REFLECTION | REFLEXÃO

Comprehensive and obstetric care in the Unified Health System (SUS): reflection in the light of Edgar Morin's complexity theory

Integralidade e atenção obstétrica no Sistema Único de Saúde (SUS): reflexão à luz da teoria da complexidade de Edgar Morin

La integridad y el cuidado obstétrico en el Sistema Único de Salud (SUS): reflexión a la luz de la teoría de la complejidad de Edgar Morin

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Abstract

Objective: To reflect on the comprehensive and obstetric care in the National Health System in the light of Edgar Morin's Complexity Theory. **Method:** Some ideas from French philosopher Edgar Morin, the Complexity Theory and some references from the health ministry were used to write this text. **Result:** The institutionalization and hegemony of the Cartesian model led to the segmentation of the human being and fragmentation of care and interfered with the achievement of comprehensive of obstetric care in the public health system. **Conclusion:** Delivery and birth care must consider the complex subject to be able to overcome the fragmented and interventionist Cartesian paradigm and achieve comprehensive of obstetric care in the public health system. **Implications for practice:** The search for a paradigm shift in obstetric care centered on user autonomy and integrated and humanized care favors the construction of practices that ensure comprehensive care to women.

Keywords: Integrality in Health; Obstetrics; Unified Health System; Nursing.

Resumo

Objetivo: Refletir sobre a integralidade e atenção obstétrica no Sistema Único de Saúde à luz da teoria da complexidade de Edgar Morin. **Métodos:** Para a construção deste texto tomaram-se algumas ideias do filósofo francês Edgar Morin, Teoria da Complexidade e alguns referenciais do ministério da saúde. **Resultados:** A institucionalização e a hegemonia do modelo cartesiano levaram a segmentação do ser humano e a fragmentação do cuidado e interferiram no alcance da integralidade da atenção obstétrica no sistema único de saúde. **Conclusão:** A assistência ao parto e nascimento precisa considerar o sujeito complexo para conseguir superar o paradigma cartesiano, fragmentado e intervencionista e alcançar a integralidade da atenção obstétrica do sistema único de saúde. **Implicações para a prática:** A busca por um paradigma na atenção à saúde obstétrica centrado na autonomia do usuário, atenção articulada e humanizada favorece a construção de práticas que garantam a integralidade na assistência à mulher.

Palavras-chave: Integralidade em Saúde; Obstetrícia; Sistema Único de Saúde; Enfermagem.

Resumen

Objetivo: Reflexionar sobre la integridad y atención obstétrica en el Sistema Único de Salud a la luz de la teoría de Edgar Morin. **Métodos:** Para la construcción de este texto, se utilizaron las ideas del filósofo francés, de la Teoría de la Complejidad y algunas referencias del Ministerio de la Salud. **Resultados:** La institucionalización y la hegemonía del modelo cartesiano han conducido a la segmentación del humano y a la fragmentación del cuidado, e interfirieron en la consecución de la integridad de la atención obstétrica. **Conclusión:** La atención al parto y al nacimiento debe considerar el sujeto complejo para lograr superar el paradigma cartesiano y alcanzar la integridad de la atención. **Implicaciones para la práctica:** La búsqueda por un paradigma en la atención obstétrica centrada en la autonomía del usuario, en la atención articulada y humanizada favorece la construcción de las prácticas que garantizan la atención integral a las mujeres.

Palabras clave: Integralidad en Salud; Obstetricia; Sistema Único de Salud; Enfermería.

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Submitted on 03/22/2016.
Accepted on 07/06/2016.

DOI: 10.5935/1414-8145.20160094

INTRODUCTION

Comprehensive of health care is one of the guiding principles of practices and services comprising the *Sistema Único de Saúde* (SUS - Unified Health System)[1]. In conceptual terms, it has been defined in a polysemous way. In the perspective of comprehensive care, health care must connect health promotion, prevention, healing and rehabilitation actions; consider the biological, psychological and social dimensions of individuals; and continuously integrate the different levels of complexity of the health system[2-4].

Several policies and ministerial decrees have been instituted throughout the years in Brazil, aiming to achieve comprehensive of health care for users[4]. However, in practical terms, the scope of this principle is not yet the reality in all routine health care practices, as they are still based on drug use, verticalization of programs and fragmentation of actions and relations[5].

In the obstetric dimension, the programs, policies and decrees that have been created could not break away from the hegemonic paradigm historically structured in his country[6-8], and, in this sense, did not have a significant impact on comprehensive, thus hindering the implementation of humanization and quality for delivery and birth care[9]. This is because aspects such as the difficulty to access health services, long waiting lines, low quality of services provided and overcrowded maternity wards represent the reality of obstetric care in Brazil[9,10].

This reality opposes the principle in question, which aims to consolidate a cooperative public health system among workers, managers and users when developing guidelines and group actions organized by types of logic geared towards the guarantee of social rights[11]. Additionally, it implies leaving behind human fragmentation. This proposal is associated with the meaning of post-modern scientific practices that follow the systemic view of a complex individual[12].

Thus, to think about comprehensive and obstetric care from a theory helps to reflect on the fragmentation in delivery and birth care, as it enables a more in-depth understanding of the meanings comprising the several facets of a systemic phenomenon. Additionally, there is a gap in the construction of the philosophical knowledge that can allow us to understand the aspects involved in this problem, its consequences and actions required to implement such health care globally.

Consequently, obstetric care must be understood in its complexity, contradictions and uncertainties. To achieve this, some of the ideas proposed by French philosopher Edgar Morin and the Complexity Theory are the basis for this reflection, as theories in this area of health must be open, rational, critical, reflective, self-critical, and fit to be transformed. Therefore, the paradigm of complexity founded on complementary and interdependent principles defined as systemic, hologramatic, from a retroactive circuit, from a recursive circuit, from an autonomous dependence, dialogical and from the reintroduction of knowledge, translating the understanding of thinking. The systemic principle links knowledge about the parts to knowledge about the whole, considering the fact that the whole is more than the sum of its parts. On the other hand, the whole can be equally less than the sum of its parts, when the qualities are hidden by the organization of this whole[13].

It should be emphasized that the following considerations are not aimed at denying the importance of the Cartesian paradigm and only promote complex thinking, as following this approach would pose the risk of inflexibility in terms of ways of thinking. This is an invitation to reflection and healthy criticism. However, by writing about this theme, a choice was made and some relevant questions are raised to improve neonatal and obstetric care.

In view of these considerations, the present study aimed to reflect on the comprehensive of obstetric care in the Unified Health System in light of Edgar Morin's Complexity Theory. It should be emphasized that the following seven principles help to understand this complexity: organizational resource, hologramic principle, retroactive circuit, autonomy/dependence recursive circuit among subject/individual/environment, dialogical principle and, finally, the reintroduction of knowledge into all knowledge[13].

The first principle represents the union between knowledge about the parts and knowledge about the whole; the second principle emphasizes that the part is in the whole and that the whole is in the parts; the third principle shows that the cause acts on the effect and the effect acts on the cause, changing it and creating a new effect (self-regulating retroaction); the fourth principle emphasizes that products and effects are producers and causers of that which produces them, belonging to a self-organized cycle; the fifth principle of autonomy/dependence among subject/individual/environment brings the importance of self- and co-organization; the sixth principle reveals that the union between order and disorder are a part of the organizations, so that they are complementary and antagonistic, forming the complex whole, i.e. the two principles that would naturally exclude each other are united; and the seventh and last principle shows the key cognitive problem: from the perception to the scientific theory, all knowledge is a reconstruction/translation performed by the mind/brains in a certain culture and time[13].

Therefore, man is included in the world as a tiny part of the whole, although this whole is found in his part. As a result, contextualizing him is essential. This is a complex unit of nature with physical, biological, psychological, cultural, social, historical and spiritual characteristics. He is a multi-dimensional being who requires connection, identity and difference among the several human aspects[14]. These conceptual references are tools for more in-depth understanding of questions related to the object of study.

THEORETICAL AND PHILOSOPHICAL CONCEPTIONS OF EDGAR MORIN'S COMPLEX THINKING TO UNDERSTAND THE ASPECTS ASSOCIATED WITH DELIVERY AND BIRTH

The practice of health professionals in delivery and birth care continues to be geared towards the biomedical model, which values interventionism and the institutionalization of actions. In this context, women are submitted to isolated, standardized, fragmented and mechanical procedures. This fact shows the negligence towards care, as it does not meet women's actual needs[15].

According to the Ministry of Health, the fragmentation of care, excessive interventionism and impersonality found in the obstetric context have led to serious consequences and harm to the biopsychosocial aspect for mothers and newborns[10]. In this sense, the art of being born changed from a natural and intimate event to a technical and medicalized one, convenient for health professionals, although at the same time unknown and frightening for women giving birth. Therefore, delivery care has become mechanical and impersonal, based on the hospital-centered biomedical model where women are submitted to a series of procedures[6]. This represents the loss of humanization in obstetric and neonatal care[15].

Consequently, the institutionalization and hegemony of the Cartesian technocratic model have led to the segmentation of human beings and knowledge, dilution of subjectivity, and appreciation of that which is pathological rather than human[13,16,17]. In this perspective, the Paradigm of Simplification should be emphasized, which has generalization, reduction and separation as its basis. These principles do not enable us to contemplate the reality in all its complexity, as they produce a simple conception of the universe. This approach poses the risk of seeing individuals as objects that are similar to machines, rather than organisms[16].

For a long time, it has been known that the dominant paradigm in science was concerned about dividing knowledge into disciplines and these into sub-disciplines. This hyper-specialization caused many professionals to focus on their objects of work, hindering dialogue with other areas and, consequently, comprehensive health care[18]. It should be noted that routine mechanical care revolving around procedures is inhumane. In this sense, comprehensive care is aimed at a wider view of health which goes beyond the disease, reductionism, fragmentation and objectification of individuals[19]. Following this approach, one begins to think about the subject-subject relationships with multiple needs that must be met in the sphere of trans-disciplinarity[20]. In this sense, advances must be made in the obstetric area, aiming to overcome the technocratic and interventionist pattern centered on the body and institutionalization of childbirth, so that a humanistic model can be followed, enabling health professionals to include parturients' physiological, psychological and sociocultural aspects[21]. Thus, humanized care in the obstetric context must be broad and aimed at women in their whole, multi-dimensionality, singularity, both in the individual and collective spheres, in all age groups, physical and psychological dimensions, and social, economic and cultural contexts in which they perform and create changes[22].

In this perspective, health care during the prenatal-puerperal cycle needs to meet all requirements women have. To achieve this, multi-professional services must be provided, based on respect for the physiology of pregnancy and childbirth, in addition to the dialogue and co-responsibility in the promotion of female autonomy, so that they may actively participate in this stage[7]. However, overcoming the Cartesian model is still considered to be a great challenge in the dimension of the institutions included in the Unified Health System. This fact opposes the ministerial recommendations of humanization founded on the autonomy and active participation of individuals, their co-responsibility, solidarity of connections established and users' rights[23].

In this sense, it could be affirmed that there are contradictions between what is recommended and what is developed in the routine care practice in the obstetric context, thus revealing the importance of the dialogical principle, i.e. new organizations can be formed from the interaction between opposing, complementary or competing ideas and actions. Consequently, actions aimed at the improvement in such services can be established, among which *Rede Cegonha* (Stork Network) stands out, which shows the importance of development towards a humanistic model in the obstetric context[24].

In view of this new movement, despite the Cartesian paradigm still determining the way of knowing, thinking and acting of human beings throughout the history of science, a new paradigm known as Complexity has emerged in modern times[25]. As complexity, Morin suggests a relationship of dependence among multiple dimensions of knowledge about biology, anthropology, sociology and physics, so that it opposes reductionist and simplifying mechanisms. This was not achieved through separation, but rather through the union of human life aspects, integrating different ways of thinking. Complexity includes an organization with a context, with all parts and the whole, with the whole and all parts, and of parts among themselves. This requires concepts be regarded as always incomplete, so that junctures can be established between parts that had been separated and multi-dimensionality can be understood[26].

Therefore, the Complexity Theory allows for an approach that considers what is "connected together", i.e. to regard the distinct parts that interact with each other in the make-up of the whole or phenomenon, included in a context that encompasses the contradictions in a dialogical perspective, thus enabling complex phenomena to be grasped[16].

The Complexity Paradigm is a set of principles that, connected to each other, can determine the conditions of a systemic view of the universe (physical, biological and anthroposocial). Based on these considerations, it can be affirmed that it is inviable to conceive hominization simply as biological, spiritual or exclusively sociological evolution, but rather as a complex and multi-dimensional morphogenesis resulting from genetic, ecological,

cerebral, social and cultural interferences[27]. Human beings are complex and bring inside them antagonistic and complementary ways of being simultaneously. Additionally, their autonomy is dependent on genetic, cultural and social conditions, which does not prevent them from deciding and acting in the world in which they live[13,16]. In view of these considerations, it could be affirmed that comprehensive is similar to the idea of transdisciplinarity, which aims to allow an interaction among disciplines, without promoting their homogenization nor creating another[28].

Additionally, isolated professionals lose their natural skills to increase and gather knowledge. Dialogue between the several types of knowledge and the development of inter-disciplinary work promotes comprehensive care. Thus, the fragmentation of disciplines prevents us from understanding complexity, i.e. that which is organized in a network, as lack of a global perception leads to the weakening of responsibility and solidarity among human beings[13]. A study has shown that the qualification of professionals according to a reductionist and hospital-centered logic is a barrier to comprehensive care[22].

According to Morin, the recursive interconnection of notions of hierarchy, centralization and specialization of the simplifying connection in which institutions are included is insufficient to respond to the complexity of self-organization and, despite such structure providing advantages, it also has risks and vulnerabilities, such as bureaucracy[14].

The reintroduction of knowledge reflects the academic qualification of professionals who will comprise the praxis, dialogue with the positivist paradigm of academic qualification and the importance of interdisciplinary work[18]. The purpose of complex thinking is to sensitize individuals about the fragmented model and to understand that mutilating thinking inevitably lead to mutilating actions[16].

According to this approach, among the areas of health care prioritized in the new existing obstetric context, the Ministry of Health defines the proposal to qualify professionals to promote systemic, trans-disciplinary, humanized care aimed at achieving comprehensive[7]. In this perspective, the new proposal presented by the *Rede Cegonha*, which deals with multidisciplinary teams for delivery and birth care, shows the importance of qualification, especially of nurses, when considering the fact that care provided by these professionals shows lower intervention rates and greater satisfaction from parturients and family members[29].

In this sense, the promotion of the qualification and training of more nursing professionals in the performance of deliveries with the usual risk is recommended, so that changes in institutional practices and routines can be achieved, as the organization of institutions is reflected in obstetric care and practice. Therefore, according to the principle of organizational resource, it could be affirmed that the fragmentation of actions can be overcome and comprehensive of care can be achieved, especially regarding delivery and birth, based on the union between knowledge about the parts and knowledge about the whole. In this perspective, the inclusion of obstetric nurses in a multiprofessional team is considered to be a relevant proposal to overcome the obstacles and difficulties for the implementation of a policy of humanization. Additionally, to achieve this, an integrated health care network that can meet these and other demands adequately and quickly is required[7].

Moreover, individuals, family members and the community must be sensitized, aiming to empower them about their rights and give them autonomy. This process requires health professionals and society to work together and public policies on social control to be implemented[30]. Following this approach, Morin recognizes that each human being has equal rights and is responsible for him/herself, for others and for life. It should be emphasized that, even in view of individual, genetic, family and social processes and in autonomous-dependent situations, one's autonomy cannot be ignored to establish strategies based on knowledge and experiences. Additionally, individuals have moral and reflective conscience to make choices, pursue goals, and to have and manifest freedoms, so that they are able to change their attitudes and become ethically committed to the perspective of comprehensive of care[16].

FINAL CONSIDERATIONS

Based on the proposed reflection, it is possible to observe that delivery and birth care must overcome the concept of the body in the perspective of a machine centered on fragmented and interventionist attitudes. In this perspective, the process of construction of obstetric health should be recovered, so that all questions and needs involving the complex subject can be taken into consideration and, consequently, the possibilities of multiprofessional practices in this area can be reflected upon. Therefore, the concept of comprehensive is intertwined with every reflection on the changes in the health care models founded on complex thinking as an alternative to overcome the fragmented and interventionist Cartesian paradigm, which is frequently found in the majority of health institutions.

To achieve this, political willingness is required, enabling the restructuring of professional qualification, the interaction between social sectors and health care networks, the participation of the population, and the commitment of all health professionals to break away from the hegemonic model based on hyper-specialization and to begin to adopt the Complexity Theory, aiming at the required changes in women's and newborn care founded on the policy of humanization.

Thus, the time has come to seek a new paradigm in obstetric health care centered on the autonomy of users as the main participants of rights and on integrated and humanized care and an ethical approach to intersubjective relationships. In this perspective, obstetric nursing is emphasized, as it qualifies professionals who can reflect and work in cooperation with the remaining team members to construct new paths, possibilities and practices, aiming to guarantee comprehensive of care for women, babies and families.

REFERENCES

1. Lei n. 8080, de 19 de setembro de 1990 (BR). Dispõe sobre as condições para promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providencias. Diário Oficial da União; [periódico na internet], Brasília (DF),19 set 1990;[citado 2016 jan 9]: Seção 1: 1. Disponível: http://www.planalto.gov.br/ccivil_03/leis/L8080.htm
2. Silva RVGO, Ramos FRS. Integralidade em saúde: revisão de literatura. Cienc. cuid. saude [on line]. 2010;[citado 2016 jan 05];9(3):593-601. Disponível: http://periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/viewFile/8726/6640
3. Paim JS, Silva LMV. Universalidade, integralidade, equidade e SUS. BIS, Bol. Inst. Saúde. 2010 ago;12(2):109-14.
4. Andrade JT, Costa LFA. Medicina complementar no SUS: práticas integrativas sob a luz da Antropologia médica. Saude soc [online]. 2010 sep;[citado 2016 jan 10];19(3):497-508. Disponível: http://www.scielo.br/pdf/sausoc/v19n3/03.pdf
5. Lucchese R, Vera I, Pereira WR. As políticas públicas de saúde - SUS - como referência para o processo ensino-aprendizagem do enfermeiro. Rev. Eletr. Enf [online]. 2010;[citado 2016 jan 10];12(3):562-6. Disponível: https://www.fen.ufg.br/fen_revista/v12/n3/v12n3a21.htm
6. Ministério da Saúde (BR). Parto, aborto e puerpério: assistência humanizada à saúde. Brasília (DF): Ministério da Saúde; 2003.
7. Portaria nº 1.459, de 24 de junho de 2011(BR). Institui, no âmbito do Sistema Único de Saúde a Rede Cegonha. Diário Oficial da União [periódico na internet], Brasília (DF), 24 jun 2011; [citado 9 jan 2016]: Seção 1: 1 Disponível: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt1459_24_06_2011.html
8. Ramalho KS, Silva ST, Lima SM, Santos MA. Política de saúde da mulher à integralidade: efetividade ou possibilidade? Cadernos de Graduação - Ciências Humanas e Sociais Fits [online]. 2012;[citado 2016 jan 10];1(1):11-22. Disponível: https://periodicos.set.edu.br/index.php/fitshumanas/article/view/462/198
9. Assunção MF, Soares RC, Serrano I. A superlotação das maternidades em Pernambuco no contexto atual da política de saúde. Serv. Soc. Rev [online]. 2014 [citado 2016 jan 10]; 16(2):5-35. Disponível: http://www.uel.br/revistas/uel/index.php/ssrevista/article/viewFile/14401/15183
10. Barbastefano PS, Girianelli VR, Vargens OMC. O acesso à assistência ao parto para parturientes adolescentes nas maternidades da rede SUS. Rev. gauch. enferm. [online]. 2010;[citado 2016 jan 10];31(4):708-14. Disponível: http://www.scielo.br/pdf/rgenf/v31n4/a14v31n4.pdf
11. Paim JS, Teixeira CF. Política, planejamento e gestão em saúde: balanço do estado da arte. Rev. saude publica [online]. 2006;[citado 2016 jan 10];40(spe):73-8. Disponível: http://www.scielo.br/pdf/rsp/v40nspe/30625.pdf
12. Silva Junior AG, Alves CA. Modelos Assistenciais em Saúde: desafios e perspectivas. In: Morosini M, Valéria GC, organizadores. Modelos de atenção e a Saúde da Família. Rio de Janeiro: EPSJV/Fiocruz; 2007. p.27-41
13. Morin E. Os sete saberes necessários para a educação do futuro. 2ª ed. São Paulo: Cortez; 2011.
14. Morin E. A cabeça bem-feita: repensar a reforma, reformar o pensamento. 20ª ed. Rio de Janeiro: Bertrand Brasil; 2012.
15. Hilana DD, Dafne PR, Eryjosy MG, Maria VCG, Pamela NL, Nayara SM. A contribuição do acompanhante para a humanização do parto e nascimento: percepções de puérperas. Esc Anna Nery [online]. 2014;[citado 2016 jan 10];18(2):262-9. Disponível: http://www.scielo.br/pdf/ean/v18n2/1414-8145-ean-18-02-0262.pdf
16. Morin E. A via para o futuro da humanidade. Rio de Janeiro: Bertrand Brasil; 2013.
17. Morin E. Ciência com consciência. 13ª ed. Rio de Janeiro: Bertrand Brasil; 2010.
18. Morin E. Saberes globais e saberes locais: o olhar transdisciplinar. Rio de Janeiro: Garamond; 2010
19. Pinheiro R, Matos RA. Cuidado: as fronteiras da integralidade. São Paulo: HUCITEC; 2004.
20. Scarparo HBK. Perspectivas de integralidade em prática de saúde na década de setenta: o sistema de saúde comunitária na Vila São José do Murialdo. Barbarói [on line]. 2006;[citado 2016 jan 10];25:115-130. Disponível: https://online.unisc.br/seer/index.php/barbaroi/article/view/731/612
21. Ministério da Saúde (BR). Política Nacional de Humanização. Brasília (DF): Ministério da Saúde; 2013.
22. Mota MF, Zampieri Erdmann AL. Cuidado humanizado no pré-natal: um olhar para além das divergências e convergências. Rev. Bras. Saúde Mater. Infant. [online]. 2010 set;[citado 2016 jan 08];10(3):359-67. Disponível: http://www.scielo.br/pdf/rbsmi/v10n3/v10n3a09.pdf
23. Ministério da Saúde (BR). Humaniza SUS: rede de colaboração de humanização da gestão e da atenção do SUS. Brasília (DF): Ministério da Saúde; 2015.
24. Ministério da Saúde (BR). Política Nacional de Humanização. Brasília (DF): Ministério da Saúde; 2013.
25. Morin E. O método 4: as ideias, habitat, vida, costumes, organização. 5ª ed. Porto Alegre: Edição Sulina; 2011.
26. Morin E. Introdução ao pensamento complexo. Tradução de Elaine Lisboa. 4ª ed. Porto Alegre: Sulina; 2011.
27. Morin E. O enigma do homem: para uma nova antropologia. 2ª ed. Rio de Janeiro: Zahar Editores; 1979.
28. Severo SB, Seminotti N. Integralidade e transdisciplinaridade em equipes multiprofissionais na saúde coletiva. Ciênc. Saúde Colet. [online]. 2010 jun;[citado 2016 jan 08];15(Suppl 1): 1685-1698. Disponível em: http://www.scielo.br/pdf/csc/v15s1/080.pdf
29. Overgaard C, Moller AM, Fenger-Gron M, Knudsen LB, Sandall J. Freestanding midwifery unit versus obstetric unit: a matched cohort study of outcomes in low-risk women. BMJ Open [online]. 2011;[citado 2016 jan 08];1:1-11. Available: http://bmjopen.bmj.com/content/1/2/e000262.full.pdf+html
30. Ministério da Saúde (BR). Secretaria de Vigilância em Saúde. Secretaria de Atenção à Saúde. Política Nacional de Promoção da Saúde. Brasília (DF): Ministério da Saúde; 2006.