ORIGINAL ARTICLE

# The integrality of care and communicative actions in the cross-discipline practice in intensive care*

A INTEGRALIDADE DO CUIDADO E AÇÃO COMUNICATIVA NA PRÁTICA INTERPROFISSIONAL DA TERAPIA INTENSIVA

LA INTEGRALIDAD DEL CUIDADO Y ACCIÓN COMUNICATIVA EN LA PRÁCTICA INTERPROFESIONAL DE LA TERAPIA INTENSIVA

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## ABSTRACT

Cross-disciplinary work in health is an important element to deliver comprehensive health care actions. The present study analyzed cross-disciplinary actions in intensive care according to Habermas. This case study was performed using a qualitative approach. The empiric material capture was collected by observing the setting and using semi-structured interviews with health workers. The information was analyzed using the meaning interpretation technique. The analysis revealed two thematic lines: individual instrumental care in view of the clinical inconstancy, and the collective care fragmented by functions. This result weakens the worker/worker and the worker/patient interactions and compromises the association between health actions. As it does not favor communicative actions, it becomes fragile and the strategic/instrumental action is evinced.

## RESUMO

A atuação interprofissional em saúde tem se constituído de um elemento importante para a produção das ações de saúde na perspectiva de cuidado integral. Este estudo analisou a atuação interprofissional na terapia intensiva segundo Habermas. Insere-se na abordagem qualitativa, elegendo o estudo de caso como modalidade de investigação. A captação do material empírico consistiu-se de observação do cenário e entrevistas semiestruturadas junto aos trabalhadores de saúde. Para análise das informações utilizou-se a técnica de interpretação de sentidos. A análise nos permitiu identificar dois eixos temáticos: o cuidado individual instrumental frente às instabilidades clínicas e o cuidado coletivo fragmentado por funções. Tal resultado fragiliza a interação entre trabalhador/trabalhador e trabalhador/paciente e compromete a articulação das ações de saúde. Por não favorecer espaços de encontros à ação comunicativa, esta fica frágil e a ação estratégica/instrumental se evidencia.

## RESUMEN

La actuación interprofesional en salud se ha constituido en un elemento importante para producción de acciones de salud en la perspectiva del cuidado integral. Este estudio analizó la actuación interprofesional en terapia intensiva según Habermas. Toma el abordaje cualitativo, eligiéndose el estudio de caso como modalidad investigativa. La captación del material empírico consistió en observación del escenario y entrevistas semiestructuradas con los trabajadores de salud. Para análisis de la información se utilizó técnica interpretativa de los sentidos. El análisis permitió identificar dos ejes temáticos: cuidado individual instrumental frente a inestabilidades clínicas y cuidado colectivo fragmentado por funciones. Tal resultado fragiliza la interacción entre trabajador/trabajador y trabajador/paciente, y compromete la articulación de acciones de salud. Por no favorecer espacios de encuentros, la acción comunicativa queda fragilizada y la acción estratégica/instrumental se pone en evidencia.



## DESCRIPTORS

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## DESCRITORES

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## DESCRIPTORES

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## INTRODUCTION

The Brazilian Unified National Health system (SUS - *Sistema Único de Saúde*) redefines the hospital as a place for patients in severe clinical conditions that require continuous care, technology resources of higher complexity, and specialist professionals. This new role should take into consideration the health care profile and assume comprehensiveness as the guiding principle of health care quality and humanization[1].

Nevertheless, hospital health actions take place among the innumerable diagnostic and therapeutic activities performed by different workers[2]. There is no agreement in terms of how the different professional categories should work, hence each responds to a specific practice without an appropriate understanding of the interface between them and the meaning of the comprehensiveness and inherent interdependence of the practice of providing care to people[3].

Introducing new rationale, as the principle of comprehensive care, in the health system implies that health care professionals must change their practice and develop a new look towards patients, co-workers, and themselves with a view to surpass the mere execution of formal tasks. Furthermore, it implies establishing places to meet with others and exchange experiences so as to strengthen the cooperation and integration among professionals.

Because the search for comprehensive health care pervades the review of the care dimension, in which health professionals are included as those responsible for the health care outcomes, it increases their ability to welcome, establish bonds, and dialogue with other dimensions besides those of the domains of epidemiology and traditional practice. In addition, health professionals must perceive themselves and see the patient as a subject, i.e., a real person that writes his or her own history and is responsible for their becoming, for their come-to-be[4].

Comprehensive hospital care, on the other hand, can occur through the combination of hard, soft-hard, and soft technologies in the search for a balanced adhesion between instrumental and communicative rationale, and understanding them as determinants of health care actions[5].

The challenge lies in strengthening the combination of the different practices by different professionals, who hold specific knowledge, in order to implement comprehensive health care. From this perspective, one of the main aspects of the challenge consists of when and how the health teams begin to operate as a group forming a worker/worker and worker/patient relationship with inter-professional interaction[6].

Another challenge is the implementation of comprehensive health care in the dynamic setting of the Intensive Care Unit (ICU), which requires knowledge in multiple domains in order to deal with the diversity of health care. This occurs because this working environment implies a constant expectation of emergencies, which involve the need for highly complex technology and a concentration of critical patients subject to a sudden change in their overall clinical condition. This setting is stressful and generates an emotionally compromised ambiance for professionals, patients, and the patients' families[7].

Another challenge is the implementation of comprehensive health care in the dynamic setting of the Intensive Care Unit (ICU), which requires knowledge in multiple domains in order to deal with the diversity of health care.

From this perspective, how do ICU workers organize themselves to ensure the necessary conditions to exchange information and establish professional interrelationships with a view to comprehensive care? How is it possible to combine the different professional initiatives with patients being the center of the working process in health? These questions point at the tension and connection that interest us: the interface and possible outcomes of inter-professional practice in the perspective of comprehensive care in the ICU.

In view of the aforementioned aspects, the objective of this study is to analyze inter-professional practice in the perspective of comprehensive care in the ICU. To do this, the study was grounded on communicative actions to shed light on a reflection about the dimension of the cooperation/interaction between health professionals.

## THEORETICAL FRAMEWORK

Communicative actions are related to human actions, which imply the concept of work and social interaction. The essence of work is to dominate nature and make it serve men, thus its rationale is similar to that of science and technic as it involves technical-strategic knowledge and action. Work, or rational teleological action, can be an instrumental action guided by technical rules supported on empirical knowledge, and achieve purposes defined by specific conditions; strategic actions, founded on rational rules based on analytical knowledge as it depends on correct valorization and communicative actions, understood as actions that seek understanding[8].

The social interaction concept, on the other hand, is conceived through communicative actions, and can be understood as peoples' conversations about something of the world, in which they address, through speech, pretentions of validity. Hence, speech guides interaction[8]. From this perspective, social practice triggers communicative actions, a symbolically mediated interaction, guided by *mandatory rules that define the mutual expectations of*

*behavior that must be understood and recognized at least by two participating subjects*[8].

Any communication established between subjects concerns three worlds: the social work of rules and institutions, the objective world of things, and the subjective world of experiences and feelings. For this reason, in communicative actions, an action is intermediated by the communication between subjects that seek to reach an agreement about the objective, social, and subjective worlds. In that action, people interact by using language and become socially organized with the purpose of reaching consensus free from any external and internal coercion, of which assumptions are the truth, argumentation, consensus, intersubjective relationships, and discourse[9].

Therefore, this communication process, which aims at reaching a mutual understanding, guides interaction. Argumentation, in the form of discourse, permits to agree about the validity of the propositions or the authenticity of the norms, and permits actors to participate freely and equally, as they see the truth as a consensual process, *verdad es una pretension de validez que vinculamos a los enunciados al afirmarlos*[8].

In this view, communicative actions occur when speaking comprehensively (normative correction), truthfully (propositional truth), sincerely and authentically (expressive authenticity). Speakers are constantly and mutually establishing pretentions of validity about what is said [8].

It is observed that language is not strictly a grammatical dimension; rather, it is understood as a means to achieve mutual understanding about something, as it follows pragmatic rules. In addition to allowing individuals to act and express themselves, rules also permit them to interpret our beliefs, values, and interests in our form of acting as well as our ability to interpret the meaning of others' actions and the way they relate with us. Therefore, a critical analysis of speech permits to understand why and for what reason the statement is made, as a way to explain its causes and consequences[9].

## METHOD

This is a qualitative study. This approach was chosen because it allows for apprehending the reality and understanding social phenomena and processes, and is thus appropriate for studies addressing health care practices and the relationships between the individuals performing those practices.

Case study was the chosen modality of investigation because it permits to achieve a detailed understanding of a group or organization (Who are they? What do they do? How do they relate between themselves and with the setting?), and develop *more general theoretical statements about the regularities of the process and social structure*. This study design permits to build knowledge based on the uniqueness of the case[10].

The study was approved by the Research Ethics Committee at the institution where the study was performed, and the subjects' identity was preserved by using fictional names.

The empirical material was obtained at the ICU of a teaching hospital located in the interior of São Paulo, using empirical field observation followed by semi-structured interviews. Measures were taken to minimize the entrance of the observer in the empirical field, such as participation of the clinical visit on a daily basis one month before collecting the data and recording the observations at the ICU[11]. A guiding script was used to record field observations, which was created and tested before the study. This technique permitted to follow the professional's practice and describe the context of the ICU at the moments of admission, clinical visit and discharge from the unit, with a view to follow up to three simultaneous cases.

The semi-structured interview permitted to learn about what happens beyond appearances and the superficial communication. To do this, a specific guiding script was created and tested before the study, containing aspects regarding the subjects' identification and professional practice. The instrument was applied at the subjects' working place, and the professionals' identity was preserved by using a number followed by the letter i. Interviews were performed with ten professionals, including physicians, nurses, physiotherapists, nutritionists, and nursing auxiliaries of different working shifts. Of all interviewed professionals, seven were female, and three were male, and their mean age was 39 years.

The collected material was analyzed according to the meaning interpretations technique[12]. In the process of analysis and interpretation, the following steps were followed: (a) comprehensive reading of the statements, aiming at impregnation, view of the group and apprehension of the particularities of the collected material; (b) identification and problematization of the explicit and implicit ideas in the statements; (c) search for socio-cultural meanings based on the study subjects' meanings; (d) dialogue between the problematized ideas and the theoretical framework of the study, with an aim to find the theme lines that could represent the logic of the interviewed subjects; and (e) the development of an interpretative synthesis based on the established theme lines, with an attempt to combine the study objective, theoretical foundation, and the empirical data.

## RESULTS AND DISCUSSION

### *Interpretation about the inter-professional practice in intensive care*

We sought to understand the meaning of the conversations between the many health professionals working in intensive care, in the area of professional interaction and in their relationships with the ICU patients and their

families in order to interpret the inter-professional actions from the perspective of comprehensive care and communicative actions with the purpose of qualifying health care practice. The analysis permitted to identify two theme lines: individual instrumental care in view of the clinical instabilities, and the collective care fragmented by functions.

The critical analysis was based on the comprehension of how health care practices were performed, referred to as specific nucleus and care taker nucleus[13]. From this view, we characterized an individual plan of the aspects referring to the specific nucleus defined by the concrete problem of the ill individual and by the excerpt that each health professional makes to intervene – and a collective plan comprising the relational processes regarding the soft technologies, which belong to every professional in their work relationships, the care taker nucleus. This reference guided the discussion about the theme lines.

**The individual instrumental care in view of the clinical instabilities**

The confrontation between the professionals' statements and the field observations show the biomedical and fragmented meaning of care. This occurs because health care is based on the biomedical model, which values the diagnosis and treatment, producing fragmented health care actions. This meaning also reflects on the teaching and learning process in the setting of providing critical care, and on understanding health as the absence of disease, on the criteria used to admit patients, on the absence of affective actions, and addressing collective health needs, as observed in the following statements:

> Does a chest X-ray, with the patient lying down, make it difficult to evaluate pulmonary edema? High blood pressure at admission can be caused by stress and distress, but when sedated the blood pressure decreases (Field diary). The care covers everything: physical, hygiene, medication; it is a very broad work. When the patient arrives, the first thing to do is the monitoring, checking the vital signs (5e).
>
> Today it is Ms. Janaina's birthday. We should sing happy birthday to her. Nobody supported the idea. The others continued talking about clinical parameters (Field diary).
>
> To extrapolate happiness when the patient is in a critical condition, during visiting hours. To what extent is happiness in the room good or bad? When people enter the ICU, the family, how will they see the setting? On the other hand, this relaxation is very important emotionally, because it is not easy to be continuously inside the hospital (1e).
>
> A programed visit, when an intern presents the case and elaborates a hypothesis, i.e. diagnoses the situation; the resident gives his/her opinion about the case, and adds the experience and the training that he/she has had (10e).

In this context, the professional practice regarding the individual plan involves health care actions in situations of clinical instability in an ICU setting. These actions, from a perspective focused on the curative model, are recognized as a form of caring for the patient, because clinical change is understood through the signs and symptoms subject to routine care. That emphasis gives evidence of the need for professionals to reflect about their actions in an effective search for comprehensive health care practices[14].

On the other hand, this form of conceiving professional practice is included in a broader social context, because, in view of the clinical instability, society expects qualified care in the biological dimension. We also know that industries have a great interest in manufacturing equipment, drugs, and state-of-the-art technology to assist critically ill patients. The family also expects accurate professional practice and appropriate therapeutic support so their loved one can return to his/her social role in good health conditions.

This practice reflects how health professionals deal with the object of work in health, in which care actions are centered in several segments, except on the patient. These observations reproduce notions that have been disseminated across history regarding the health thoughts produced based on the comprehension that men have about nature's phenomena.

Although in the health area there is a notable recognition of treatments with a biological approach, this practice eventually overcasts the coverage of the care actions in meeting the subject's health needs, which propose new directions for hospital care, considering that, in order to be effective, it needs to do more than simply provide a diagnosis and treatment, and respond to the diversity of the health problems that involve the many dimensions of life, from those of the body to those of social and subjective domains[15].

We did not identify in the statements any health care actions aimed at meeting collective health needs. Living with distress, for families and workers, appears as an indication of that need, but is poorly elaborated. On the other hand, the need for actions to provide collective health care in the hospital setting appears with the purpose to recover the patient, treat the disease, and the primary health care units respond for issues related to health promotion to improve quality of life.

The biomedical and fragmented meaning of professional practice that also reflects on the teaching and learning process in the ICU setting, based on the traditional education model, makes a small contribution for the reflexive movement, the development of patient autonomy and the interaction between professionals.

In this case, work, as a rational teleological action, can be characterized as an instrumental action, i.e., action is guided by technical rules supported on empirical knowledge and performs actions with purposes defined

by established conditions, which promote interaction in a multi-professional perspective.

Through inter-professional work, the professionals are able to build a common knowledge regarding the interrelation practices that would express the communicational dimension of the instrumental practice. However, when there is unequal authority in a inter-professional team, tension emerges from the dispute between complementarity and interdependence and the search for improving the technical autonomy of the professionals. Nevertheless, the efficacy and efficiency of services require both technical autonomy and the combination of actions[16].

From this perspective, we understand that the studied health care professionals working in intensive have been aiming at the care practice implied in the cognitive-instrumental domain, despite the fact that comprehensive care also requires incentives of practical-moral and practice-esthetic values.

It is important to establish a connection between three cultural domains: cognitive-instrumental, practical-moral, and practical-esthetic; with the purpose to assure the production of knowledge and permit communicative practice to take place in the everyday work place. However, a disarranged growth of economic rationality, hindering dimensions such as ethics and esthetics, leads to a *colonization of the world of life* by the systemic world. Modern reasoning is reduced, as it becomes restricted to the scientific dimension[8]. In this context, communicative actions become weaker and the strategic/instrumental action prevails.

There is a clear need for investments in studies to elucidate the professional hospital practice from the perspective of producing health actions that meet collective health needs in critical care, as a way of caring for the patient/family as well as the worker.

### *The collective care fragmented by functions*

By confronting the professionals' statements with the field observations, the meaning care centered on tasks was assigned to the professional attitude in the collective plan, which was related to a functionalist organization. As health care actions are based on protocols, hierarchy and control, the disarranged coordination of actions, the discontinuity of actions, and on professional-centered decisions, this meaning refers to the care action in the logic of the disciplines, in the positivist biological model of understanding the disease, as illustrated in the following statements and field observations:

> We are able to create some protocols as a group, one protocol that is really interesting is the one to sedate patients submitted to mechanical ventilation (10i).

> We have a team of physicians, residents, nurses, physiotherapists, but we still cannot call it a inter-professional team because they never meet, they don't discuss the cases(6e).

> Visits are very important, when there are no visits, we feel lost, because there is no direction (4i).

> Caring is making people work with me, those who are my subordinates, to work together, with the team (6i).

> The physician asks is the bed is ready to transfer a critical patient, the nursing auxiliary gets angry because she was unaware about the admission, because the patient who had been discharged is still in the bed (Field diary).

> Because I work part-time, I miss a lot regarding the patient (2i).

> On the weekend, sometimes something we had planned is not done because only one nurse stays at both ICUs (4i).

The professionals' statements and the field observations regarding the professional practice in the collective health plan, showed that the working organization follows the rational model grounded on the General Theory of Administration. This model aims at mass production, the products are hegemonic, time and movement management prevails, the work is divided and fragmented according to the functions, the concept and performance of work are separated, and group work is isolated[17].

Following this logic, professional actions constantly deal with hierarchic command relationship: someone holds the information and does not share it with the group, as hospitals traditionally follow the classic administration framework to organize managerial practices. This framework does not take consider the individuals as subjects capable of understanding and contributing to the development of the actions. Nevertheless, in literature as well as in the observed situation, we see that this attitude causes dissatisfaction and compromises the quality of care. This behavior weakens the worker/worker and worker/patient interactions and the combination of health actions because it does not promote meetings.

The organization of care followed in this setting differs from comprehensive care, which consists of a national premise to overcome fragmented care and establishes teamwork as the organization strategy. Professionals should guide their practice by the perspective on inter-professional actions, based on the need to combine health actions and understand that comprehensive care is developed through the complementarity and interdependence of health actions.

The observed meanings about professional practice in the collective plan demonstrated how distant these actions are from the SUS guidelines, because workers are not sufficiently encouraged to see the hospital as a social organization, than contributing with the municipal health system.

Health professionals must work with social responsibility, becoming committed to others, with patient care, as a form to overcome the disclaims of normative programs

that tend to make each worker feel responsible only for the activities in their specific area[18].

It has been reinforced that professionals must *build interaction among them, exchanging knowledge and implementing a field for the production of care* based on the concept of competence field, as chances emerge for the professional to *use their whole creative potential* to develop a project of care as a group[19]. Therefore, they share the belief that the qualified presence of professionals in the work setting promotes interaction.

Another important aspect is that comprehensive care has been pointed at teamwork as a strong form or health work organization, which implies the participation of all health team members in the decision making process. That organization consists of a practice different from the classic form of organizing services and establishes new power relationships when making decisions. Teamwork means more than categories working in the same physical area, or with the same object of care; *it implies the feature of a common knowing-doing, a working with*[20].

On the other hand, implementing teamwork as a means to comprehensive health implies that health professionals must assume a distancing attitude towards the current way that work is organized, with the purpose of seeking and developing consistent, appropriate arguments to start a negotiation to reach a different outcome. It should be understood that, in the microarea, professionals express their autonomy and heave the chance to change their practices.

The fragilities of the interaction in the working world can be related to the capitalist way of producing goods and services, due to two evolution tendencies of advanced capitalism – the increased interventionist activity of the government, which guarantees the stability of the system, and the growing technical interdependence, which changed science into the first productive force[21].

The policy of government interventionism demands the depoliticization of the population, by ensuring work and income stability and social security, it also guarantees population loyalty and pacifies conflicts. This tendency aims at avoiding risks that could threaten the system and has a view to solve technical issues, excluding the practical ones. However, the institutional organization of society remains an issue of praxis associated with communication, and not merely a technical-scientific issue.

The second tendency is characterized by the scientification of the technique through the institutionalization of the technical-scientific advancement. In this case, the potential of the productive forces assumes a position that place work and interaction on a secondary level in men's conscience. Social interests still determine the direction, functions, and speed of technical advancement. Nevertheless, those interests are still defined by maintaining the system, as economical development remains the goal. These interests are also grounded on a structure of immediate privileges and opportunities in life with which the loyalty of the mass is obtained through compensations aimed to satisfy private needs[21].

The rapid technological development is related to the imposition of professional work, the ethics of income competitiveness, values of possessive reification, the presented substitutive satisfactions, with the view to maintain an institutionalized battle for existence, the discipline of isolated work and the isolation of sensitivity and esthetic satisfaction[21]. In view of this panorama, the working world are materialized, as do the interactions between professionals and the combination of actions, and health care projects are developed. These aspects compromise quality of life, the possibility of creating autonomy in the people to lead their own lives, and, as a consequence, the possibility of emancipation.

## CONCLUSION

In conclusion, we stress the challenge of health work when seeking the commitment by health workers in a view to combine health actions and establish an interaction between the professionals with a view to comprehensive care. Inter-professional work, on the other hand, has become an important element for producing health actions considering the complexity of the health-disease process. However, today there is an incipient approach to the ethical-esthetical dimension of health practices, which are the precursors of the interaction between professionals. In view of this setting, there is a need for expressive and continuous investment on comprehensive care and communicative actions in the everyday intensive care work setting.

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