at work. His research and professional experience led him to the construction of a theoretical-methodological model called Psychodynamics of Work, which encompasses suffering at work and related mental pathologies, as well as conditions in which work is a source of pleasure and can play a role in the construction of health⁷. In this way, Dejours seeks to understand how subjectivity is mobilized in work, as workers reflect on and act upon reality, adapting tasks to their subjectivity, but also adapting to the reality imposed by the circumstances in which the work takes place⁸.

Research conducted with nurses at a university hospital in Paraíba⁹ identified indirect relationships between nurses' work and the presence of illness processes, which negatively impact the professional's quality of life and the safety of care provided to the patient. Thus, considering that the work of nurses is permeated by various situations of suffering, ranging from the working conditions imposed by the way the organization of work is structured in the institution (overload of tasks, demands, precarious conditions, etc.) to the intrinsic characteristics of the daily life of the profession (coexistence with the pain and suffering of others, for example), the need to understand the context of action in the hospital environment becomes apparent.

At a macro level, this problem is not unique to the Brazilian context. The World Health Organization (WHO) for Europe, through the largest study ever conducted on this category (MeND report), revealed that between 28% and 32% of European doctors and nurses report depressive symptoms, with more than 10% reporting passive suicidal ideation¹⁰. This data confirms that the suffering of the health workforce is a continental crisis, closely linked to

work organization and the shortage of professionals, and not just an isolated phenomenon.

Despite the growing body of literature on occupational health in nursing, studies specifically employing Dejours' Psychodynamics of Work as a theoretical lens to examine hospital nurses' suffering in the Brazilian public university hospital context remain scarce^{5,9,11}. While previous research has documented the prevalence of burnout, depression, and physical ailments among nursing professionals^{2,7,8}, few investigations have delved into the subjective mechanisms through which work organization — particularly rigid hierarchical structures, fragmented communication flows, and constrained autonomy — impedes workers' ability to adapt tasks to their psychological needs^{7,8}. Understanding these dynamics is essential for designing interventions that go beyond individual coping strategies and address the structural determinants of suffering⁶.

This study, therefore, aims to examine, through the conceptual framework of Work Psychodynamics, how hospital nurses perceive and make sense of work-related suffering, with particular attention to the organizational conditions that either facilitate or constrain their capacity for psychic structuring through work.

Materials and Methods

This is a holistic, descriptive, single case study with a qualitative approach¹², using the Psychodynamics of Work Theory as the theoretical framework for this research, as it is a suitable approach for understanding the dynamics of work situations and the possible harm to the worker's health. In order to qualify the writing of the study production, the guidelines of the Consolidated Criteria for Reporting Qualitative Research (COREQ) were adopted¹³. This study was developed at the *Hospital Escola* (HE) of the Federal University of Pelotas (UFPe) in Rio Grande do Sul, which has been managed by the Brazilian Hospital Services Company (*EBSERH*, acronym in Portuguese) since 2014. Most of the HE's employees are linked to the *EBSERH* network; however, there are also employees under the Unified Legal Regime (*RJU*, acronym in Portuguese) working at the hospital.

The participants were identified by Arabic numerals (1, 2, 3...) followed by the letters "V" for the Vignette data collection technique and "E" for

the Interview (*Entrevista*). Since there are two situations in the vignettes, these are VI and VII. Similarly, since there are two interviews, they are EI and EII. Thus, the codes are: 1VI, 1VII, 1EI, 2VI, 4VII, 7EII, etc.

Nurses working in the inpatient sectors that make up the Nursing Management Support Unit (*UAGENF*, acronym in Portuguese) of the *HE-UFPe* (*Hospital Escola* of the Federal University of Pelotas) were invited to participate in the study: Medical Clinic, Emergency and Urgent Care Network II, and Emergency and Urgent Care Network III. These professionals totaled 36 nurses in April 2023. The selection criterion for participants was working at *HE-UFPe* as a nurse, assigned to *UAGENF* for at least six months. Thus, 33 nurses were approached, and all agreed to participate in the study. However, one participant withdrew after completing stage I of data collection (vignettes), leaving 32 participants. Therefore, this participant's responses were excluded from the study.

A vignette is a strategy used in research, consisting of a brief description of a situation, real or fictional, structured in a way that attracts attention, produces sensations, and obtains information about respondents' perceptions, attitudes, or knowledge about a particular phenomenon¹⁴. The vignettes and interviews were subjected to a sensitization study¹² with nurses from a unit other than *UAGENF*, in order to verify their suitability for the research objective, before being applied to the participants of this study.

All stages took place at the nurse's own workplace and during their working hours, in a private room within the unit, providing privacy and favorable conditions for them to answer the questionnaires. Data collection was conducted by the lead author, who has experience in qualitative research, during the months of April and May 2023.

A substantial interval between data collection and manuscript submission occurred due to multiple factors. First, the complete transcription and thematic analysis of 32 in-depth interviews and 64 vignette responses — totaling approximately 1200 pages of textual material — required extensive time investment to ensure analytical rigor. Second, the principal investigator underwent a period of sick leave and subsequent academic relocation, which temporarily interrupted the research timeline.

Third, the authors deliberately chose to revisit the data after a cooling-off period, which allowed for more reflective and theoretically grounded interpretation of the findings. It is noteworthy that the phenomena described — work overload, inadequate organizational structures, and interpersonal conflicts in nursing work — remain persistent and structurally embedded in the Brazilian hospital context, as corroborated by recent literature¹⁵⁻¹⁹, suggesting that the temporal gap does not compromise the validity or relevance of the findings.

The data were analyzed in three sequential steps:

Stage I – Vignettes: Participants were provided with an instrument containing two vignettes (plots) and questions to identify their perceptions of these plots. Participants answered these questions in writing and returned them to the researcher on the same day, or later, depending on the participant's availability. The vignettes were created by the researchers themselves, based on their professional perceptions.

Stage II – Interview I: In this stage, an in-depth individual interview was conducted²⁰ to identify the socio-professional characteristics of the study participants and aspects related to their work context. These interviews were conducted after the completed instrument from Stage I was returned and were audio-recorded, with an average duration of 45 minutes.

Stage III – Interview II: Approximately one week after Stage II, a date was scheduled for the third stage of data collection, which corresponds to a second in-depth individual interview. This interview aimed to deepen the discussion on the research topic, since it reconnects with the study participant a few days (three to seven days) after they had already been exposed to the subject, providing time for the mobilization of feelings, doubts, and reflections that could then be addressed in greater depth. The interviews in this stage were also audio-recorded and had an average duration of 25 minutes.

After transcribing the vignettes and interviews in full, the collected data were treated as a single textual set, according to the Thematic Analysis approach²¹.

Results

Of the 32 nurses who participated in this study, 28 are female. About employment status, 29 nurses

are employed under the Brazilian labor law (*CLT* acronym in Portuguese) of *EBSERH* and three under the *RJU*. The participants have an average of 30 years of work at the institution, with 15 participants having worked at the hospital for less than five years and the other 14 having between five and 10 years of work at the study site; 27 nurses have only one employment relationship, while five have two; age ranged from 26 to 56 years (average 39 years). Concerning skin color, 24 self-identified as white, one as black, and the rest as mixed race. Regarding marital status, 10 are in a stable union, 10 are married, 10 are single, and two are divorced; 18 participants have no children, 11 have only one child, two have two children, and one has three children.

After analyzing the narratives, it was possible to define the following themes, related to the nurses' perceptions of suffering at work:

PHYSICAL SUFFERING

Participants report physical problems or illnesses possibly resulting from their professional practice and also related to working conditions, which interfere with job performance:

- *Professionals have chronic pain. Lower back, shoulder, and knee pain are very common (1VI).*
- *Spinal diseases [...] you have work overload, poor pay, which culminate in these diseases that are very characteristic of overload. I believe that 90% of colleagues have some chronic disease that causes some type of pain or discomfort resulting from our work (10VI).*
- *The spine and gastritis [...] I feel that I am already becoming very limited in many things, mainly motor skills, because of the loss of strength in my hands, a lot of joint pain as well, in my wrists (10EI).*

PSYCHOLOGICAL SUFFERING

Nurses reported situations that are associated with psychological suffering: burnout, anxiety, sadness, anguish, demotivation, insomnia, job dissatisfaction, stress, irritation:

- *A very strong anxiety crisis, due to work (5E).*
- *Sometimes it's sadness, something that happens in everyday life, or the loss of someone, or you're not feeling well, there are days when you're really not feeling well, when you wouldn't want to leave the house (9E).*
- *When the service becomes mechanical [...] when you're not comfortable in the environment you're*

working in, when you don't identify with it. There are people who won't identify with pediatrics and it just doesn't work. And sometimes the person has to be there out of obligation. So you're there and you're not feeling well (20E1).

- I'm having an anxiety attack [...] I take anxiolytics and I can't sleep without the medication [...] the stress, the irritation (10E1).

It is highlighted in the following statements that psychological suffering can lead to problems in interpersonal relationships or even compromise the professional performance of the nurse:

- Exhaustion, with migraine attacks, and sometimes we end up being stupid with a team member or a family member (3V1).

- It's a lot of rushing around and depending on the sector you're in, you really freak out. I'm a very anxious person (3E1).

Some participants reported symptoms of psychological distress even before arriving at their workplace to begin their shift, as can be seen in these statements:

- I was starting to have mental health problems. I had tachycardia when I went to my shift (6E1).

- I have no motivation to come to work. Actually, I have crazy anxiety, the day of the shift arrives, I get tachycardia and I come because I have to come. It's suffering to come [...] because I can't take it anymore [...]. I have a lot of anguish, a lot of anxiety, insomnia, sadness (14E1).

- I cried every day before going to work [...] I went unhappy, I went to work with a heavy heart (16E1).

EXCESSIVE WORKLOAD

Study participants report distress when they feel overwhelmed, which impairs their task performance, especially in relation to patient care, as demonstrated in the following statements:

- There is a very high demand, there are many tasks [...] there is a huge bureaucratic part [...] the fact of the overload often brings suffering (11E1).

- I think it's a lot of workload. It's a lot of things, you do the administrative role, the care role, and one person calls and another calls and you get very confused (14E1).

- The high demand that patients have brought to professionals, reduced in the face of so many sick leave certificates that are frequent at my workplace, the team also becomes overburdened

[...] it generates dissatisfaction for this professional and ends up making them sick as well (19E1).

- I feel kind of overwhelmed [...] we have a lot of paperwork, here at the hospital there's a lot of bureaucracy, that mountain of checklists, lists of this, lists of that, and then you often end up falling short in the care aspect (28E1).

DISTRESS OF PATIENTS AND THEIR FAMILIES

The work of nurses involves the systematization of patient-centered care. Therefore, the suffering perception in daily work, associated with the suffering of the patient themselves, appears in the participants' statements:

- The sufferings of daily work are the illnesses, that's what we see here directly, it's the suffering of each patient, mainly (5E1).

- We see a lot of difficult things. Patients in end-of-life situations, with serious illnesses, families who are also a little helpless [...] we see a lot of physical suffering, of patients, psychological suffering, especially more serious patients [...] the suffering of seeing some health conditions that are not being well managed, that for me is suffering, it bothers me (6E1).

- There is the suffering of the patient and the family [...] during the COVID-19 pandemic I cried a lot, the loss of the patient, of the family member. It creates a very strong bond with the patient, with the family (7E1).

- Working with the pain of others is very complicated because we end up absorbing it. We see the suffering there [...]. It's very stressful working in a hospital (26E1).

INADEQUATE WORK ORGANIZATION

The nurses in this study emphasize their suffering due to the lack of a satisfactory physical space, adequate for providing quality patient care, as well as a proper place for rest and basic needs:

- We have a terrible physical space issue here. If we have to bring in a stretcher, you have to move all the beds in the room. If there's a cardiac arrest, you can't put the crash cart next to the patient's bed [...]. I think the organizational issue brings a bit of suffering (11E1).

- Inadequate physical space, very small; the units are small, air circulation is very impaired; patients are very crowded and companions are poorly accommodated [...]. Also, our rest area is totally inadequate, it's a mixed dormitory (26E1).

- *There's no space here at the hospital. I would like to be in an environment with more space, where I feel like I'm in a hospital. The place where you eat [...] I don't feel comfortable, I don't like it. And the breaks, I think we deserve some comfort, especially a bathroom. We use the patients' bathroom. We don't have a bathroom in our sector, we don't have a changing room (12E1).*

The organization of work was also an aspect that caught the attention in the participants' testimonies, especially regarding the communication flows between the hospital units, in addition to the lack of systematic execution of routines and protocols:

- *There is a lack of some organization, some Standard Operating Procedures, some forms. Sometimes we get a little lost in some procedures, some routines. There should be more dialogue, more meetings, dialogue with the heads on the issue of work organization (30E1).*

- *I see a lot of disorganization for a hospital environment [...]. It's as if it's every man for himself and God for all. The processes are very different between sectors [...] the sectors don't communicate and don't follow the protocols very well (16E1).*

- *There is no standardization in the sectors, each clinic I go to work at is different [...] there is no flowchart. I do therapy, something I had never done in my life. But I do it, after I came to work here [...] there aren't even meetings here (15E1).*

- *This is suffering for me. The issue of this lack of communication [...] is fragmented communication, it doesn't reach everyone and then things end up becoming disorganized (19E1).*

FRAGILE RELATIONSHIPS IN THE WORKPLACE

In the testimonies of the nurses interviewed, it is observed that interpersonal relationships, whether between members of the nursing team or between the nurse and the manager, reflect characteristics of the work organization itself, structured in a vertical way, with a marked division of labor and tasks of little significant content.

The participants pointed to the lack of autonomy, the lack of respect and recognition, the lack of dialogue and the vulnerability of hierarchical relationships:

- *We can work, work however we can, whether we are well or unwell, but we are not recognized [...] I'm not going to kill myself anymore. Nursing out of love, no (16E1).*

- *We don't give a warning because we don't have the support [...] the technicians don't respect the nurse, they don't treat their superiors well, they don't respect the hierarchy [...]. The order, very vertical, where we don't give our opinion, we don't discuss, but we have to fulfill certain roles established by the managers. The biggest challenge is teamwork, where you have a team that, because they are in a public service, feels entitled to everything and obligated to do little (14E1).*

- *With management, you only talk to them when you have a need. We haven't had any meetings in a long time (21E1).*

- *There is a lack of communication [...] the relationship between the staff in general is very bad, it's awful. Especially the hierarchy between nurses and technicians. The technicians are very disrespectful towards the nurses and the nurses are very afraid to do anything [...] I think respect has been completely lost (24E1).*

Discussion

Among the sufferings perceived by the participants are physical ailments or illnesses possibly resulting from professional practice and related to nursing working conditions, which interfere with work performance, such as chronic pain, physical limitations, exhaustion, fatigue. This suffering stems from exposure to occupational diseases and various other factors that cause harm to the worker's health, such as excessive working hours, occupational stress, and workplace accidents²².

Other situations found in the work of nurses refer to psychological suffering, translated as: burnout, anxiety, sadness, anguish, demotivation, insomnia, job dissatisfaction, stress, and irritation. Some participants reported symptoms of psychological distress, even before arriving at their workplace to begin their shift. According to the accounts provided, psychological suffering can lead to problems in interpersonal relationships or even compromise the nurse's professional performance.

In this case, mental suffering sets in from the moment the worker is unable to adjust the task according to their needs and desires.⁸ That is, when rearranging the organization of work is no longer possible, when the worker's relationship with the organization of work lacks flexibility, suffering begins and the struggle against the elements that trigger mental illness begins²³.

Under these circumstances, the person no longer controls their work; instead, they are controlled by it. Work no longer offers conditions for their psychic structuring, nor does it provide opportunities for pleasurable experiences. The desire for production surpasses the individual's desire, giving rise to a feeling of displeasure and tension²⁴, as a reflection of the mode of production of capitalist society.

In this socioeconomic context, the following are characteristics of nursing work: long working hours, low salaries, understaffing, and a wide range of responsibilities, leading to precarious working conditions²⁵. Consequently, study participants reported experiencing suffering due to excessive workload, which impairs their performance, especially in relation to patient care. Work overload often stems from situations inherent to precarious working conditions and impacts the health of nurses²⁶.

When work organization is rigid and imposed, established by management, it is not possible to freely structure the task, that is, for the worker to adapt the operating method to the needs of their mental structure. This can compromise their psychosomatic balance⁸. Thus, the exhaustion of mental functioning and the inadequacy of work organization are reflected, firstly, as a perception of dissatisfaction, characterized by fatigue – which can turn into a somatic (physical) complaint. However, the feeling of fatigue is not necessarily associated with an excessive physical workload⁸.

These findings align with the concept of "exploitation of the living body" (exploitation du corps vivant) described by Dejours⁸, wherein the worker's physical integrity is progressively eroded not merely by task demands per se, but by the impossibility of negotiating work rhythms and modalities. When the organization denies workers the margin of maneuver to adjust their bodily engagement — whether through inadequate staffing ratios, poorly designed physical spaces, or the relentless pressure of bureaucratic documentation — the body becomes the locus where organizational contradictions are somatized. This interpretation resonates with recent international studies demonstrating that ergonomic interventions alone are insufficient without concomitant changes in work organization and professional autonomy^{4,5}.

In this sense, a study carried out with nursing workers in the Central-West region of Brazil²⁷

identified an association between aspects related to high emotional exhaustion of an occupational nature and Burnout syndrome. This syndrome is directly related to feelings of discouragement, frustration, devaluation and low recognition experienced in professional practice. The scope of these phenomena is still poorly understood, however, the study warns that Burnout syndrome can lead to loss of productivity and quality of care, as well as harm the health of workers and interpersonal relationships, etc.

Inclusive it is worth noting that the work of the nurse involves the systematization of patient-centered care. Thus, the suffering in the daily work associated with the discomfort of patients and family members in the hospital environment appears in the statements of the participants in this research. Continuous exposure to work overload and daily feelings of suffering cause wear and tear on the worker, which can progress to illness²⁶.

The suffering resulting from inadequate work organization stands out in the testimonies of the nurses in this study, especially due to the lack of a satisfactory physical space that allows for quality care for patients, as well as bathrooms in the work units, in a suitable place for rest and meals for professionals during their workday. Due to the limited physical space, they also highlighted, for example, the difficulty of moving around within the wards, in the case of transporting or providing emergency care to patients, which is an important type of demand for better care practices.

These perceptions described by the participants reflect the precariousness of nursing working conditions, which became evident especially after the COVID-19 pandemic. Nursing professionals faced very stressful and challenging situations during and after the pandemic, mainly with regard to the lack of institutional appreciation, the fragility of professional autonomy, the scarcity of resources – both material and human – to provide safe care, and the omission of care for the mental health of workers who worked on the front line in hospital care²⁸⁻³¹. In this context, it is emphasized that appropriately directed investments could promote a supportive environment in socio-professional relationships, as well as support and acceptance among peers amidst adversity and the necessary improvements in the working conditions of the category, with recognition and appreciation³².

Another aspect that drew attention concerns the communication flows between the hospital units, as well as the lack of systematic execution of routines and protocols. Workers complain about the lack of meetings and that the units do not follow the same routines. Nurses, especially those on the Technical Safety Team (relief nurses), feel frustrated because there is no standardization of routines in the hospital's inpatient units, so that all follow the already established Standard Operating Procedures. Each sector follows a specific flow, generally according to the work organization established by the nurse on each shift, resulting in a lack of cohesion, continuity of work between teams within the same sector, and poor quality in the transition of care. Therefore, the Technical Safety nurse who works shifts at alternating times or in alternating sectors suffers from the lack of systematization of care in the hospital as a whole and, consequently, from the difficulty of leading teams with such diverse work routines. This often generates conflicts and feelings of frustration, burnout, and dissatisfaction, which are intrinsically associated with perceptions of suffering at work³².

Weakened relationships in the workplace (lack of autonomy, lack of respect/recognition, lack of dialogue, and vulnerability of hierarchical relationships) also constitute experiences of suffering for nurses, reflecting characteristics of the work organization itself. Thus, nurses often face difficulties in interprofessional and interpersonal relationships in the workplace, given their lack of autonomy in the face of the culturally established dominance of the medical profession³².

The verticalized communication structure and lack of regular team meetings reported by participants exemplify what Dejours terms "organizational silence" — a condition wherein the absence of deliberative spaces forecloses the possibility of collective elaboration of suffering⁸. In healthy work dynamics, informal and formal spaces for peer discussion serve as "defensive ideologies" that transform individual suffering into collective strategies⁸. The absence of such spaces in the studied hospital suggests a pathogenic organization, wherein suffering remains privatized and, consequently, intensifies. This finding echoes broader concerns in nursing workforce literature about the erosion of collegiality in contexts of managerialism and performance metrics^{4,9}.

On the other hand, it should be noted that an environment with interdisciplinary practices involves the integration of actions, exchange of knowledge among professionals, and effective communication; factors that can contribute to the quality of care. However, the greater the number of workers and professional categories, the greater the number of conflicts in the hospital organization. If work is fragmented, there is a restriction on the subjectivity and creativity of employees, in a model that promotes the suffering of these individuals³².

When work follows an imposed rhythm, hierarchical relationships are a source of anxiety that overshadows that related to rhythm, productivity, awards and bonuses, insofar as supervision aims to maintain this anxiety related to demanding maximum output from each worker⁸. In this sense, business leadership tactics often use recriminations and favoritism in order to divide workers. Therefore, this division relates to the worker's anxiety regarding productivity, or to demonstrate better performance and occupy the space of being favored and having privileges, or that they may be "punished" as a result of some personal and family situation, such as illness, which implies a drop in work performance and this has repercussions in negative evaluation and recriminatory attitudes by the team and superiors⁸.

These techniques of discrimination and psychological manipulation are especially common in the tertiary sector, since in these places the times and rhythms of work are more difficult to control. In this way, rivalry and discrimination guarantee great power to supervision, which has human relations intensely influenced by the organization of work⁸. As a consequence, the suffering of nurses involves physical and psychological illnesses resulting from the discomfort felt by patients and their families, in the context of inadequate working conditions, overload and fragile work relationships with excessive power by superiors.

This study extends the application of Dejours' Psychodynamics of Work to the specific context of Brazilian university hospitals, demonstrating how the interplay between macro-structural factors (neoliberal management models, chronic understaffing, EBSEH governance) and micro-organizational dynamics (fragmented communication, lack of recognition, spatial inadequacy) constrains nurses' capacity for sublimation — the psychic

process through which work can become a source of pleasure and identity construction⁷. From a practical standpoint, our findings suggest that interventions aimed at reducing nurse suffering must transcend individual-level wellness programs. Instead, they should prioritize: a) the creation of regular, protected time for team deliberation and collective case discussion¹⁸; b) the redesign of physical spaces that accommodate both patient care demands and workers' basic needs for rest and privacy⁹; c) the implementation of participatory management models that grant nurses meaningful autonomy over task organization;^{4,11} and d) the standardization of protocols across units to reduce the cognitive and emotional burden of inconsistent workflows, particularly for float nurses¹⁹.

STUDY LIMITATIONS

This research refers to the perceptions of 32 nurses regarding their working conditions and suffering in the hospital environment. Therefore, the results presented here do not seek generalizations or effective solutions, since the organization of work may differ according to the health institution and individuals dynamically perception new situations in their workplaces.

CONTRIBUTIONS TO THE NURSING FIELD

The data collected in this study showed that the organization of nurses' work exerts a significant influence on the health of these professionals. Perceptions of suffering are related to the conditions offered by the organization and the freedom in employing strategies to perform their tasks. Therefore, this study sought to expand knowledge about the suffering of nurses and highlight the need for the administrative bodies of health institutions to pay attention to how the organization of work is structured, in order to allow workers flexibility and freedom in performing their activities.

Understanding perceptions of suffering can facilitate the search for solutions and strategies to adapt to this reality, making the daily work more satisfying for professionals. This can positively impact the quality of care provided by nurses, as well as the worker's own health.

Conclusions

Considering recommendations to intervene in the reality of a growing number of nurses who perception suffering in their workplace, it is

suggested that hospital managers pay attention to how the organization of nursing work is established, in order to provide conditions for the psychic structuring of professionals, as well as to offer opportunities for pleasurable experiences in the performance of their activities. This requires vigilance regarding the work rhythms imposed on teams and the performance demands of employees, so that it is still feasible for them to adjust the task according to their needs, so that the work does not become inflexible or lose its meaning for those who perform it. Furthermore, it is essential to provide opportunities for meetings and closer interaction between teams and managers, fostering openness and dialogue. A policy for retaining professionals within the units must be developed, taking into account their profiles, so they can be allocated according to the sector they identify with. The environment of the physical spaces must also be adapted accordingly, among other factors.

Based on the findings, the following practical recommendations are proposed for hospital managers and nursing leadership: 1) establish weekly 30-minute team meetings, protected from clinical interruptions, to discuss workflow issues and collective challenges; 2) conduct a participatory ergonomic assessment of nursing units to identify and remedy spatial constraints that affect both patient care and staff well-being; 3) develop a formal mentoring program that connects experienced nurses with newer professionals to mitigate the emotional impact of patient suffering and death; 4) implement a standardized onboarding and cross-training protocol for roving nurses to ensure continuity of care expectations across units; 5) finally, create a dedicated ombudsman role or peer support network, specifically addressing hierarchical conflicts and recognition deficits within nursing teams.

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