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"Fiefdoms" and co-management: the paradox of autonomy in an experience of democratization of hospital management

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Abstract *This study aimed to analyze the implementation of Management Committees and Production Units in a hospital in Rio de Janeiro based on the views of the actors responsible for this process, focusing on the issue of autonomy of the subjects involved in care delivery. This case study adopted a qualitative clinical psychosociological research approach using mainly semi-structured interviews. The management arrangements were valued by the interviewees principally as a way of increasing worker commitment, since the inclusion of workers in the Management Committees is likely to widen decision-making capacity and, at the same time, make staff more committed to care delivery. On the other hand, workers mentioned resistance arising from a struggle to maintain the concentration of power within the professional categories, and the challenge of dealing with differing conflicts of interests. The study suggests that the Management Committees and Production Units should include possibilities of addressing conflicts and intersubjective processes to avoid becoming excessively idealized and ineffective spaces.*

Key words *Health Care/organization and Administration, Professional Autonomy, Hospital Administration*

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Introduction

This work evaluates hospital management by analyzing two management arrangements designed to democratize labor relations and improve care: Production Units (*Unidades de Produção* - UPs) and Management Committees (*Colegiados Gestores* - CGs).

Traditionally, the organizational structure of hospitals has tended to produce unequal distribution of power, while at the same time reinforcing work fragmentation and hindering interdisciplinarity[1]. The purpose of UPs is therefore to reformulate organizational structure according to the goals and end activities of each unit rather than different professional categories.

CGs are collective management bodies that aim to include the lifeblood of an organization - its professional staff - in managerial decision-making. UPs and their respective CGs are structured in such a way as to in involve staff in the formation of bodies and construction of identities, whether provisional or partial, which are in tune with the organization's goals. UPs are both enabling arrangements, permitting the formation such bodies, and a product of this collective work effort[1]. These arrangements are proposed under the National Humanization Policy[2,3] and discussed within the public health field, both in the theoretical realm[4-6] and in the practical, in terms of the experiences related to their implementation[7-11].

However, the experiences of implementing the CGs and UPs reveal certain challenges[6-9] showing that there is a significant gap between original expectations and practice, particularly with regard to democratization, given that these spaces are not always recognized by staff as being permeable to their effective participation. This assumes that the staff feel technically, subjectively and politically prepared to participate, and that, at the same time, there is sufficient degree of "permeability" to ensure that their inputs are materialized in the plans and joint decision-making. This interrelation between the subjects' own resources and the politico-institutional conditions to develop and utilize them has to do with autonomy. We understand that autonomy is not a value or absolute condition, but rather relative[12], assuming, on the one hand, creativity, freedom, and purposeful capacity, and, on the other, capacity to listen, respect for differences, and openness to dialogue and negotiation. Thus, autonomy is a nodal category for understanding the possibilities of constructing democratic relationships in such settings.

Study design and methodology

The main objective of this article is to analyze the implementation of CGs and UPs in a hospital in Rio de Janeiro, based on the discourse of the actors responsible for this process and focusing on the issue of the autonomy the subjects involved in delivering health care. Its specific objectives are: understand the objective and implementation of CGs and UPs, and possible successes and challenges; and understand the organizational imagery surrounding the sense of autonomy that informs/sustains this implementation.

We drew on the following theoretical and methodological inputs during analysis: contributions from health planning and management theorists with emphasis on the theme of subject/subjectivity and the issue of autonomy and co-management[1,6,7]; French psycho-sociology, particularly the theoretical contributions of Eugene Enriquez[13,14], which enabled us to analyze the imagery, intersubjective and group aspects of this organizational phenomenon that produce effects on the limits and possibilities of cooperation and development of collective projects, as well as on the bond that the subjects establish with the organization and their work, which go beyond the material and political dimensions.

This case study adopted a qualitative clinical psychosociological research approach[15] using mainly semi-structured interviews. The analysis of empirical evidence involved successive listening and reading of the recordings and transcriptions of the interviews guided by the research questions. Throughout this study, empirical categories were produced, understood, and later analyzed and discussed using a conceptual framework. In accordance with clinical psychosociological methodology, another important guiding element in the reading and listening process and analysis of the empirical evidence were subjective issues, such as the researcher's perceptions and feelings, set in motion by the setting and interaction with the subjects present there. The following categories were elaborated using this process: *the issue of autonomy in the implementation of the management committees and production units; professional categories, 'fiefdoms' and commitment to the construction of a new groupality; inclusion of service users in the hospital management democratization process; the management committee as being responsible for a change in organizational culture; imagery that sustains change.*

The study was conducted between 2011 and 2012. The following subjects responsible for the

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undergoing project to implement the CGs and UPs were interviewed: five professionals that provided project support and one of the hospital managers. The interviews lasted an average of one hour.

The study was approved by the Ethics Committee of the National School of Public Health of the Oswaldo Cruz Foundation in 2012 and all participants signed an informed consent form.

Results and discussion

Implementation of the management committees, production units and areas of care in the hospital

In August 2011, the hospital management decided to carry out a management reform based on the guidelines of the National Humanization Policy (*Polítca Nacional de Humanização* – PNH)[2,3]. Up until this point, the administration of the hospital was fragmented and divided into departments, each of which was linked to a particular professional category or function. The transformation proposed by the management was founded on the creation of UPs and Areas of Care (*Áreas de Atenção* - ATs) rather than departments in order to restructure care, focusing on delivering care to service users with similar problems rather than on specialized services, and foster co-management.

The UPs are a way of reorganizing work in order to defragment organizations and productive processes and articulate workers by acknowledging the mutual objectives of the tasks they carry out in the unit[1], while ATs can be defined as core areas linked to the institution's mission and the whole care and health management process, encompassing one or more UPs. Each AT and UP should have one Management Committee (CG).

At the last contact with the research subjects, the ATs were organized into the following areas: Medical and Surgical Care for Women, Medical and Surgical Care for Pregnant Women, Medical Care for Newborns, Medical Care for Children and Adolescents, and Surgical Care for Children and Adolescents. These five ATs incorporated a total of 22 UPs each with interprofessional paired management: for example, the AT Medical Care for Children and Adolescents was made up of the Acute Unit, Intermediate Unit, the Pediatric Ward, the Pediatric Clinic, and Specialty Care Clinic.

The committees of the UPs are composed of health workers who form the teams that make up these units. The UPs are coordinated by a pair of health workers from different professional categories who represent the UP on the committee of the AT. At the time this study was carried out, these pairs of coordinators comprised the old heads of departments (all doctors), together with an additional representative from another profession (all the professionals chosen to form the pair with the doctors were nurses).

The reason for this set up, according to the research subjects, was a strategic decision taken to avoid resistance from the doctors, who previously occupied the position of head of department. Therefore, the hospital opted, at least initially, to maintain the doctors who were heads of department forming a pair with another elected representative, necessarily from another professional category.

The committees of each AT are made up of paired managers who represent their respective UPs. For example, an AT made up of five UPs will be composed of five pairs. In addition, there is a Steering Committee made up of representatives of the Board of Directors of the hospital and committees of the ATs.

During the fieldwork, the organization of the ATs changed. This change tends to be continual, given that it is a continual process involving disputes and consensus. In December 2012, there were five ATs bringing together 22 UPs. This organization involved a great deal of discussion and resistance regarding the redefinition of the previous organizational structure of the old departments.

The implementation of the UPs and CGs had supporters from the Ministry of Health connected with the PNH and "supporters" from the actual hospital, which, according to the interviewees, would be a way of sustaining the proposed change.

It was observed that the formation of the committees was inconsistent across the different ATs, and the process is more advanced in some areas, meaning that some committees have already managed to hold more purposeful discussions. For example, one of the ATs was able to discuss the service profile of care offered by the area and made such "progress" that one of the pair of coordinators left the position and a replacement was chosen, while in other AT's the discussion still focused on the formation of the committee.

The issue of autonomy in the implementation of the management committees and production units

The participation of health professionals in the CGs and UPs was mentioned, particularly by the "supporters" and hospital manager, as a way of increasing workers' *commitment* to the organization, given that a low level of commitment is seen as a problem that strongly affects the performance of health services and a significant barrier to the management of the hospital. The supporters of the project believe that increased worker autonomy resulting from the implementation of the CGs means that it will be possible to make health workers more accountable.

According to the interviewees, workers are more likely to make themselves more accountable when they recognize their influence on the management processes. By participating in decisions about changes in productive process, health professionals are likely to be more engaged in the implementation of these changes:

[...] *try, through shared management, to achieve greater staff participation in decisions, commitment, I think is the keyword, which is something we have lost a lot of in public service* [...]. (Interview 2)

For the interviewees, staff participation and commitment are a way of making planning more effective and avoiding elaboration of plans solely by the management that, consequently, are not adopted by the workers. Furthermore, the interviewees suggest that the inclusion of workers in management processes and the realization that they have an influence over the decisions made in the organization is likely to lead to a sense of greater "well-being" among workers.

However, the interviewees recognize that there are inherent contradictions in the implementation of the committees. On the one hand, there is a general understanding among workers and managers that the structure proposed under the CGs is the most adequate model of management for the hospital; while on the other, they assume that the proposal is likely to come up against a lack of belief among some staff members in the possibility of organizational change for the better and the individual demands of the health professionals, such as fear of losing power/autonomy:

Everyone, whether they have a position of power or not, understands that the committee is a better way of working; more democratic, more efficient and so on. [...] *you could say it's obvious* [...] *However, just as people naturally think that* [there is] *a better way of managing, they also understand that it's going to take away some of their power.* (Interview 1)

In the opinion of the interviewees, in a new management structure that seeks greater commitment from the workers, the implementation of committees is always likely to come up against workers' interests. Paradoxically, however, it is also understood as a way of increasing autonomy (referred to at certain moments as "empowerment"):

[...] *people will feel more at ease, more empowered to give their opinion and demand that this opinion is considered.* (Interview 7)

The concept of autonomy appears to have two different meanings in the discourse on CGs. On the one hand, an increase in the degree of worker autonomy is sought as both a means and an end in its self; to increase the capacity of workers to make decisions and democratize the management settings within the hospital. On the other, the hospital seeks an increase in cooperation and commitment from these actors, since the power of these categories of professionals appears to be a complicating factor for the committees, given their goal: expand the possibilities of governance over what the workers do (autonomously).

Cecílio[6] helps us to understand these paradoxes by presenting two meanings of autonomy: one which ties the notion to the ideal of building a democratic society, which considers autonomy both a *means* and *an end in itself*, linking it to the possibility of increasing workers' capacity of self-analysis and self-management; and the other[6] that considers autonomy as being inherent to *the nature of work* in the health sector – especially that of doctors, who enjoy great freedom of action and are often responsible for a large part of the care decisions taken in the health services. From a micropolitical perspective, we can assume that health care preserves a large degree of autonomy, when understood as work as a living act[16].

Professional categories, "fiefdoms" and commitment to building new groupality

The interviewees mentioned that the interests of the professional categories have a strong influence over hospital management, particularly on the type of organization, which the construction of the UPs seeks to transform. Furthermore, they stated that there is a great deal of dispute and tension between professional categories, characterized by doctor hegemony:

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[...] *these days hospital organization obeys mainly class interests and within these class interests there is a class struggle and class hegemony.* (Interview 7)

The formation of UPs is organized around multiprofessional teams and coordination between different departments, which is still in the incipient stages in the hospital. According to one of the interviewees, [...] *it's difficult for us to accept sharing power. Each of the categories, regardless of how empowered they are, are scared of losing Power. The fact that we surround ourselves in secrets in our closed spaces is proof of this.* (Interview 5)

Peduzzi[17] defines multidisciplinary work as "a collective work modality configured in a reciprocal relation between multiple technical interventions and the interaction of agents from different professional backgrounds". One of the interviewees expresses these values as follows: *I think that one of the various effects of the formation of committees proposed by the PNH is that you no longer see it as particular professional class, but rather as a work process with an objective*. (Interview 7)

Although the creators of the organizational restructuring project show themselves to be imbued with these ideals, the configuration of spaces that promote healthy professional interaction and exchange remains a major challenge in the context of this hospital. In this sense, it is interesting to note the emphasis given by one of the interviewees on the need to "demystify" personal and group interests:

Demystify in terms of being able to have your own personal interests: I can have mine, the group can have theirs, but the personal interests within the committee will have to come up against other interests, will come up against the interests of society, which has certain expectations of the hospital and the SUS [...] (Interview 7)

Doctors' autonomy within the organizational restructuring is mentioned as something that creates tension with other professional categories. In terms of power, it is apparent that doctors are the least affected by the implementation of the UPs, since they do not go through the same process as the department heads from other professional categories.

It is important to note that these positions cease to exist or are transformed into technical coordination positions that have limited governance over the management processes in the newly created UPs. This reality raises certain questions such as: *The doctor is not here, where is the doctor? In the coordination of the areas and the production units. That is the first thought, and that results from this reaction: so am I a paramedic? Do I support the doctor?* (Interview 3)

As we mentioned above, the heads of the old medical departments remain as managers, as coordinators of the ATs and UPs paired with elected coordinators from other professional categories. Thus, through the eyes of other health professionals, if the committees do not work and the decisions continue to be taken solely by doctors, this could increase the power of doctors over other professional categories.

[...] *technical matters are discussed in this technical coordination, while management is discussed in the production units. So, for example, holidays, leave, etc.. isn't discussed. But, outside the production unit, it's discussed in the committee. What are the criteria, why? Because it affects the work process.* (Interview 3)

The old hospital departments are described by some interviewees as "fiefdoms", which suggests that departments had a certain degree of independence or autonomy, both in relation to the hospital management (reducing its capacity to manage), and, principally, in relation to other departments.

The word "fiefdom" suggests, apart from poor relations between departments, the presence of "bosses", or heads of departments that commanded the service for a significant amount of time and performed the function with great authority and legitimacy. Hence, the following comment: ... *the guy has been head of the clinic for 12 years, has made his mark on the department, he controls everything, decides everything, he's the only one in touch with the management* [...]. *If he leaves or dies, you have to start all over again.* (Interview 1)

With respect to this kind of situation, Campos[1] emphasizes that some experiences of implementing CGs in UPs have shown "a tendency for people to close in on themselves, heading swiftly towards a form of departmentalization, if not towards fiefdom [...] forgetting the clientele and favoring a corporate perspective".

These kinds of problems are also evident in the interviewees' interpretation that the heads of department, given their great degree of authority and legitimacy, could create obstacles to the implementation of the committees. This means that, at this stage of the implementation of the CGs, the subjects strategically avoid discussing organizational restructuring based on the implementation of Production Units, since this would mobilize the departments to organize themselves based on their use value to the institution or, in

other words, their capacity to meet the health needs of the service users. The following extracts illustrate the web of difficulties involved in this process:

So we have the first 'trauma', which is bringing these units together [...] *if you bring two units together* [...] *there's one head here, another there, there's a head and a team. If you bring two units together, one head goes; that's where the problem begins.* (Interview 1)

This discussion has already been on the agenda and is already [...] *let's say... on hold for now* [...] *Because, politically, you have to opt for the following: at the moment, is it better for us to focus on the structure of the committees, or otherwise get into this discussion, which is going to be tough?* (Interview 1)

Amid these issues, the interviewees emphasized the challenge of coordinating the actions of the different departments and ensuring comprehensive care for service users arising from coordination between diverse areas of knowledge. One interviewee affirmed that staff are likely to become aware of the need for coordination between the different departments when they acknowledge their own department's "shortcomings" in delivering comprehensive care to service users:

Because departments don't work alone. A child arrives here and, if necessary, he/she sees a specialist; if necessary, he/she is admitted; if the situation gets worse, he/she goes to intensive care; after, he/she comes back to the ward; and so on. The shortcomings of each department they need to be acknowledged to be coordinated, something that, mysteriously, doesn't happen. So, each fragment wants to have complete autonomy to work alone. (Interview 7)

This view can be extended to include the need to acknowledge not only department shortcomings, but also workers' shortcomings. It is possible that this acknowledgment would facilitate awareness of the need for teamwork and coordination between different areas of knowledge, which in turn would make collective discussion more productive.

In addition, the transformation of the organizational structure of this hospital requires building a new groupality that is more heterogeneous than that formed around the professional categories and, therefore, more difficult to develop. By new groupality, we mean a new group dynamic which entails a new way of "being" in a group[18]. For this to happen, workers, departments and categories must acknowledge and value differences, as well as accept shortfalls[19] in the mission to fully meet the health needs of service users.

We therefore believe that these new arrangements have the potential to function as spaces for fruitful dialogue between diverse realities, such as the psychic reality and material reality, subjective and intersubjective reality, and individual and organizational reality, enabling the development of a mutual project to produce use values. This proposal is founded on the concept of intermediate formation developed by Renè Kaës[20], which, due to its complexity, is beyond the scope of this article.

The inclusion of service users in the democratization of hospital management

The possibility of including service users and their family in the CGs was mentioned by the interviewees only when they were questioned by the researcher. In general, interviewees recognized the importance of the participation of service users in the management process. However, the inclusion of service users was seen by the interviewees as something that should be strategically put off to avoid "unnecessary confusion".

In this sense, according to the interviewees, it would be more prudent first to strengthen the teams and committees to later allow the admission of service users since [...] *the problem is that there is a lot of resistance and a lot of processes to deal with. If you are already working along these lines, in this new way of doing things, adding users, I believe, would create unnecessary confusion.* (Interview 2)

In light of the above, the CG is apparently seen as a space that, once up and running well, will function smoothly without conflicts and fissures, where service users will participate without being exposed to the existing tensions in the relationships between the subjects that are part of, and give life to, the hospital. One of the interviewees defends: *introducing the user has been thought about, but everyone agrees that we can't introduce the user until we have organized ourselves well* [...] *if a user participated in a committee meeting today he would see quarrelling.* (Interview 1)

Some interviewees mention that the participation of service users in the democratization of hospital management is important because it is likely to provide users with a greater *understanding* of the difficulties faced by the hospital. Such a view can be interpreted as an instrumental apprehension of the inclusion of service users, considered as a way of generating an understand-

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ing on the part of users in relation to the efforts made by the hospital and the specificities of its mission, rather than as an end in itself.

Finally, the interviewees also considered that involvement of users comprises inclusion in discussions about health care processes and participation in meetings together with workers, as an alternative to the traditional approach that sees users as clients and mere receivers of a service strictly provided by a technical team.

In our view, promoting the participation of service users and their families who experience hospital reality could avoid the tendency to bureaucratize CGs, bringing the demands sent to the hospital closer to the health needs perceived and experienced by "real users", who suffer firsthand from the barriers to the effective functioning of the unit. In accordance with Campos[1], the inclusion of service users, apart from achieving the objectives of social participation and radical democratization of healthcare settings, thus reinforcing the public nature of health care, should be a driving force that aids and neutralizes the possible effects of the corporatization and bureaucratization of democratic spaces within hospital management structures. However, this raises the challenge of promoting the participation of service users and workers in management settings, considering the differences in the knowledge and responsibilities of these actors and the resulting asymmetric power relations.

Management committees as a change in organizational culture

The interviewees also view the CGs as a tool for promoting change in hospital culture that would otherwise tend to undergo a natural transformation over time. The supporters/interviewed managers affirm that workers are likely to "adhere" to the way the committees work in the future, acquiring greater work decision-making autonomy and changing their perceptions of the coordinators, who they will no longer see as management.

It could be said that some of the interviewees appear to have an idealistic attitude towards the CGs, attributing them responsibility of promoting the transformation of a series of characteristics incorporated into the organization of the hospital over the years. We agree to a certain extent with Campos[1] that it would be naive to assume that the simple, albeit revolutionary, implementation of UPs and committees will eliminate, as if by Magic, the tendency towards bureaucratization and concentration of power in hospitals.

It could be said that the actors involved in this experience underestimate the capacity these settings have to reproduce the webs of power that give life to the hospital and end up permeating and constituting the CGs. This observation reminds us that the Management Committee is a necessary arrangement, but not enough to produce more shared management modes[7].

Thus, without denying the importance of these arrangements, it is important to consider that change is not automatic. It is not enough to merely transform the modes of distribution of power to achieve more democratic management, since it is crucial that there is coherence between this format and the meanings participants assign to their work and to the organization, and their type of relationship and level of communication[14].

Furthermore, it is important to observe, as Rivera[21] points out, the process of cultural change in organizations does not comprise a radical substitution of new for old. This process has different and contradictory characteristics coexisting with dialectical tensions. In this sense, the traditional pattern of hospital identity, which is manifested, among other things, in professional atomization and lack of coordination between specializations, coexists with practices that recognize the need for a focus on networks and teamwork, and question the fragmentation of care generated by the excessive specialization of care.

Transformation or inertia: the imagery that sustains the implementation of change

To discuss the expectation that the implementation of the CGs will provoke change in organizational culture it is important to address, although briefly, the concept of imagery, as proposed by Enriquez[13]. For this author, all organizations are founded on a system of imagery, equivalent to the collective representation that provides the basis of a values and belief system, enabling the mobilization of subjects around a common action. It can be presented in two forms: motor imagery and misleading imagery.

Motor imagery functions as a representation that mobilizes subjects to construct a joint innovative project. It is made possible when groups welcome the differentiation of its members and therefore have a nonmonolithic view of the joint project that favors creativity and introduces differences, as opposed to repetition, considering cooperation as the fruit of how conflict is

treated[22]. The function of misleading imagery is to conglomerate workers around the kind of idealization proposed by the management of the organization, giving a prior meaning to every action carried out by the individuals[13].

Tied to this concept is Enriquez's reflection[14] on the myth of "good power"". Founded on the idealization of power, it concerns a mythical creation that conceals the conflictual dimension present in all power relations, tying group actions to a utopian image of the project, desired as a perfect artifice, without any fissures or clashes. This posture can lead the subjects to build what Enriquez calls a "community of denial", in which reality is denied to live supported by an illusion.

In our view, the committees that we investigated foster motor imagery that will induce democratization together with an increase in the influence of workers on decision-making, and responsibility in health care delivered to service users. However, on the other hand, they can also function as misleading imagery, idealized by the managers/workers responsible for their implementation, when these spaces should serve to appease and be free of contradictions and disputes.

This last type seeks to tie health professionals to institutional projects that are not necessarily elaborated collectively. This imagery can be experienced "paranoically" on the part of staff who fear an increase in control over their world and a loss of autonomy. The likely consequence of this context is resistance to the proposed changes.

For this process to resemble motor imagery depends on whether the group has the capacity to deal with the tension between autonomy and control, with the aim of providing the best possible care for service users. However, users can be represented by workers in various ways and therefore the inclusion of their perspectives is crucial in order to obtain greater realism in understanding the users' demands that should be met by the workers.

Final considerations

This study identified some of the meanings of autonomy expressed by the interviewees and a number of challenges related to the organizational arrangements of the CGs and UPs implemented in the hospital.

The interviewees appear to have a utopic vision of the committees, which blurs the perception of the tensions that arise in the implementation of these arrangements. With regard to autonomy and the case of the CGs, on the one hand, an effort was made to increase worker autonomy, expecting an increase in the capacity for reflection and work decision-making as professionals from different categories began to participate in the unit's decision-making spaces. On the other hand, an effort was made to build a space of governance (collective) over autonomous actions, in an attempt to increase cooperation and commitment among workers, mainly through the visibility and agreement of work processes in the UPs.

In our view, you cannot expect a solution to this problem just to happen by itself. It is necessary to promote the effective and sufficiently flexible operation of the committees and make them permeable to the two forms of autonomy described above to enable negotiation between the various actors involved in delivering health services. This process will not be free of conflicts and tension, and therefore the management committees must have access to a space that fosters permanent negotiation between workers' desires and interests on the one hand, and the demands of democratization on the other.

In this way, certain questions must be continually raised during the implementation of the CGs. These problems do not necessarily have immediate solutions, but need to be addressed continuously: how should the interests of hospital workers from various professional categories who interact in a climate of tension and dispute power be articulated? How can democratization be enhanced to avoid the domination of discussions by disputes between professional categories?

Tackling these issues depends on the acknowledgement that the implementation of work teams has deal with a professional setting involving distinct practices and kinds of knowledge that are valued differently within the health sector[23]. Health workers commonly build their identity and sense of security by clinging to their core specialty, which makes it difficult for them to open up to an inevitable interaction in interdisciplinary settings[23,24].

Therefore, interdisciplinarity demands both a cognitive effort to dialogue with various types of technical rationalities, and a subjective disposition towards leading with uncertainty and difference, giving and taking criticism, and shared decision-making. These conditions contribute towards building a cooperative relationship and exchange between disciplines, rather than the crystallization of reactive identities with a para-

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noid perception of differences in the work place. The principal element of this type of groupality should be the coordination of care delivery to health service users.

Finally, the implementation of CGs and UPs as a proposal for change should be subject to constant evaluation and monitoring which should address the capacity of the proposal to coalesce interests and generate idealizations that encourage sharing of the proposal among hospital workers without blinding them to the inevitable conflicts and contradictions.

Collaborations

AM Silva contributed to project conception, conducting the interviews, analysis of the material, and drafting this manuscript. MC Sá and L Miranda contributed to project conception, analysis of the material, and drafting this manuscript and critical revision for important intellectual content.

References

1. Campos GWS. *Um método para análise e co-gestão de coletivos*. 3ª ed. São Paulo: Editora Hucitec; 2000.
2. Brasil. Ministério da Saúde (MS). Secretaria de Atenção à Saúde. *Política Nacional de Humanização da Atenção e Gestão do SUS*. *Gestão participativa e cogestão*. Brasília: MS; 2009.
3. Brasil. Ministério da Saúde (MS). *HumanizaSUS: documento base para gestores e trabalhadores do SUS*. 4ª ed. Brasília: MS; 2010.
4. Guizardi FLE, Cavalcanti FOL. O conceito de cogestão em saúde: reflexões sobre a produção de democracia institucional. *Physis* 2010; 20(4):1245-1265.
5. Faria HP, Santos MA, Aguiar RAT. Gestão Colegiada: conceitos e pressupostos para o alcance da alta responsabilidade organizacional. *Saúde Digital* [internet]. 2003 [acessado 2014 out 1]; Edição 22. Disponível em: http://www.pbh.gov.br/smsa/outobro2003/especializacao.html
6. Cecílio LCO. Autonomia versus controle dos trabalhadores: a gestão do poder no hospital. *Cien Saude Colet* 1999; 4(2):315-329.
7. Cecílio LCO. Colegiados de gestão em serviços de saúde: um estudo empírico. *Cad Saude Publica* 2010; 26(3):557-566.
8. Bernardes A, Cecílio LCO, Nakao, JRS, Évora YDM. Os ruídos encontrados na construção de um modelo democrático e participativo de gestão hospitalar. *Cien Saude Colet* 2007; 12(4):861-870.
9. Bernardes A, Cecilio LCO, Évora YDM, Gabriel CS, Carvalho MB. Modelo de gestão colegiada e descentralizada em hospital público: a ótica da equipe de enfermagem. *Rev. Latino-Am. Enfermagem* 2011; 19(4):1003-1010.
10. Rates SMM. Unidades de Produção como espaço de construção democrática. In: Araújo GF, Rates SMM, organizadores. *Cogestão e humanização na saúde pública*: *experiências construídas no Hospital Municipal Odilon Behrens*. Ijuí: Editora Unijuí; 2009, p. 53-63.
11. Pereira AB, Ferreira Neto, JL. Processo de implantação da política nacional de humanização em hospital público. *Trab. educ. saúde.* 2015; 13(1):67-88.
12. Onocko Campos RT, Campos, GWS. Co-construção de autonomia: o sujeito em questão. In: Campos GWS, Minayo MCS, Akerman M, Drumond M, Carvalho YM, organizadores. *Tratado de saúde Coletiva*. São Paulo: Hucitec; 2006. p. 669-714.
13. Enriquez E. O papel do sujeito humano na dinâmica social. In: Lévy A, Nicolai A, Enriquez E, Dubost J, organizadores. *Psicossociologia: análise social e intervenção*. Belo Horizonte: Autêntica; 2001. p. 27-45.
14. Enriquez E. *As figuras do poder*. São Paulo: Via Lettera Editora e Livraria; 2007.
15. Lévy A. *Ciências clínicas e organizações sociais*. Belo Horizonte: Autêntica; 2001.
16. Merhy EE. A perda da dimensão cuidadora na produção da saúde - Uma discussão do modelo assistencial e da intervenção no seu modo de trabalhar a assistência. In: Merhy EE, Campos CR, Malta DC, Reis AT, Santos AF. *Sistema Único de Saúde em Belo Horizonte - reescrevendo o público*. Belo Horizonte: Xamã Vm Ed.; 1998. p.103-120.
17. Peduzzi M. Equipe multiprofissional de saúde: conceito e tipologia. *Rev. Saúde Pública* 2001, 35(1):103-109.
18. Oury J. *O coletivo*. São Paulo: Hucitec; 2009.
19. Birman J. *Arquivos do mal-estar e da resistência*. Rio de Janeiro: Editora Civilização Brasileira; 2006.
20. Kaës R. O interesse da psicanálise para considerar a realidade psíquica da instituição In: Correa OBR, organizador. *Vínculos e Instituições*. São Paulo: Editora Escuta; 2002. p. 11-31.
21. Rivera FJU. Cultura e liderança comunicativa. In: Rivera FJU. *Análise estratégica em saúde e gestão pela escuta*. Rio de Janeiro: Editora Fiocruz; 2003. p.185-218.
22. Azevedo CS. A dimensão imaginária e intersubjetiva das organizações de saúde: implicações para o trabalho gerencial e para a mudança organizacional. *Cien Saude Colet* 2010; 15 (Supl. 1):977-986.
23. Campos GWS, Domitti AC. Apoio matricial e equipe de referência: uma metodologia para gestão do trabalho interdisciplinar em saúde. *Cad Saude Publica* 2007; 23(2):399-407.
24. Matos E, Pires DEP, Campos GWS. Relações de trabalho em equipes interdisciplinares: contribuições para a constituição de novas formas de organização do trabalho em saúde. *Rev. bras. enferm* 2009; 62(6):863-869.

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