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Nursing officers at the military hospital in the year of 1995

Oficiais enfermeiros no hospital militar no ano de 1995

Oficiales enfermeros en el hospital militar en el año de 1995

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Abstract

Objective: to analyze the capacity and distribution of the first class of nurse officers, at the end of the Officer Training Course, with the rank of 2nd Lieutenant, at the Hospital Central da Polícia Militar of the State of Rio de Janeiro, in 1995. **Method:** historical study in written and oral documentary sources produced through 19 interviews, of which 18 are nurse officers and one civilian. Pierre Bourdieu's concepts of symbolic power and capital substantiated the analysis of the findings. **Results:** the classification obtained in the training course for officers and professional experience, although with less weight, were preponderant for the distribution in the hospital sectors. **Final considerations and implications for practice:** the criteria of seniority in military life influenced the configuration of the nursing team at the military hospital. It is noteworthy that the occupation of the heads by the nurse officers was determined by the capital incorporated in the probationary period, which was institutionalized by the patent.

Keywords: Nursing; Nursing History; Military Nursing; Nursing Team; Military Hospitals.

Resumo

Objetivo: analisar a lotação e distribuição da primeira turma de oficiais enfermeiros, ao término do Curso de Formação de Oficiais, com a patente de 2º Tenente, no Hospital Central da Polícia Militar do Estado do Rio de Janeiro, em 1995. **Método**: estudo histórico em fontes documentais escritas e orais produzidas por meio de 19 entrevistas, sendo 18 oficiais enfermeiros e um civil. Os conceitos de poder simbólico e capital de Pierre Bourdieu consubstanciaram a análise dos achados. **Resultados:** a classificação obtida no curso de formação de oficiais e a experiência profissional, embora com menor peso, foram preponderantes na distribuição nos setores do hospital. **Considerações finais e implicações para prática:** os critérios de antiguidade da vida militar influenciaram na configuração da equipe de enfermagem no hospital militar. Destaca-se que a ocupação das chefias pelos oficiais enfermeiros foi determinada pelo capital incorporado no estágio probatório, o qual foi institucionalizado pela patente.

Palavras-chave: Enfermagem; História da Enfermagem; Enfermagem Militar; Equipe de Enfermagem; Hospitais Militares.

Resumen

Objetivo: analizar la capacidad y la distribución de la primera clase de oficiales enfermeros al término del Curso de Formación de Oficiales, con el grado de 2º Teniente, en el Hospital Central da Polícia Militar do Estado do Rio de Janeiro, en 1995. **Método:** estudio histórico en fuentes de documentos escritos y orales producidos a través de 19 entrevistas, 18 de las cuales fueron enfermeras y una civil. Los conceptos de poder simbólico y capital de Pierre Bourdieu fundamentaron el análisis de los hallazgos. **Resultados:** la clasificación obtenida en el curso de formación para oficiales y la experiencia profesional predominaron en la distribución en los sectores hospitalarios, aunque con menor peso. **Conclusión e implicaciones para práctica:** los criterios de antigüedad en la vida militar influyeron en la configuración del equipo de enfermería. Se destaca que la ocupación de los comandos por oficiales enfermeros fue determinada por el capital incorporado en la etapa probatoria, institucionalizada por el grado.

Palabras clave: Enfermería; Historia de la Enfermería; Enfermería Militar; Grupo de Enfermería; Hospitales Militares.

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INTRODUCTION

The Staff of Nursing Officers of the Military Police of the State of Rio de Janeiro (Polícia Militar do Estado do Rio de Janeiro – PMERJ) was created through Law No. 2,206, of December 27, 1993, under the then governor Leonel de Moura Brizola. In this law, in its article 8, there is the conversion of 163 vacancies of MP soldiers into 57 Nursing Officers vacancies of the Health Officers Staff. These vacancies were distributed between the following patents: two vacancies for major; ten for captain; 20 for 1st Lieutenant; and 25 for 2nd Lieutenant. This workforce was called "Permanent Staff I"[1:26]. Such a conversion would not financially burden the planning of the state of Rio de Janeiro.

The Public Notice of the Selection Process for 2nd Lieutenant MP Nurse published 56 vacancies for 2nd Lieutenant MP Nurse, despite the fact that the number of authorized personnel was a total of 57 officers. In addition, the military career should be initiated by the lower rank of the staff, in order to fulfill the interstice for promotions. This explains the fact that 56 2nd Lieutenant MP Nurse entered[2].

To achieve approval, candidates were subjected to the eliminatory and qualifying tests. Thus, after almost a year, the governor of the state of Rio de Janeiro, through the Official Diary, in 1994, appointed the officers of the Health Officers Staff – HOS, of Staff I, being part of the Class of Probationary Period of Officers' Adaptation (PPOA), with the following distribution: 1st Lieutenant MP Doctor Trainee (seven), evangelical pastors (two), 1st Lieutenant MP Chaplain Trainee (four) and 2nd Lieutenant MP Nurse Trainee (fifty-seven)[3].

With regard to nurses, initially, the first 100 classified in the intellectual examinations (written test and practical test) were invited to participate in the other stages (physical, medical, social and psychotechnical examination). In the end, the 57 first places were classified to the PPOA 94, in accordance with State Law 2,206/1993, which created the personnel. Nevertheless, the final classification was 56, due to a withdrawal[1].

The Probationary Period for the Adaptation of Officers took place from November 1994 to May 1995, with the first stage taking place at the Escola de Formação de Oficiais (ESFO) and the second at the Hospital Central da Polícia Militar (HCPM), in order to carry out specific health training in the area of military nursing.[4] Those approved in the probationary period were appointed to the rank of 2nd Lieutenant MP Nurse and, incorporated into the Health Officers Staff of the PMERJ, starting May 24, 1995, in accordance with Article 11 of Decree Law No. 216, of July 18, 1975 and Article 43, item II and III, sole paragraph and 3rd paragraph of Decree No. 532, of December 23, 1975[5,6].

The officers' graduation took place at the Escola de Formação de Oficiais (ESFO), on May 26, 1994. The class of officers (PPOA/94) made up of 56 nurses, seven doctors and five chaplains, was named Lieutenant MP Manoel Veja Cesário, in honor of the soldier killed on duty, in the city of Rio de Janeiro, in 1995 (Int. Bul. No 70, 05/29/1995). The entry of the nurse officers already with the rank of 2nd Lieutenant MP Nurse, took place on May 29, 1995[7].

The position of 2nd Lieutenant in the corporate hierarchy corresponded to the position of junior officer, placing them in disadvantageous positions in relation to other health professionals, especially doctors. In addition, Nursing Officers could only reach the rank of major, which would permanently exclude them from command posts in the Military Police. Such exclusion also occurred in the Navy, Army and Air Force, in addition to the Fire Department of the State of Rio de Janeiro.

When the concerns were brought up, in the face of the problem presented, the following investigative question was elaborated: how did the classification obtained in the Officer Training Course and the incorporation of the rank of second lieutenant affect the distribution of the first class of nurse officers in the military hospital? In order to answer it, it was necessary to reach the objective, thus formulated: to analyze the capacity and distribution of the first class of nurse officers, at the end of the Officer Training Course, with the rank of 2nd Lieutenant, at the Hospital Central da Polícia Militar of the State Rio de Janeiro in 1995.

METHOD

Historical study whose search for evidence is based on the reading and analysis of historical content materials, in order to build a marked and erudite version of the period in all its dimensions, through the criticism of the past and its speeches[8].

The concepts of symbolic power and capital of the French sociologist Pierre Bourdieu substantiated the analysis of the findings. Such concepts were useful for understanding the process of allocating and distributing nurses with officers' patents in a space occupied by professionals with different capitals, namely, military capital, represented by patents and degrees and, indirectly, economic capital, represented by respective salaries, that is, military remuneration; and the professional, related to the health professions with their degrees and related patents.

The time frame of this study is the year 1995, when the nurse officers finished the Officer Training Course (OTC) and were assigned to the Hospital Central da Polícia Militar, with the rank of 2nd Lieutenant MP Nurse of the PMERJ.

It should be mentioned that the Hospital Central da Polícia Militar, in 1995, was 53 years old and had about 220 hospital beds. It was a general hospital, where several specialties were served, with emphasis on General Surgery and Orthopedics, in view of the great demand from patients. It also had specialized clinics for the treatment of chronic-degenerative diseases. In addition, police officers injured by firearms were attended on a daily basis, whose physical condition led to the need for assistance[5].

The historical sources used were written and oral documents. The writings, consisting of bulletins, HCPM's Orders and Occurrences (1995) and HCPM's Nursing Supervision (1994) books, which were located in the HCPM's collection. The oral presentations were produced by means of semi-structured interviews, with 18 nurse officers from the first class of Nurse Officers of the PMERJ Health Staff being interviewed, in 1994. A civilian nurse who performed the position of head of nursing was also interviewed, in the period under study.

The interviews, recorded by digital means, were consented by signing of the Free and Informed Consent Term, after all the objectives of this research were clarified. After the transcription of the recordings, the interviewees performed the reading with a view to validating.

As an inclusion criterion, with regard to nurse officers, were elected those assigned to the HCPM who performed functions of head of sectors, in the studied period, namely, 1995 to 1997. Those who did not have physical conditions or had any other impediments to granting an interview, such as living outside Rio de Janeiro, on leave or on vacation, were excluded. The inclusion criterion for the civil nurse was her stay in the hospital after the arrival of the Nursing Officers and the fact that she was the head nurse of the hospital before their arrival. The exclusion criteria were the same as those applied to nurse officers. The identification of the interviewees consisted of the acronym corresponding to the profession of Nurse, followed by a sequential number.

In order to compose the documentary corpus, the criteria of relevance, sufficiency, completeness, representativeness, homogeneity and organization of the documents were considered[9]. The analysis of the findings, according to the historical method and with emphasis on studies on the history of nursing, took into account the documentary set and not the documents in isolation.

The study derived from a doctoral thesis project under development, approved by the Ethics and Research Committee of the Escola de Enfermagem Anna Nery and Hospital Escola São Francisco de Assis (Certificate of Presentation of Ethical Appreciation nº 67049517.0.0000.5238, on 04/25/2017), followed the ethical guidelines according to Resolution 466/12 of the National Health Council.

RESULTS

After graduating, the 2nd Lieutenant MP Nurses were assigned to the Hospital Central da Polícia Militar, on May 29, 1995, to be allocated at the HCPM sectors. Regarding the distribution of the nurse officers in the health units of the PMERJ and, later internal distribution in the HCPM, extracts from the interviews show that the classification obtained in the Probationary Period for the Adaptation of Officers was preponderant, followed by professional experience:

> *So, at the time of the choices, there were people who had their preference for HCPM and the other units of PMERJ, by seniority. With regard to the internal classification by the HCPM sectors, I no longer remember how this distribution went, if we ... I remember that at some point we answered some questionnaires of experiences, of specializations that some already had, if I'm not mistaken, I think this distribution was based on that* [...] (N1).

> *So, we were received by a civilian nurse and like in other hospitals, it was necessary to have nursing supervision 24 hours a day and that did not exist here, because there were no nurses and staff for that... and as a military hospital, this figure of the supervisor was placed with the nurse during the day, as well as the doctor for the day and the day administrative officer. And there were not enough nurses, to cover all sectors of the hospital 24 hours, and then at first we were on the shift and distributed in the sectors on the shift, I remember* [...] (N2).

> *The distribution took place in order of classification, according to what we call seniority, those who had a better classification could choose some sectors, the oldest were in the leadership and the most modern were in the subsequent sectors and where was still left. As I was one of the last ones there, I didn't have much of a choice, I tried to choose a sector that was more or less suitable for my medical and surgical training, I ended up choosing PAR, at the Surgical Center and I stayed specifically in this Sector of Anesthesia* [...] (N2).

> *I remember that the class was gathered in the auditorium and within the sectors that were available to be filled, using as a criterion the seniority and the background an identification by sector. So, what I remember from that time was this* [...] (N5).

> *A meeting was held to identify the quantification, the experiences of all of us, and the leadership at the time distributed according to the needs of the hospital and according to the experience of each one ... I remember that a meeting was at the study center with the whole class, where it was distributed ... we have several units here in the police ... there are several sectors of health care, and the professionals who were going to stay in each unit were divided ... we have the hospital in Niterói and here the Central Hospital, and then in my case for living nearby and living close and also having the experience ... I myself chose to stay here at the central hospital and I was placed in the nursery* [...] (N6).

Respondents, at the time of distribution by the HCPM sectors, commented on the complexity of developing criteria for such distribution, in view of the expressive shortage of nurses in the hospital unit:

> *It was very complex because it had no staff ... very small ... I only had one, who was on duty 12X60 during the day, and, at the ICU, which consisted of ten beds, which were practically 11 ... It was under construction, anyway, but it was ready fast. Anyway, there were 11 beds for two nursing technicians, two privates and I as a nurse* [...] (N4).

> *I consider that it was very difficult because there was no structure, as I can say, thus, assistance, even because there was no planning for the management of the sectors* [...] (N5).

> *We were the first class... so, for us it was a very new thing... to face the situation that the Hospital was in... without nurses. There were civilian nurses. We arrived here to*

> *change the situation of the hospital... to organize... even because the nurses there were, civilians, were few. So, they couldn't handle everything. It was a huge burden. Then, with our coming, it opened a door of hope for the hospital in my view. When we arrived here we came across a head nurse, the nurse [Name], who was the civil nurse. The moment we arrived she redistributed our class. I don't really remember how many we were, but I think we were like 57 nurses to distribute at HCPM and HPM-NIT. So, her mission was arduous, because redistributing nurses in the sectors, and it was very good, like... She ... the division she made by sector* [...] (N8).

Thus, the distribution made by the civil nurse was perceived by the nurse officers as a difficult and successful activity. This perception is corroborated by the civil nurse who performed the distribution:

> *I interviewed one by one asking where they wanted to stay. I don't remember well, but I think that was it. I remember that I had a meeting with everyone, showing the weaknesses of the hospital and asking for harmony between everyone. But, it was not easy, many wanted to insurge (insubordinate) and stay at the head, but I had the unconditional support of Doctor Emanuel, then director of the hospital, who gave me carte blanche* [...] (N9).

Still in the distribution process, regarding the occupation of the position of Head of Nursing that would be filled by the nurse officer, replacing the civil nurse, the seniority criterion would determine that the first place of the probationary period occupied the most important position of the nursing team. However, the first-place was not assigned. About this situation, we have the following report:

> *There was a detail at the end, the 01 [male] took 1st place, but the director [name] did not like him. So he put him in the Hospital Medical Material Central and the 02 [female] took over as head of nursing. He was unsettled [replaced word] but had to obey* [...] (N9).

At the time of the distribution of the nurse officers, the nursing supervision of the unit was performed by civilian nurses and, due to the staff insufficiency of nurses, the sub-lieutenants and sergeant nurses also participated in this activity, as stated in the hospital's order and occurrence book. One of the nurse officers who already worked at the unit as a private, before conducting the contest, commented on the performance of the civil nurses who worked at the unit:

> *And then I didn't have a lot of direct contact with the civil nurses, so, supervision, head of the sector that in this case [name] was my boss when I worked in pediatrics as a corporal specialist. The employees who supervised the hospital were very few, very restricted, to [names]. So, basically they passed through the sectors, supervised, made the relocations, passed some guidelines and that was all. It was what restricted me because during the day I had no contact with them* [...] (N1).

As pointed out by the interviewee, the number of civil nurses who worked at the hospital was very limited, hindering performance and even contact with the nursing team. Another interviewee also mentions that the few civilian nurses who were at the HCPM, during the period of insertion of the nurse officers, found it difficult to work with the Nursing team:

> *And for the team, they also saw us with a certain reserve, because they already conducted their work the way they thought was fit... And then the arrival of new people, with a new thinking to the hospital. The few civilian nurses did not have the power because the hospital is militarized, so they didn't have the power in their hands, they were heads... but there was direct interference on the resources, who goes, who leaves, who takes, who will change the schedule, so it was not really that* [...] (N2).

A nurse officer who had been in the military (private), also talks about the nursing team, especially with regard to the scarcity of human resources, especially nurses:

> *So, it was one, two, three [civil nurses] and, then, we relied a lot on the colleague who, sometimes, came from another sector and helped us to do/resolve a determined situation in the sector, then we went in the sector of the other and we were very alone, we were very alone. We had no voice, understand? We had no voice. So, we counted a lot on the partnership of colleagues* [...] (N1).

Other fragments of the interviews also point to the scarcity of human resources at the unit, focusing on the nature of the work in the face of the great demand:

> *So, at the time, there were only the privates... there was no nurse, so suddenly we arrive as a duty worker... there was a daily nurse to supply the sector with material, but I couldn't handle it. I couldn't handle it* [...] (N4).
>
> *We had to structure it from scratch practically. There were people who were said to be responsible, but who actually did not have the technical knowledge for that* [...] (N5).
>
> *Look, in the sector, there were no nurses there, actually, there was a civilian nurse who worked at night [there was no contact]... But, I entered the sector without a nurse, without previous references ... what were there were the nursing assistants and the doctor in charge, the on-duty doctors* [...] (N6).

Nursing care at the hospital was badly affected, since the small number of nurses interfered with the development of activities to satisfaction. In addition, nursing technicians had almost no contact with the unit's civil nurses. This situation led the medical team to assume responsibility for the nursing team, unaware of the role of the nurse.

In the opinion of another interviewee, the hospital was not properly organized to provide assistance to clients, before the arrival of the nurse officers:

> *So let's say we find the hospital the way it was. The nurses who were working, our friends at the time who were here as civilians, they worked like that... tirelessly, but, I believe they could not reach the goal, because the hospital was very big, there was a lot to do, a lot of administrative stuff, so I think that our arrival added a lot, you know* […] (N8).

The interviewee highlights the difficulties encountered when the nurse officers arrived at the hospital. It is evident that the small number of civil nurses who worked in the unit made nursing assistance extremely difficult, in addition to the structural aspects highlighted in the interview of the civil nurse. The interviewee also adds that:

> *I think it was just me and [name] ... I don't remember well. I know that I was in the Head of Nursing and [name] at the ICU* [...] (N8).

Regarding her role in the leadership, she also highlights some difficulties faced with the nursing team and the medical team, since she perceived manipulation strategies from the only civil nurse in charge of Nursing.

> *It was hell due to the lack of staff. Basically adjusting schedules. The military boycotted me... if I had no support from the leadership, I would do nothing. Doctors sent orders every hour, like vacation and time changes; of course I didn't comply, because the management did what I wanted. They were uncomfortable [word replaced by the researcher] and even threatened me* (N8).

It is worth mentioning that the role of nurses in the position of head of nursing always demands many challenges in any health unit and, in a military space, it becomes more challenging, especially for a civilian nurse. However, it appears from the interviewee's speech that the condition of civilian gave her the possibility of not complying with military determinations. The support of the leadership, certainly occupied by high-ranking military personnel, also gave her a certain empowerment when establishing an alliance with the military.

The creation of the cadre of nurse officers in the PMERJ took place at a time when the Armed Forces and an auxiliary force, namely the Firefighters, already had military nurse officers[10]. Furthermore, the internal circumstances of the unit only having civilian nurses, led to conflict situations. The excerpt below records the perception of the pressing need to create a staff of nurse officers:

> *I was winning. In the end, I took over the leadership alone. When the group of officers arrived, there was no longer a war between the civilian and the military in the hospital. We started to assume everything. That's because they were responsible, but they weren't nurses ... they didn't have a degree. Then COREN came, but COREN didn't solve it because it was intimidated at the time... a series of situations. The director knew that we had come and would have to stay... it was a reality. So, to resolve this impasse, we started thinking and it was one of our fights at the time, to take the nurses training course for officers* [...] (N11).

After the distribution of the nurse officers in the sectors, new challenges were initiated, since the majority of the nurse officers came from civilian life and there women were predominant in a misogynistic space. In addition, they were professionals with little experience and still very young. Despite having gone through the probationary period of adaptation, military life was full of military rites, which were not fully incorporated. These rites fulfilled the symbolic function of ratifying hierarchy, strict discipline and unquestioned obedience. The excerpts from the interviews below bring to light situations inherent to the challenges mentioned above:

> *The experience I had at the hospital, at the HCPM was a little complicated because as I was already at the unit as a corporal specialist. There was a bit of rejection on the part, some people who thought that I had changed my behavior because I was a private and returned as an officer. A little of this confusion... this thing of not being accepted very well. Some privates that there were here also did not accept the nurse officer very well. There were some sergeants and sub-lieutenants who acted "in quotes" as a nurse officer* [...] (N1).
>
> *Look, as I recall the sergeants and the lieutenants carried out all the activities, they were not prepared to receive people, and I also remember that not even the medical heads of the services were prepared, in fact they saw us with reservations and, many times, they mixed the rolls... We are more involved with administrative duties, so, I realized that we were, for the medical chiefs, we were, as an improved secretary... look at the drain! Did you change the drain? Look at the light! Change the light! Get the lamp* [...] (N2).
>
> *We saluted everyone. We were framed and the doctors even made fun of us and even laughed. If it were nowadays I could say it like that, it was like a little bullying. And we were like that, sometimes even more demanded. I don't*

know why the doctors at the Surgical Center, especially the anesthesiologists, were the ones I had contact with. They required a lot. They realized that I was worried, but we were over-framed and, these times had repercussions in a way, sometimes even a little negative, especially for the privates that were the oldest [...] (E3).

It was the oldest sergeants, at the time called sector coordinators, I remember this phase well ... in my sector it was specifically very difficult, because the person was a very resistant sergeant, he was not open, he was not willing to add [...] (N5).

When we arrived, I noticed that there was resistance from these people, that is, the middle-level military. They did not see us as a person who would come to collaborate to improve the situation, but as a person who would come to supervise, a person who would be... the task collector. That's how I saw our reception [...] (N7).

DISCUSSION

The creation of the Staff of Nurse Officers at PMERJ took place at a time when officers already existed in various military forces in Rio de Janeiro. The Brazilian Navy had already created the Female Auxiliary Corps of the Navy Reserve (Corpo Auxiliar Feminino da Reserva da Marinha – CAFRM), through law 6,807 of July 7, 1980, with the entry of 56 nurse officers approved in the training course in 1981[10].

The creation of the Staff of Officers in the Army with the presence of nurses was reported, highlighting that the first class of the Complementary Staff's Officers Training Course (OTC) was formed in 1990. After two years, in 1992, the course started to incorporate the female segment in the ranks of the Army, inaugurating the first mixed group in the Brazilian Army[11]. It is noteworthy that the entry of nurses in the auxiliary forces was recent, since also in 1992, the Military Fire Brigade of the State of Rio de Janeiro, created the staff of nurse officers, with the entry of eight nurse officers, being in charge of pre-hospital care[12].

Regarding the pre-hospital care (PHC) performed by nurses, this is "a recent practice in Rio de Janeiro and started in 1992, with the entry of eight nurse officers in the Military Fire Brigade of the State of Rio de Janeiro. Subsequently, in 1994, four nurse officers from the 1992 service examination entered"[12:13].

The creation of the staff of nurses for the Military Police of Rio de Janeiro presented the rank of 2nd Lieutenant as its initial rank, the maximum being that of Major. In this sense, if, on the one hand, the creation of a cadre of nurse officers in the Military Police symbolized the achievement of yet another space for nursing, on the other hand it marked limits, by containing the nurse's rise to the highest ranks in the military institution. Such demarcations reflect the power relations, derived from traditional symbolic constructions on the hierarchy between the sexes, since nursing was a profession with a female predominance, being inserted in a military environment of male prevalence.

It is pertinent to emphasize that, already in the adaptation period, the pioneering class of nurses started their course with a lower rank than that of the other members of the class, which represents an unequal treatment to the group of nurses. It is worth noting that, despite having specific higher education, like the other categories of the health staff, nurses were not recognized with the same patent. Inequality covered not only the military hierarchical aspect, but extended to other factors such as remuneration, among other distinctions. This differentiated treatment of patents marked undeniable discrimination between the groups of the Officer Training Course.

Thus, the distribution by different professional categories can be presented as a form of symbolic power, where most of the nurse officers initially failed to understand this differentiation, as a way of gaining control of the group, through the power exercised. This misunderstanding is complete in the sense of showing symbolic power, since such demarcations of power are not recognized and are transfigured and legitimized by other forms of power[13].

When entering the hospital space as a nurse officer of PMERJ, they realized that they would need to undertake strategies, in order to obtain professional recognition and continue their military career, in an unprecedented space for nursing, specially, in Rio de Janeiro. The symbolic gains resulting from the approval and classification in the training of officers were the initial seal of approval for the first demarcation of spaces of power in the scenario of professional performance.

The strategies for incorporating military capital by the group took place in a rigorous manner, in order to promote the inculcation of hierarchy and discipline, bringing in tow a feeling of belonging and devotion to the corporation's values. This is because the incorporation of this specific capital, through discipline of the body and subjection to military rules and regulations, under the representation of its inescapable fulfillment makes the military feel as exceptional people, distinct from the others[11].

In 1995, HCPM received 42 nurse officers, members of the first class of nurse officers with the rank of 2nd Lieutenant MP Nurse, who would become part of its staff. The nursing team that was part of the hospital in the period, was made up of three civil nurses, as the others had requested exoneration, for having been approved in other examinations. In addition, four civilian nurses who already worked at the hospital passed the examinations for nurse officers.

As for the distribution of nurse officers at the HCPM, the criteria of seniority and experience or affinity with the service were obeyed. Nevertheless, the designations in the top five were made by the then director of the HCPM. This is because, historically, the distribution process of military nurses is based on two main aspects: hierarchical classification and choice. The better the position occupied, the better the chance of achieving the desired allocation option[4-11], as it is a meritocratic process, therefore, there is differentiation between the first and the last, creating even more distance between everything and nothingness[14].

Furthermore, it should be clarified that, in the structure of the Military Police, the hierarchy constitutes one of the pillars of the

corporation, as established by Law 443 of July 1, 1981: "the Military Police hierarchy is the ordering of authority at different levels, within the structure of the Military Police. The ordering is done by posts or ranks; within the same post or within the same rank, it is done by seniority in the post or rank. Respect for the hierarchy is embodied in the spirit of complying with the sequence of authority"[15:2]. In this sense, the occupation of different hierarchical degrees influences the acceptance of orders and guidelines, and this command authority must be respected the higher the hierarchical level.

In the occupation of the hospital's Nursing command, replacing the civil nurse, the substitution of the first placed by the second placed, certainly, had important implications, since the classification based on the use of the course evidences an act of ordering, where a social difference was instituted, consecrating competence and ensuring social distinction. Such reordering also evidenced the director's power regarding the appointment of the head of military nursing, as he did not comply with the classification criteria for that function. Certainly, the civil nurse and, then, chief, was heard and had the support of the director in his decisions. Nevertheless, the nurse's authority was granted by that holder of legitimate symbolic violence.

The 1st place was moved to the administrative area, at the Hospital Medical Material Central, until then headed by a sergeant from the unit. This fact caused strangeness in the majority, mainly in officer No. 01, the first placed in the classification that, at the time, had already informed the group of officers that he would assume the command of nursing at HCPM, in view of his classification. Regarding the non-confirmation of the occupation of his name in the position, it appears that he tried to argue with the director, but was not successful[4].

The designation of officer No. 2, replacing No. 1, can be explained by virtue of having a volume of social and cultural capital, which were considered important by the hospital director, having them high-ranking military relatives[16]. This type of capital is transmitted through networks of family relationships, becoming an element of main differentiation. This element can be considered one of the most influential factors, which meets the characteristics of the selected officer, since coming from a military family, it might have the requirements for political capital, added to the other forms of capital he accumulated.

With the arrival of the nurse officers, there was a distribution in the various sectors of the hospital, giving rise to changes in the organization of nursing, with reflexes in the care for the sick, as the activities developed by civil nurses and mid-level professionals (sub-lieutenant and Sergeant) became developed by nurse officers. These began to act and direct not only nursing care, but also the administrative aspects of the sectors, to which they were assigned. In this sense, there are several changes in the constitution and performance of the Nursing team at the HCPM.

The role of civilian nurses in various sectors of the HCPM, since 1982, was very important. The facing of several difficulties, especially of decision-making power in the field of action, is highlighted by the civil nurse interviewed and by the military personnel who previously worked at the hospital, as a civil nurse.

Several changes related to the distribution of the nursing team occurred in the period, with emphasis on the transfer, upon the arrival of the nurse officers, of the civil nurse, then Head of Nursing at the HCPM, to the Training and Education Sector (advisory sector of the Nursing Section), which meant for her the loss of decision-making power over issues related to Nursing.

Regarding this transfer, no record was found, however, internal sector documents and reports, signed by this nurse, allowed to prove her performance in the sector, since the admission of the Nurse Officer to the Head of Nursing at HCPM, in 1995. Such transfer shows how it was less worth her professional capital in a military hospital, after the arrival of nurses with military capital institutionalized by their patents.

In the case of the HCPM, there was no explicit resistance, certainly due to the small number of civilian nurses. The few civilian nurses chose to make alliances with the nurse officers, accepting the new order established as natural in a military space. Add the fact that the head of nursing has been replaced by a nurse officer who had previously been a civil nurse at the institution.

This reclassification consists of a kind of symbolic violence, since the acceptance of a new order as being legitimate, results from a process of concealment and suppression of the arbitrary, which has the complicity of the recipients of domination. This is because the symbolic power that embodies symbolic violence "is only exercised if it is recognized", that is, ignored as arbitrary[13:14].

Military institutions follow strict discipline and unquestionable hierarchy, which can generate certain conflicts in civilian life. As explained above, the relationship difficulties of the civil nurse being able to work in a military institution can lead to compromised work relationships, interfering with assistance.

The speech of the civil nurse revealed the difficulties of dealing with a small number of nurses to cope with the demands of the hospital and the difficulties inherent in her condition as a civil nurse in a military hospital whose newly arrived nurse officers should assume the leadership functions. To get around this situation, the head of nursing had the support of the director of the hospital, who gave her the authority to command the group and give the guidelines during this transition period.

As head of nursing, as a civil nurse, her performance was anchored in the support of the hospital management. Every head of nursing in military units can only act and develop their duties when they obtain the support of the director. In the military environment, this function constitutes a position of trust, based on the criteria of classification and political capital raised. The volume of social capital, as resources owned by a person, constitutes an important element, which allows the condition of power and recognition of a given social group[17].

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

The insertion of the first class of Nursing Officers of the Military Police of the State of Rio de Janeiro had its distribution in the HCPM based mainly on the criteria of hierarchical classification,

except the position of head of nursing, since the first place was not confirmed to the maximum position of the hospital's nursing staff. In his place, the second place assumed, as determined by the director of the hospital. The first place was assigned to the Hospital Medical Material Central.

The head nurse, after her replacement in the position of head of nursing, was transferred to a training and teaching sector of the hospital, considered at the time, an advisory sector of the Nursing Section. The distribution process of the other nurse officers in the hospital sectors was carried out successfully, in the opinion of the officers, by the then head nurse.

Certainly, the occupation of spaces of power, represented by the heads of sectors assumed by the nurse officers, was determined by the capital incorporated in the training probationary period, which was institutionalized by the patent. In addition, the previous professional practice in the hospital, of some officers, in the condition of civilian or private, facilitated the incorporation of military capital, whose volume and weight are important in a military space. Nevertheless, the professional capital raised in the undergraduate course and updated both in the process of training a nurse officer and in professional practice in the daily work of the HCPM, although with less weight, was important to add value to the military capital of these nurses and, consequently, take over the spaces of power in the hospital.

The limitation of the study was the impossibility of interviewing two of the three civilian nurses who worked at the hospital, on the occasion of the arrival of the nurse officers, in view of their health conditions.

In conclusion, the study made it possible to build a historical version based on documents on the distribution of the nurse officers at the Hospital Central da Polícia Militar, contemplating the strategies of struggles for the occupation of the spaces of power, therefore, new studies are needed on the repercussions of these occupations for the visibility of military nursing.

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