

Social representations of citizenship by inpatients: implications for hospital care

Representações sociais dos usuários hospitalizados sobre cidadania: implicações para o cuidado hospitalar
Representaciones sociales de pacientes internados sobre ciudadanía: implicancias en el cuidado hospitalario

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ABSTRACT

Objective: examine the social representations of citizenship by inpatients receiving hospital care. **Method:** qualitative approach, using the Theory of Social Representations as a framework, with 31 inpatients in the internal medicine sector of a public university hospital. Semi-structured interviews were conducted, whose data were submitted to the Alceste program, with application of lexical analysis. **Results:** patients understand their rights, and citizenship in the care process is understood based on the right to health, to receive good care from a technical and human standpoint. **Conclusion:** being well treated as a person and the provision of technical-procedural care are rights of patients; the absence of one or the other implies, therefore, lack of respect for their citizenship.

Descriptors: Right to Health; Patient Rights; Hospital Care; Social Psychology; Nursing Care.

RESUMO

Objetivo: analisar as representações sociais de usuários hospitalizados sobre a cidadania no cuidado hospitalar. **Método:** abordagem qualitativa com referencial da Teoria das Representações Sociais, realizada com 31 usuários hospitalizados no setor de clínica médica de um hospital público, universitário. Realizou-se entrevista semiestruturada, cujos dados foram submetidos ao programa Alceste, com aplicação de análise lexical. **Resultados:** os usuários conhecem os seus direitos, e a cidadania no cuidado é entendida à luz dos direitos à saúde, de modo que sejam bem atendidos do ponto de vista técnico e humano. **Conclusão:** o bom trato relacional e a prestação do cuidado técnico-procedimental são direitos dos usuários; logo, a ausência de um ou de outra implica o não respeito à sua cidadania.

Descritores: Direito à Saúde; Direitos do Paciente; Assistência Hospitalar; Psicologia Social; Cuidados de Enfermagem.

RESUMEN

Objetivo: analizar las representaciones sociales de pacientes internados sobre la ciudadanía en el cuidado hospitalario. **Método:** abordaje cualitativo con referencial de la Teoría de las Representaciones Sociales, trabajo realizado con 31 pacientes internados en el área de clínica médica de un hospital público, universitario. Se aplicó entrevista semiestructurada, cuyos datos fueron sometidos al programa Alceste, utilizándose también análisis del léxico. **Resultados:** los pacientes conocen sus derechos; la ciudadanía en el cuidado es entendida a la luz del derecho a la salud, de manera tal de que sean bien atendidos desde el punto de vista técnico y humano. **Conclusión:** el buen trato relacional y la prestación del cuidado técnico y de procedimientos son derecho de los pacientes; la ausencia de uno u otro implica faltar el respeto a su ciudadanía.

Descriptor: Derecho a la Salud; Derechos del Paciente; Atención Hospitalaria; Psicología Social; Atención de Enfermería.

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INTRODUCTION

The construction of the National Humanization Policy contains an ethical contribution and, consequently, its content deals with the rights of users of the health system. It highlights the rights and responsibilities of health professionals and managers, as an expression of the value assigned to these social actors in the workplace, demonstrating the ways health care can be implemented and managed for the benefit of others, referred to in this study as health system users. The National Humanization Policy is a vehicle to make the Unified Health System (SUS) comply with the Federal Constitution; so, it can be argued that the concept of citizenship is central to health care, according to this policy⁽¹⁾.

The mass media and television and print media address citizenship as related to education, health, housing and transportation. Thus, politicians often replace the expression “the people” with citizens, i.e., it is no longer the people that want, but “citizens want”; therefore, citizenship assumes the place of the subject, “it’s the talk of the town [the people]”⁽²⁾.

Citizenship is presented as a relevant theme for social practice and public policy, aimed at obtaining a health care system that supports its construction and exercise by users⁽¹⁾. Ensuring it among professionals and health service users is a goal to be achieved in the planning and implementation of care, as well as in management; however, recognition occurs by hospital service users when citizenship is tied to the health care sphere⁽³⁾.

Consequently, citizenship is a particular subject of debate in this article since it strives for the inclusion of civil society in the public sphere, given that the right to health includes the social right of citizenship, which entails citizens taking part in collective assets, and is articulated through ethics since it deals with the rights of citizens in the realm of health. The concept of citizenship encompasses the participation of citizens belonging to society, since they are the holders of rights⁽⁴⁾. Overall, the users of services know what their health care rights are, although their participation in the pursuit of these rights is not as common as it should or could be.

Therefore, it is essential to understand the relationship between thoughts and actions of users insofar as citizenship in its practical dimension in the world of health care, particularly hospitals. The hospital is an institution that does not permit patients to participate in their care, due to its biomedical form of organization and because it is an environment in which the patient is weakened by illness⁽⁵⁻⁶⁾.

For this reason, this study focuses on the thoughts and actions of inpatients in relation to citizenship in hospital care, since this theme circulates among social groups, enables the formation of ideas, attitudes and practices, is present in health policies and constantly receives attention from the different media. The relationship between thought and action can be investigated on the basis of the Theory of Social Representations (TSR)⁽⁷⁾, since this theory deals with social knowledge, which includes “the knowledge produced in and by everyday life.” In other words, TSR seeks to reveal how the knowledge of individuals and social groups is produced in daily life⁽⁸⁾ and, from there, how this knowledge guides the actions and ways of acting of individuals in society.

In sum, the objective of this study is to analyze the social representations of citizenship in hospital care by inpatients. Exploring this theme with inpatients who experience the everyday hospital environment will contribute to the discussion of issues related to the exercise of citizenship in health care and will generate input for critical thinking by professionals on health and nursing practices, in order to delineate strategies to insert patients within the care process.

METHOD

This is a descriptive, qualitative field study whose theoretical and methodological framework is the Theory of Social Representations (TSR)⁽⁷⁾. The TRS procedural approach was applied, which enables access to the knowledge content of subjects, through the establishment of links between their knowledge of the care they receive and their position (action) in regard to it^(3,9). This creates the means to understand this dynamic and reflect on it, with the goal of creating resources to intervene in health care, which includes nursing care. Knowing what patients think about the care they receive and their response to it enables health professionals to contribute so that inpatients can exercise their citizenship during the care process.

The study field was a large federal general hospital located in the city of Rio de Janeiro. The sector studied was internal medicine which has beds to receive 60 inpatients. Of this total, 31 patients participated (17 women and 14 men), in an age range from 20 to 89 years. The inclusion criteria were: men or women 18 years of age or over, hospitalized in the internal medicine sector during the time the study was conducted, with cognition and speaking abilities intact. The exclusion criteria were: those under age 18, in isolation of any kind, with impaired cognition or speaking ability or hemodynamic instability that would prevent participation in the study.

Semi-structured interviews were used to identify the formulation of knowledge of the subjects, with a priority on communication and language as conditions for the production of social representations. The questions from the script explored information, images, beliefs and opinions, and focused on the practical everyday life of the subjects⁽¹⁰⁾. The data collection took place from December 2011 to January 2012. The interview instrument consisted of closed questions designed to obtain data on hospitalization and the identification of patients; and open questions on how patients understood the concept of citizenship, how this phenomenon was manifested in hospital care, the ways in which it was exercised and what factors facilitated it or made it more difficult; questions were also asked about the care given, the professionals administering this care and the characteristics of these professionals. The interviews were electronically recorded with permission of the interviewees, in accordance with CNS Resolution 196/96, in force at the time of the study, and the observations of the participants were recorded in a field log.

The Alceste (*Analyse Lexicale par Contexte d`un Ensemble de Segments de Texte*) system was used (2010 version), which performs lexical analysis through the conjugation of a number of statistical procedures when applied to a textual database⁽¹¹⁾.

In this study, the database was comprised of the interviews, called initial context units (ICU), which formed the corpus of analysis; the latter, after the running of the aforementioned program, generated 914 segments of texts called elementary context units (ECU), corresponding to 77% utilization of the *corpus*.

Each ICU was characterized with the user profile data, such as gender, age, educational level, length of stay, previous hospitalization, previous place of hospitalization and whether or not the person was a health professional, in order to consider the inpatient social group profile in the analysis of the social representations. For the focus of this article, the content explored is from lexical class 2, which assembles content about health care in the hospital environment, so as to achieve the study objective.

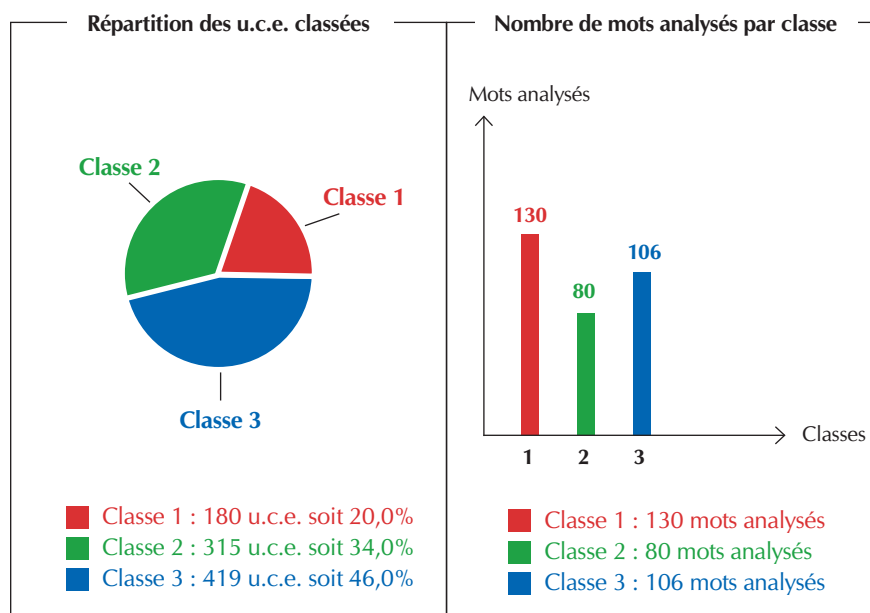
The interpretation work of the analysis performed by Alceste took into account the content from the lexical class, through analyzable words characteristic of this class, with higher frequency of appearance (chi-square - χ^2), and the ECUs related to it, for the purpose of understanding the meanings and significance of the dialogues of patients based on TSR. The χ^2 value shows the relevance of the word in the construction of the class, because it provides an idea of the meaning assigned by the patient to the object examined.

Ethical requirements were met and the study was approved by the Ethics Committee of the Anna Nery School of Nursing and São Francisco de Assis University Hospital. The anonymity of the participants was ensured through the use of alphanumeric codes in the ECUs utilized to exemplify the analysis and discussion of the results: letters F (female) and M (male), followed by the number corresponding to the order in which the interviews took place.

RESULTS

It can be seen in Figure 1 that lexical class 2 has 315 ECUs, corresponding to 34% of the total ECUs classified, and contain 80 analyzable words.

The profile generated by the program, using as a reference the Dendrogram of Hierarchical Descending Classification (HDC), resulted in words with χ^2 greater than or equal to 13. The illustrative lexicons of this class, as generated by the ALCESTE program, with their respective χ^2 are: trat+ (68), med+ (49), reclam+ (41), hospital (33), sentindo (31), paciente (28), carinh+ (24), enferm+ (22), falt+ (21), medic+ (19), daqui (16), atenção (16), enfermeir+ (16), otim+ (15), vez (14), gente (14), fal (13), teve (13), consult+ (13), relação (13), hospitais (13).



Source: ALCESTE Report.

Figure 1 – Distribution of the classified elementary context units and number of analyzable words per class

The predominant profile of inpatients corresponding to this class is women, with previous hospital stay experience and an age range of 60 to 79 years, which served as the field for the study. This social group, therefore, is composed primarily of elderly women.

Class 2 refers to the characteristics of citizenship in health care during the hospitalization process, specifically in the living of this process. This idea-synthesis was based on the words with higher χ^2 , which have higher intra-class representativeness, such as treated/treat, physicians, complaint, well, hospital, feeling, patient, loving care, nursing/nurses and lack, associated with the specific ECUs of this class.

The interpretation of the analyzable words brought into view two large intraclass groups, one of which refers to the relationship between nurse, patient and physician regarding know-how in the hospital context, objectified in technical-procedural aspects; while the other deals with the relational and subjective dimension, necessary in health care and characterized by the words "treat, people, care and loving care". The issue of citizenship, from the standpoint of the right to health, cuts across these two large groups.

The ECUs show that patients approach their care experiences during the hospitalization process via procedural techniques used in the care linked to the needs of the illness, which characterizes the activation of citizenship in the hospital context.

They did everything just right, they helped her. It was all fine. What really hurts is when you're feeling pain and they keep you waiting. So far, whenever I've needed them, they've come quickly. I can't fault them for anything. (F1)

They are treating me according to the needs of the illness. I can't complain about the care that I am receiving from the doctors and nurses. (M28)

Technical-procedural care is one of the elements of the representation of citizenship in hospitals, since it is considered a right of patients; therefore, it is valued by them.

More technical, more exact, much more, well-given [care], not just done mechanically. (Uf6)

In their dialogues patients refer to the latest advances in biomedical knowledge, found in their daily conversations, and thus express their opinions about health care, so that they can participate better in the care process, as shown in the following ECU:

There's a drug for cancer, and everyone is happy because there's so much cancer, but there's no cure. However, they're developing a way to make a drug to cure cancer, to cure AIDS, as a result of the research they're doing, of the unity they have. Brazilians are receiving a lot of recognition for this in the world, because they are discovering things that people don't know about abroad, not even Americans. (M28)

It can be seen in the ECU cited above that the patient attributes value to the care which focuses on the needs of the illness, which can be objectified in technical/procedural aspects: *They are treating me according to the needs of the illness.* This excerpt reaffirms that patients know what their health care rights are, based on the biomedical knowledge circulating within this social group.

However, hospitals cannot incorporate, within the services provided, the rights of health service users to receive care when there is a need for health care:

I can't complain. My rights have always been respected. Sometimes you read things in the newspaper about someone who did not receive their right to at least receive care or assistance in a hospital during a time of difficulty. (F7)

When they don't do much, you get there and people make you come I don't know how many times, but do little for you. They don't attend to you. (F19)

The subjective and relational dimension which overlaps with care also created meanings about citizenship, when patients mentioned promptness when approaching the technical/procedural aspect. This indicates that the subjective and relational issue is perceived as a qualifier of care.

This time everyone was very respectful indeed. I can say that from experience. They are incapable of treating some people better than others. They treat everyone very well. I've noticed this in all of them, the doctors, how they treat you, with a lot of loving care and respect. (F5)

Here the doctors and nurses treat you with loving care, as though you were a member of the family. I think the way they talk to people here shows they care about people, if they're feeling well, or not feeling well. (M17)

Care not only revolves around the technical procedure side, focusing on the illness, but also on the subjective and relational dimension.

But I see people complaining in lots of hospitals – the professional isn't nice, they don't treat you well, they're impatient with you – things like that. (F11)

Mentions were made of professionals who respect the rights of patients less, those who are brusque, impatient and don't converse with patients.

Among all of you, you feel, there's no point saying it's not so because I know it is, you feel there are people who are very stuck-up. (F2)

Any profession has their good and bad professionals, the ones who are only there for the money and not for love of the profession, as occurs in all professions. (F7)

They act coldly and with contempt, but now it's changed a lot. It was worse before, but I can't complain at all about most of them there. There are some who haven't grasped it yet. (F24)

One of the study subjects commented that the relationship between health professionals and patients (or their family members) should be based on warmth, this being one of the elements of citizenship. When it is not like this, conversation can be used, to restore warmth in the treatment and ensure respect for citizenship.

[Do you consider yourself a citizen?] No, it can't be like that: no, period. I tell her off, nicely, but I tell her off. (F3)

Linked to the image of health professionals, with varying levels of respect for the rights of patients, there are good and bad health professionals, according to characteristics that help make up this representation.

Good professionals are those who love what they do above all and want to comply with all the requirements that that profession demands of them. For example, nurses and doctors must be dedicated to patients, study a lot, be continuously updating. A good professional will seek after this, but bad ones not so much. They'll neglect things, won't be up to date or be that dedicated. They're in a bad mood when they care for patients. (Uf7)

Patients also argue that the technical/procedural side must be connected to the subjective/relational dimension as a vehicle that enables comprehensive care.

I refer both to receiving good care and how people are treated. Their treatment is excellent and the hospital side is also great. Medicines right on time. The care of the nurses is excellent. They treat you in a loving way, which is important for people as patients. (M16)

DISCUSSION

Based on the contents that comprise the knowledge of inpatients about citizenship, health rights stood out, from the perspective of the right to health found in the actions of existing policies since the promulgation of the Constitution and

Organic Law of Health, with an emphasis on the National Humanization Policy^(1-2,12). Patients refer to social rights, as represented by the right to health, to address the phenomenon of citizenship in relation to the object of this study. By bringing in the positive and negative perspectives of hospital care, with citizenship as the guiding principle, they enable the concrete implementation of this right.

It is through the carrying out of procedures in the care process, aimed at keeping the body functioning and to eliminate the disease/injury that affects the body, that patients give meaning to the exercise of the right to health, especially in the hospital context, and consequently understand that their citizenship has been respected.

The concept of the right to health includes the guarantee of its protection, promotion and recovery for users of the services provided by the State⁽¹²⁾. To this end, care of a technical and procedural nature has its degree of importance, guided by know-how centering on biomedical knowledge.

The right to health in Brazil is broad, but its effectiveness is complicated, since it is characterized by decent living and health conditions, which includes issues related to work, housing, food, education, transportation and leisure, as well as universal, equitable and equal health care for the entire population⁽¹²⁾. Thus, this article addresses the issue of this right from the perspective of one of its conceptual elements: health care in hospital services.

Reflection on the insertion of biomedical knowledge in the health field involving the social actors that comprise it (patients, professionals and managers) enables testing the relationship between production and dissemination of this knowledge and the representation of citizenship for these inpatients. Biomedical knowledge, which underlies health practices, especially in hospital environments, is developed through a scientific and technological approach, because "the production and dissemination of biomedical knowledge is an input as essential to public health as the traditional material inputs, such as vaccines and medicine"⁽¹³⁾.

In light of this discussion, information play an important role in the construction of knowledge of individuals, because the media contributes to scientific dissemination, when it allows scientific knowledge go beyond the walls of universities and research institutions and become accessible to the population in general⁽¹⁴⁻¹⁵⁾. Patients are mindful of these new advances in biomedical knowledge and integrate them into their daily conversations and form opinions on the subject, which enhances their means to participate in the care process.

Coupled to this, there is the reality experienced by hospital patients. The hospital is an environment historically characterized as being focused on the treatment and cure of diseases/pathologies, a conception rooted in the social consciousness, which contributes to the characterization of the technical/procedural aspects present in care as a right, constituting an element of the social representations of citizenship in the hospital context. Consequently, specific responses addressing the peculiarities of diseases support hospital care, which is marked by specialized knowledge of health professionals⁽¹⁶⁾.

Hospitals, therefore, are expected to be equipped to handle acute events and provide efficient care that is therapeutic,

proposes treatment options and supplies an adequate environment for patients and better working conditions for professionals, as well as other management and care issues, with the intent to make it more efficient⁽¹⁷⁾. Thus, the end goal of hospital services is to meet the clinical needs of patients, as well as subjective and social needs, taking into consideration the health professionals operating within this service context.

The results analysis also shows the difficulty patients face in accessing health services and exercising their right to receive the care they need. This difficulty of access to hospital services has a direct impact on the social dimension, creates dissatisfaction and increased social and political pressure for changes in the approach to these services⁽¹⁷⁾.

Health care is characterized as necessary for living in dignity. Dignifying the lives of individuals means protecting the elements that constitute the right to health⁽¹⁸⁾. To this end, the National Humanization Policy represents a way to implement it, as opposed to being just an abstract policy, but rather a concrete prerogative, both in health management and care⁽¹³⁾. Thus, the legitimization of social rights requires ensuring dignified living conditions for members of society. However, this legitimization is not enough put these rights into effect, but efforts must be made to protect them⁽¹⁹⁾.

The subjective and relational dimension constitutes elements that are part of the social representation of citizenship by hospital patients. This dimension restores the individual to a place of prominence. The relational dimension qualifies care because it gives value to the interaction between professionals and patients⁽²⁰⁾.

In Brazil, the relationship established between patients, their social and family networks and the hospital often unfolds with little participation in the care process and access to information, and where the care is impersonal and fragmented⁽¹⁷⁾. This approach to hospital care can be offset through the application of principles of cross-cutting care, inseparability between health production and production of individuals, leadership, co-responsibility and autonomy of individuals⁽¹⁾.

To ensure the rights of patients, a commitment must be made toward those who are ill according to their particularities and needs, demonstrating responsibility and ethical commitment by seeking the autonomy of patients, listening, creating ties and warm bonds, information, dialogue and respect for differences⁽²¹⁻²²⁾. Whether patients consider the work of professionals and the health services provided as being acceptable depends on their subjective valuations, combined with the adaptation of the care to their wishes, expectations and values⁽¹²⁾.

The position taken by an individual or member of a group in relation to the social context in which he or she is inserted, combined with the social values involved, configures the attitude that expresses the subjective and affective aspect of the social representations shared in groups⁽⁴⁾. In this regard, the verbalization of their dissatisfaction about the absence of characteristics associated with being treated well in the production of meaning about care, linked to issues that are important to citizenship, illustrates the value that patients assign to this dimension of care.

Values exist in the social world and are characterized in relation to man, as a social being. Therefore, values exist "by man and for man"⁽²³⁾. The value attributed by patients to the

subjective-relational nature of care was established in the relationship between this dimension and inpatients as social beings.

The figure/image of professionals who respect rights less, associated with behavioral characteristics such as brusque and impatient interaction, corresponds to figurative elements of the social representations of citizenship by these inpatients in this care experience. In the representations, ideas are linked to images⁽²⁴⁾ and characterizations use metaphors (“stuck up”, as F2 said) and explanations serve to give solidity to the construction of knowledge about the object, illustrating the formation processes of social representations⁽⁸⁾.

Some mute zone characteristics of the social representations were identified in the ECUs, when individuals verbalize their representations of a phenomenon and attribute it to others and not to themselves, because of the normative pressure to which they are subjected⁽²⁵⁾, which is to be expected since the subjects from this study spoke of their hospitalization experiences at the same time as they were being hospitalized. This partly explains the meanings produced in relation to it, with positive elements, of good treatment, but not in terms of what they saw happen to others who, in theory, are they themselves in the projection of the group, which generates sustainability in the discussions on contents that are part of the social representations being addressed here.

As far as health care, the inclusion of individuals and their social and family networks in the care process is necessary, based on values of respect for subjectivity and protection of the rights of patients, wherein inclusion is a right of citizenship. Inserting the individual into the hospital care process and striving for the relationship between him or her and the health professional results in the patient’s citizenship being put into effect. If the focus is only on the disease as the object of care, then according the approach of current hospital care in most institutions, the patient’s citizenship will only continue to be standardized, but not concretely implemented. The challenge is to “restore comprehensive care for individuals”⁽¹⁷⁾. The relationships between professionals, patients and their families need to be strengthened, extending beyond the authoritarian/paternalistic dimension of the relationships, expanding the autonomy of patients in their therapeutic process^(5,26). On this particular point, an excellent study was conducted about patient participation in nursing care in Iran, where care agents worked together in an interactive process established between nurses, patients and family⁽²⁷⁾.

It should be emphasized, however, that the citizenship of patients is not achieved simply by changing the care approach;

for this to happen, a change is also needed in management since both are inextricably linked to each other.

FINAL CONSIDERATIONS

The citizenship of inpatients is reflected in their right to receive quality nursing care. This assertion is based on the fact that the study participants associated the idea of citizenship with the care they experienced. The qualification of care through the combination of the relational aspect with the technical shows that the individual, as a patient, needs to receive specialized technical and professional treatment, and as a human being deserves respect and to be treated well. This technical and expressive (subjective/relational) association in health care embodies the civic responsibility of nursing professionals. Partial nursing care, in the absence of one of these aspects, does not characterize respect for the rights of citizenship of the patients involved in the care, as noted in their social representations.

The contents that support the social representations of citizenship by inpatients lie in their knowledge and recognition of the right to be well cared for, although, within the limits of this study, they still experience difficulties exercising their citizenship, manifesting evidence of this through complaints and talking. Discussing the exercise of citizenship by patients in hospitals is relevant for health policies, since the National Humanization Policy advocates that inpatients should be autonomous and participate in their health/disease process and in the managerial issues of health services. This relevance is made explicit in national health conferences, public policies and laws wherein the citizenship of health system users is important.

In view of this, a steady eye needs to be kept on the hospital sector, addressing issues related to the protection of citizenship and the right of patients which, in turn, entails ensuring adequate conditions of supply — infrastructure and human and material resources — so that professional care occurs with the necessary quality, so aptly characterized by patients that the right to health entails ensuring the right to quality care.

The limitations of this study are related to the restricted field, since only one university hospital was used. Expanding the number of fields and patients would provide more input for delving deeper into the issues addressed, due to the possibility of obtaining stratification of social groups, in gender and age range, consolidating the assertions about the social representations of citizenship in hospital care.

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