Original Article

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Perception of family members and health professionals about institutional violence against hospitalized children

Percepção de familiares e profissionais de saúde sobre a violência institucional à criança hospitalizada

Percepción de familiares y profesionales de la salud sobre la violencia institucional a niños hospitalizados

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ABSTRACT

Objective: To understand the perception of family members and health professionals about institutional violence against hospitalized children.

Methods: Qualitative, exploratory-descriptive study, used approximations with Foucault's thinking, carried out in a pediatric unit of a large hospital in Salvador – Bahia. 10 mothers and 39 health professionals participated. Data collection took place between November/2018 and October/2019 through semi-structured interviews. Data content analysis was performed with the help of the NVIVO12 software. The study, approved by Ethics Committee, complied with resolution 466/2012.

Results: The Institutional Violence was understood by the participants evidenced in three categories: abusive care practices; problems in the relationships between professionals, child and family; precariousness of the hospital structure.

Conclusion: The perception of family members and health professionals about the presence of Institutional Violence in children's hospital care demonstrates the need to establish actions in their confrontation to ensure the dignity of the child during hospitalization.

Keywords: Child abuse. Child, hospitalized. Child care.

RESUMO

Objetivo: Compreender a percepção de familiares e profissionais de saúde sobre a Violência Institucional à criança hospitalizada.

Método: Estudo qualitativo, exploratório-descritivo, de aproximações com o pensamento foucaultiano, realizado em unidade pediátrica de hospital de grande porte em Salvador/Bahia. Participaram 10 mães e 39 profissionais de saúde. A coleta de dados ocorreu entre novembro/2018 e outubro/2019 através de entrevista semiestruturada. Foi realizada análise de conteúdo dos dados, com auxílio do *software* NVIVO12. O estudo foi aprovado por um comitê de ética e respeitou a Resolução 466/2012.

Resultados: A Violência Institucional foi compreendida pelos participantes como: práticas de cuidado abusivas; problemas nas relações entre profissionais, criança e família; precarização da estrutura hospitalar.

Conclusão: A percepção de familiares e profissionais de saúde sobre a presença da Violência Institucional no cuidado hospitalar infantil demonstra a necessidade de estabelecer ações para o seu enfrentamento para assegurar a dignidade da criança durante a hospitalização.

Palavras-chave: Maus-tratos infantis. Criança hospitalizada. Cuidado da criança.

RESUMEN

Objetivo: Comprender la percepción de familiares y profesionales de la salud sobre la violencia institucional contra los niños hospitalizados.

Métodos: estudio cualitativo, exploratorio-descriptivo, que utilizó aproximaciones con el pensamiento de Foucault, realizado en una unidad de pediatría de un gran hospital de Salvador – Bahía. Participaron 10 madres y 39 profesionales de la salud. La recolección de datos se realizó entre noviembre / 2018 y octubre / 2019 a través de entrevistas semiestructuradas. Data content analysis was performed with the help of the *software* NVIVO12. El estudio, aprobado por el Comité de Ética, cumplió con la resolución 466/2012.

Resultados: El Violencia Institucional fue entendido por los participantes evidenciado en tres categorías: prácticas de cuidado abusivo; problemas en las relaciones entre profesionales, niño y familia; precariedad de la estructura hospitalaria.

Conclusión: La percepción de familiares y profesionales de la salud sobre la presencia de Violencia Institucional en la atención hospitalaria infantil demuestra la necesidad de establecer acciones en su enfrentamiento para asegurar la dignidad del niño durante la hospitalización.

Palabras clave: Maltrato a los niños. Niño hospitalizado. Cuidado del niño.

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INTRODUCTION

Institutional violence (IV) is defined as an action or omission committed in/by institutions that results from asymmetrical power relations between users and professionals. Within health services, infractions range from lack of access to poor quality of care, when this is done through rules, operating norms, bureaucratic and political relationships, reproducing inequities arising from unfair social structures[1].

Over the years, IV has been discussed in a primary and fragmented way. This occurs due to the scarcity of information, scientific studies and discussions about it, which makes it difficult to understand it and negatively affects the engagement of both managers and health professionals[2].

Nonetheless, research that confirms IV in health services reveals that it is practiced by professionals from different areas (nursing, medicine, social work, among others) and also clarifies that IV has as main characteristics: violation of client rights; user's pilgrimage to different services in search for care; abuses; communication and relationship problems between users and professionals; prohibitions during the period of hospitalization that infringe on patients' rights; disqualification of the user's life experience to the detriment of the knowledge of health professionals; negligence; physical violence or any type of abuse of a symbolic or psychological nature, practiced in the institutional sphere[1–3,4].

In fact, considering the results of national and international research that present child IV, studies reveal that there is a greater approach to this problem in educational environments such as schools, day care centers and orphanages[2–5]. On the other hand, in a multicentric research carried out in 2020 in Nepal[6], whose target population was newborns, it was found that abuses committed within health services occur frequently and in high numbers, however, it showed that there is a gap in IV research in health services covering the age group from preschool to adolescence.

Thus, when considering the condition of vulnerability of the child, due to the immaturity of their neurocognitive and motor systems, the experience of IV in this age group can have even more serious consequences, affecting child development. Corroborating this statement, research confirms that hospitalized children are more likely to develop psychiatric disorders in the medium and long term, such as anxiety, depression, obesity and other chronic diseases[7–8].

For the contemporary philosopher Michel Foucault, the hospital, since its origin, has been a disciplinary place, established by the medical order, evolving towards the depersonalization of the hospitalized patient[9]. In this space, the body of individuals is considered both a target of care and an object of power[1–9]. The professional controls, prescribes and monitors behaviors, often through punishment, threats, screams and anger. However, humiliation and demoralization are intended to keep the patient passive and harmless, which makes it difficult to face this problem[1].

Therefore, it is necessary to deepen the studies on this theme to better understand the nature of these abuses against children. Thus, we present the following guiding question: How do family members and health professionals perceive IV against hospitalized children? To answer this question, we aim to: Understand the perception of family members and health professionals about Institutional Violence against hospitalized children.

The relevance of this study lies in the possibility that, by drawing the attention of family members and health professionals to this issue, they are able not only to identify situations of IV against the child, but also to promote strategies to mitigate it. Furthermore, this study intends to contribute to minimize the existing gap in studies of child IV in health services.

METHOD

Qualitative, exploratory-descriptive study, presented as part of the research: "Institutional violence against hospitalized children from the perspective of companions and health professionals", which sought to use approaches with the thinking of Michel Foucault.

Data collection took place between November 2018 and October 2019, in a pediatric unit of a reference university hospital in Salvador/Bahia. The participants were the family members and the health professionals of the referred unit. As inclusion criteria, the following were considered: for family members, being accompanying the child for more than seven days and being the child's main companion; for health professionals, to be working in the pediatric unit that constituted the field of research. Exclusion criteria were: companions who had recently arrived at the pediatric unit, as they had less time to adapt to the service; and age below 18 years. In the case of health professionals, those who were on leave during the period in which the researchers sought contact to schedule the interview, or who had less than two years of experience in pediatrics were excluded, as this was considered a minimum period for acquiring experiences that would allow a better understanding on the issues addressed in this research.

Participants were intentionally selected (those who were present at the unit at the time of data collection), and the interview took place by prior schedule. The companions were chosen according to information contained in the unit's nursing report, which included the name of the child and companion, day of admission and diagnosis; then, the interviewers introduced themselves to the companions and invited them to participate in the research. In the case of health professionals, the interviewers sought to introduce themselves to those on duty at the time of data collection, invited them to participate in the research and scheduled the interview. Then, the interviewees indicated their colleagues and provided their contact details for the researchers. At the time of the approach, they were presented with the Free and Informed Consent Form (FICF), containing the research objectives and authorization for participation and disclosure of data by preserving the confidentiality and anonymity of the participants. All of them agreed to participate in the research and, after being presented to the FICF, they duly completed and signed it, and a copy of this document was delivered to the participant and another copy to the researcher.

At the time of the interview, the participants were led to a reserved place in the pediatric unit. The technique used was the interview, which was guided by a semi-structured script. The interview script contained closed questions, to characterize the sociodemographic profile of the interviewees, and open questions, which allowed the interviewee to talk freely about the researched topic.

The open questions for the family members were: Did you identify any situation that is characterized as IV during your child's hospitalization? Which one or which ones? Did your child and/or family members experience any problems during the hospitalization period? Which one or which ones? For professionals: Have you identified any type of IV to the child during hospitalization? Which one or which ones?

During data collection, an informative folder was also used to present the definition and characteristics of IV in health services, considering the lack of knowledge about the topic. The interview was conducted by a team of previously trained scientific initiation fellows and postgraduate students. The semi-structured script was previously tested (pilot) to check for duplicity or distortions in the questions and information.

Data collection was described according to the Consolidated Criteria for Reporting Qualitative Research (COREQ). The interviews ended after data saturation, which occurred when data became redundant and repetitive. The interviews were recorded in an audio application on a cell phone and, soon after, transcribed in full, typed into a Word file.

The data were analyzed using the technique of content analysis, having sought approximations with Foucauldian thinking to anchor the analysis discussions. The stages that followed this type of analysis were: exhaustive reading of the interviews and organization of the material. In the categorization phase, the classification of sets by differentiation was performed and, later, a new grouping was made, which gave rise to the categories of analysis. To assist in the categorization, it was used the software NVIVO12.

The research complied with Resolution 466/2012 of the National Health Council, with submission and approval by the Ethics Committee of the proposing institution (CAAE: 99681518.0.0000.5531) and co-participant (CAAE: 99681518.0.3001.0049).

RESULTS

Ten mothers and 39 health professionals participated in the research (01 social worker, 06 nurses, 02 pharmacists, 05 physical therapists, 01 speech therapist, 05 nutritionists, 07 physician, 01 psychologist and 11 nursing technicians). All participants were female and aged between 19 and 64 years. Most of the children's mothers had completed high school and had an average income of up to one minimum wage. Most of the health professionals had 6 to 10 years of experience in pediatrics and an average income of 5 to 10 minimum wages.

According to health professionals and family members, institutional violence against hospitalized children is anchored in three categories: abusive care practices, problems in interpersonal relationships between health professionals, children and families, and the precariousness of the hospital structure.

Chart 1 illustrates the characteristics described in the participants' reports according to the categories found in the study, which show the presence of IV against the child from the moment of seeking care until the stay in the hospital.

Despite the perception of IV described in Chart 1, it was found that the presentation of the three categories (precariousness of the hospital structure, problems in interpersonal relationships and abusive care practices), when the two groups (professionals and family members) were analyzed together, proved to be balanced. However, when the analysis took place separately, IV was perceived differently, as professionals reported that IV was more related to problems in the precariousness of the hospital structure, followed by abusive care practices and problems in interpersonal relationships, while family members they gave more emphasis to abuses committed in care practices, followed by problems in interpersonal relationships and, finally, the precariousness of the hospital structure.

ABUSIVE CARE PRACTICES	PROBLEMS IN INTERPERSONAL RELATIONSHIPS BETWEEN PROFESSIONALS, CHILDREN AND FAMILY	PRECARIOUSNESS OF THE HOSPITAL STRUCTURE
• Multiple manipulations • Not obtaining consent from the child • Service failures • Fragmentation of care (when professionals do not seek alignment of actions in health practices) • Rigid guidelines and routines • Disqualification of practical knowledge, of life experience, by scientific knowledge • Inaccurate diagnoses • Impositions of the professionals' will • Sanctions • Try to adapt the patient to the needs of the service • Disrespect to the child's privacy	• Communication problems • Lack of attention, listening, neglect and omission • Lack of sensitivity • Coldness, harshness, rudeness • Prejudice, discrimination • Loss of autonomy • Breach the principle of justice • Threat, intimidation	• Lack of material and human resources • Inadequacy in physical spaces • Slow administrative processes • Pilgrimage (search or difficult trajectory for health care) • Precariousness of materials and equipment • Administrative failures • Violation of rights

Chart 1 – Recognition of IV against the hospitalized children and its characteristics according to family members and health professionals.
Source: Research data.

It is also important to point out that some participants (both professionals and family members) demonstrated that did not recognize situations related to IV against the child, even when they were presented with the definition and characteristics of this in the informative folder. These perceptions can be confirmed by the reports below:

> *I don't see it here, I think children are well assisted.* (Nursing technician 02)

In the first category, the participants understood that the IV against the hospitalized child was perceived by the abusive care practices that lead to the exposure of the child's body through multiple manipulations, pain, discomfort, deprivation and determine failures in care, inaccurate diagnoses and the increase in the occurrence of unfavorable outcomes.

The following reports express these situations:

> *This doctor pulled my son's probe early and ended up hurting his surgery, then I had to take him to the hospital in the city where I live [,] because he had an infection that was already taking him, if I didn't take him, he was going to die. Because she did this to my son, she pulled before the day. Because the probe was stuck, but she pulled, forced, kept pulling and the boy was crying, blood came out, the surgery site swelled too much.* (Companion 02)

> *People are full of routine. Time to take the medication, bathe, wake up and the child is not used to it, we impose everything on them and sometimes they get more stressed and sometimes it's not just because of the illness, it's because of having to adapt to so many new things. The team lacks sensitivity to understand that sometimes the bad mood is not because he/she is spoiled or has a tantrum, it's just because they tend to express their stress that way.* (Pharmacist 01)

The second category presents the problems in the relationships between professionals, children and families. According to the participants, the IV situations were: communication problems; omission, due to lack of listening and attention; ethical problems, such as loss of autonomy, breach of the principle of justice; psychological violence towards children and family. The following excerpts bring these findings:

> *Sometimes the doctor says to me: "Mom, I want to talk to you." Then my son says: "No, Auntie, it's about me! I want to know!". But, on the other hand, he is not prepared*

to listen to reality. He said, "No, but I don't want to! You have to listen to the patient! And the patient? Does the patient have a voice? I am the patient!". Then I said: But you're underage, I'm the boss of you. (Companion 10)

Treating with coldness, harshness, not paying enough attention, not taking it seriously, not giving due importance to what the parents are saying. Sometimes this narrative is disqualified because it is not the language you are used to. I remember seeing people disdaining the situation, the patient's complaint. (Nutritionist 02)

One professional says he is going to do a procedure with the patient, another says he is going to do another one, this is very recurrent and confuses the patient, the family member and it makes difficult the adherence process. (Psychologist 01)

The precariousness of the hospital structure is presented as the third category of this study, having been mentioned by the participants and attributed to the presence of longer hospital stays, risk of complications and worsening of the child's clinical condition. The participants confirmed this in their statements:

Unfortunately, people end up taking it out on those who least need to receive that mistreatment, which is that patient, that patient's family member. I've had the opportunity to see overcrowded hospitals, overcrowded emergencies, overworked professionals who generated these things. (Nurse 01)

In ward 7, the children do not have a toilet. It's a sink that the mother has to put the child on and then he/she does it there. It is complicated. (Nursing technician 08)

She also has an endoscopy to do with a ligature, which I can't schedule here, because there's no material. (Companion 07)

It is very common here in the institution for us to receive patients who come from the third institution that the patient goes on pilgrimages, because they do not have the exam they need to since the first institution. This is a type of violence that we notice when we catch a child here upset, annoyed, because he/she is going from institution to institution. (Physician 01)

DISCUSSION

The participants' reports showed how family members and health professionals perceived IV against children during the period in which the child is hospitalized. It could also be evidenced that the IV presents itself in a different way (problems in care practices, in the structure of the service and interpersonal relationships).

According to the problems related to abusive care practices, the existence of multiple manipulations of the child's body and the disrespect for the privacy of individuals were perceived by the automated way in which the service was offered, based on complaint-conduct standards, deepening the disease-centered view.

Through the participants' reports, it can be seen that hospital practices in child care are still under the strong influence of the biomedical view, whose theoretical bases are supported by medicalization, through thorough examination, control of bodies and discipline[9]. Such an understanding makes multiple manipulations, failure to obtain consent and other abusive health practices natural due to the frequency with which professionals perform them.

For Foucault, discipline is the political anatomy of detail, in which the individual's body must be excessively watched and controlled. In turn, medicine uses the discipline to perform several practices that include distributing individuals, isolating them, scrutinizing them and controlling them through rules, training and records[9].

In this study, the participants recognized that abusive care practices caused care failures that resulted in physical and psychological damage to the child. Among the physical damage, they mentioned deprivation (hunger, sleep), excessive manipulations that caused pain, infections and worsening of the health condition. Psychological damage resulted in stress and anxiety.

A study that estimated the occurrence of damage in hospitalized children in the United Kingdom found that one in seven children suffers damages during hospitalization[10]. Regarding the occurrence of errors in health care, studies reveal that it is necessary to admit that, in the investigation of damages occurred during child hospitalization, it is necessary to consider both the reports of health professionals, as well as those of the child and family. Corroborating this statement, research confirms that parents of hospitalized children are able to report avoidable adverse events in their children that are not recorded in medical records, which demonstrates that the records of injuries resulting from care practices and their nature are still very limited, and that the family, which is an important source of data, has been little used in this monitoring[11–12].

In situations in which problems in the relationships between professionals, children and family were recognized, it was possible to perceive the presence of abuse of power. For Foucault[9], power is characterized by a set of practices that define how some should lead and govern the conduct

of others, however, it is in this relationship understood as a conduction of conduct that the games of truth will produce knowledge to define what position the subjects must occupy in a certain space, above all, within the institutions.

In this aspect, relating Foucault's thinking with the findings of this research, it can be seen that the hospitalized child subject, when formally administered by an institution (hospital), is considered as a diseased, a patient and, therefore, decision-making about their health should be in charge of the medical subject (in this study, the health professional can also be considered in this position), who will conduct the treatment in the way they deem to be correct. Thus, the way in which these relationships between individuals occur opens space for numerous problems, such as: communication difficulties, loss of autonomy and even psychological violence.

In this study, communication difficulties were mentioned by the participants as the main problem in the relationship between professionals, children, and family. Communication failures were characterized by the lack or fragmentation of information, which occurred when professionals did not communicate properly with each other and with the child and family, which generated stress and service failures.

Corroborating the data from this study, national and international research reveal that communication problems are very common in pediatric inpatient units, being related to the fact that the professional usually addresses the mother or companion to provide information about the child's health status and disregarding his/her need to obtain knowledge about his/her treatment and prognosis. This situation results in the loss of the child's autonomy, since he/she is deprived of essential information for decision-making about his/her health[13–14,15].

As a way of allowing better communication with children and family, it is important to use assertive tools such as therapeutic toys, which help reduce children's pain and stress before performing painful procedures, making them adopt more collaborative behaviors in the face of the difficulties involved in performing invasive procedures[14].

The lack of information and the loss of the child's autonomy are also strongly related to the behavior of prejudice and discrimination, which can constitute psychological violence. Psychological violence against children, despite being much tolerated by society, includes any action and omission that results in damage to the self-esteem, identity and development of the individual, since its victims remain subject to the power of adults who coerce them to exercise their interests[4–16].

Regarding the effects of emotional abuse, research confirms that it can be as harmful as physical and sexual abuse, being related to the occurrence of mental problems, neurological symptoms without medical explanation, obesity and heart disease[16–17].

In this study, family members confirmed situations in which children wanted to know more about their treatment, or even to have information about tests, however, this condition was not respected, because, according to the participants, the child was still considered as someone who did not have conditions to make decisions or even to participate in these.

The devaluation of the child has its historical bases in the Irregular Situation Doctrine, which considered children and adolescents as an object of guardianship and, therefore, they were offered a set of social policies based on the paternalistic, welfare and tutelary character. With the creation of the Child and Adolescent Statute (*Estatuto da Criança e do Adolescente* – ECA), discussions about the child as a subject of law advanced, guaranteeing their participation in decisions and the best interest of the child [4].

Furthermore, threat and intimidation in this study were confirmed during hospital care by mothers of hospitalized children, however, they were not described by health professionals. Such discrepancy reveals that the professional's way of addressing the family, in some cases, is considered authoritarian by the family, but ends up going unnoticed by them, revealing the naturalization of behaviors that sometimes manifest as domination, sometimes manifest themselves through a paternalistic conception. This data is also confirmed in studies that describe the presence of gender violence within health institutions[3].

Regarding the precariousness of the hospital structure, pilgrimage was highlighted by the participants as a very common problem, which corroborates data from other national and international studies[18,19,20].

The presence of pilgrimage, constituted by the difficult trajectory of the user in the search for care in health services, is related to the difficulty of establishing an effective referral and counter-referral system to meet the health needs of children. Among the factors that make it difficult to search for health care, we can mention: the lack of professionals, lack of service infrastructure, reduction in the offer of specialized services, especially in child care and the lack of organization of the service at the time of reception[18–19].

Other problems in the structure described by the participants make it even more difficult to serve this public, such as: shortage of beds and lack of materials available for pediatric care. According to Foucault, the problem of scarcity can be understood as a strategy of biopolitics, in which the State must exercise population control based on the principles

of economic rationality, using population growth rates and statistics to maintain and define what should exist or not within the scope of health actions[20].

An example to be mentioned is the closing of emergency care units and pediatric hospitals, as well as the reduction of human and material resources in pediatrics, having as a parameter the drop in infant mortality and birth rates. Despite the logic, such action becomes a failure and has repercussions in several situations, such as pilgrimage and structural difficulties in child care[18].

Therefore, it is necessary to pay attention to the fact that health care models are not based and biased only on statistical outcomes that stand out in the national panorama, as, in this way, they will not be able to meet the needs and specificities of children's public[20].

For Foucault[20], the logic of the biopolitics strategy is formed from the population and must be understood by the general regime of economic truth within governmental rationality. In this way, the market (and even society) is not a place of justice, but of jurisdiction, since the State, acting through governmental rationality, is more interested in building and developing policies that are based on social utility and economic benefit, not the fundamental rights and freedoms of individuals.

From this perspective, biopolitics becomes a strategy to rationalize governmental practice, using statistics to control, intervene and establish regulation, in order to generate a sense of balance or security, however, it does not look to change in the individual's condition. Thus, it is clear how such a regime has influenced the creation of policies and, perhaps, even the system of guaranteeing the rights of individuals. Furthermore, violations of children's rights demonstrate the fragility of their implementation, which may be supported by the principle of invisibility.

For Foucault, the principle of invisibility is indispensable, since the collective good must not be made visible to the detriment of the economic benefit, that is, since children's right is a collective good, its invisibility is supported by economic rationality, which does not allow the right to be made visible, since implementing rights in health institutions is expensive. In this way, invisibility serves economic rationality and economic rationality serves violence[20].

Similarly, the denial of IV by some participants, revealed when they demonstrated that they did not recognize IV, even when they were presented with its characteristics and definition, proved to be worrying, as it reveals the naturalization of IV in care environments. Such evidence confirms the invisibility of IV against children and the urgent need to develop public policies to minimize it.

As limitations of the study, given that it was carried out in only one hospital in the State of Bahia, it should be noted that this research had limited representation. As contributions to teaching, research, management and nursing care, the relevance of this theme is highlighted, since, through the identification and study of institutional violence against children in health services, it is possible to act assertively in planning of actions to cope with it. In this way, studies of this nature become fundamental for the engagement of users and health professionals in the exercise of health advocacy, with a view to expanding safe, humanized and quality care for children and their relatives.

FINAL CONSIDERATIONS

According to family members and health professionals, IV against hospitalized children was perceived differently, evidenced by abusive care practices, problems in interpersonal relationships between professionals, children and family, as well as the precariousness of the hospital structure.

The evidence of the presence of IV while the child remains hospitalized found in this study reinforce the need for intersectoral and interdisciplinary actions, since this type of violence presents itself in a silent, naturalized way, which hinders the engagement of professionals, managers, and users in the process of coping.

Thus, it is urgent that health professionals and family members recognize, reflect and intervene in the promotion of strategies to face IV as a way of preserving the humanization and quality of child care, to ensure the dignity and adequate development of children while they remain in hospital institutions.

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