THE HEALTH-ILLNESS CARE PROCESS AND THE LOGIC OF THE NURSE'S WORK IN THE ICU[1]

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The present study aims to learn the health production logic in the ICU based on the discourse defended by nurses and on the professional practice that is recognized by the relatives accompanying the hospitalized patients. This is a qualitative and dialectic investigation performed with seven nurses and five relatives in an ICU for adults of a teaching hospital in Santa Catarina. The theoretical-philosophical referential was based on Marxist and Gramscians readings. The results show that the logic of the health production in the ICU is inserted in a dialectic rhythm of autonomy, dependence and co-responsibility for the care. We understand that this reality can demonstrate the need to rethink the knowledge and practices to promote the constant re-formularization and transformation of the assistant context of intensive care.

DESCRIPTORS: nursing; empathy; health-disease process; work

EL PROCESO DE SALUD-ENFERMEDAD-CUIDADO Y LA LÓGICA EN EL TRABAJO DEL ENFERMERO EN UCI

Este estudio pretende conocer la lógica de producción en salud en la UCI basado en lo que es expresado - defendido por el enfermero dentro de su práctica profesional, la cual es reconocida por los familiares que acompañan a los pacientes internados. Se trata de una investigación cualitativa con orientación dialéctica, realizada con 7 enfermeros y 5 familiares de una UCI de adultos dentro de un hospital universitario de Santa Catarina. El referencial teórico-filosófico escogido se basó en lecturas marxistas y gramscianas. Los resultados demuestran que la lógica de producción en salud en UCI se encuentra incluida dentro de una red compleja, la cual se da dentro de un ritmo dialéctico basado en autonomía, dependencia y co-responsabilidad para con el cuidado. Comprendemos que la realidad refleja la necesidad de repensar sobre el saber y las prácticas profesionales promoviendo la constante reformulación y transformación de los cuidados intensivos dentro del contexto asistencial.

DESCRIPTORES: enfermería; empatía; proceso salud-enfermedad; trabajo

O PROCESSO SAÚDE-DOENÇA-CUIDADO E A LÓGICA DO TRABALHO DO ENFERMEIRO NA UTI

O presente estudo pretende conhecer a lógica da produção de saúde na UTI com base no discurso defendido pelo enfermeiro e na prática profissional que efetivamente é reconhecida pelos familiares acompanhantes dos pacientes internados. Trata-se de uma pesquisa qualitativa, de orientação dialética, realizada com 7 enfermeiros e 5 familiares em uma UTI de adultos de um hospital universitário de Santa Catarina. O referencial teórico-filosófico baseou-se em leituras marxistas e gramscianas. Os resultados mostram que a lógica da produção de saúde na UTI está inserida em uma complexa teia que se move em um ritmo dialético de autonomia, dependência e co-responsabilização para o cuidado. Entendemos que essa realidade possa demonstrar a necessidade de repensar saberes e práticas profissionais para promover a constante reformulação e transformação do contexto assistencial de cuidados intensivos.

DESCRITORES: enfermagem; empatia; processo saúde-doença; trabalho

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INTRODUCTION

Throughout history, the health-disease process has offered a series of intriguing inquiries that make us rethink our discourse and professional practice. Whenever we look at health promotion, we also think of disease. These are interdependent concepts which tend to generate approximations and distances in health professionals' work at a dialectic rhythm.

The health/disease situations have been gradually constructed and reconstructed according to society's interests in each age. Political-economic changes, the reorientation of work goals, the division of social classes and the growing proliferation of epidemic diseases were factors that reformulated the concepts about health and disease conditions and also reoriented intervention forms[1-2].

Nursing has accompanied the historical-structural evolution of health-disease in the world, including before its professionalization in the 19th century, and took a more humanistic vanguard position. It received considerable contributions from related human science areas, such as philosophy, anthropology, psychology and sociology. Nursing followed this formation line, also as a way of turning its care actions independent from technical medical knowledge[3].

In this sense, thinking about health-disease-care concepts nowadays means understanding that strategies to guarantee health conditions are a complex process that mixes the realities of the social context, the team's and the patient's needs, among others. Thus, they are, above all, a set of discourses, practices, philosophies, work organization and people with needs and particularities.

This study aims to get to know the logic of health production at the ICU, based on the discourse the nurse defends and on the professional practice that is actually acknowledged by accompanying family members. It is based on the thesis that nursing care can reveal a contradictory nature, which is reflected in certain moments of the care context, as well as in nurses' discourse and professional practice. We think that the reality we present can allow for reflection on and constant transformation of the intensive care setting.

METHODOLOGICAL TRAJECTORY

This qualitative and dialectic research was carried out at the intensive care unit – ICU of the University Hospital at Santa Catarina Federal University. Together with the project, a document was sent to the institutional Research Ethics Committee, which gave a favorable opinion.

Data were collected through participant observation and semistructured interviews. For this paper, we chose fragments of the semistructured interviews held with nurses and accompanying family members we selected.

In total, 08 (eight) nurses work at the ICU, 07 (seven) of whom participated in this study, according to previously defined criteria, such as the type of employment contract with the hospital, service time at the unit and willingness to participate in the study.

Accompanying relatives were selected during field observations in the data collection phase. On the whole, we interviewed 05 (five) relatives, in accordance with criteria of physical or affective proximity with the patient, willingness to participate in the research, communicative conditions and understanding to collaborate in the study.

For data analysis, we constructed a specific script for nurses and another for accompanying relatives. To analyze these data, we read and reread the interview texts, until reaching the categories that best indicated what the informants were saying. In the next phase, when we were already starting to make inferences and interpretations, we constructed two discussion axes. In this paper, we address the issue about the logic of health and care production at the ICU.

The research subjects received guarantees of anonymity and respect for any decision to cease participation, in accordance with the Free and Informed Consent Term, Resolution 196/96 by the Brazilian Health Ministry and the Ethics Code of Nursing Professionals. Nurses were identified with the letter "E" followed by their order in the interview (E_2 for example). Family members were identified with the letter "F".

Theoretical-Philosophical Framework

We believe that the construction of nursing as a social practice goes beyond the relations between subjects, to the promotion of integral, relational, intersubjective care. We observe this construction as a set of complex characteristics, including subjectivities, politics, history and social life. In this

sense, we use some contributions by Karl Marx and Antonio Gramsci, about the material conditions of existence and about work, to support discussions about health-disease-care knowledge and practices and the health production logic transmitted at the ICU.

History covers a series of generations, each of which explores the material goods, capitals and productive forces from the preceding generations and the nature all of this is situated in. This succession of discourses and practices is transmitted at a dialectic rhythm: to the extent that they are radically transformed, in their succession, they modify the former circumstances and make them radically different[4].

If we looked at man as a historical product, we could say that history is also a production of man, both in a dialectic process of acknowledgement and transformation. Man is a being in process, more exactly the process of his own desires and attitudes[5]. In this sense, we consider that man, in dominating nature, constructing his social life, produces himself, revisits his existence, his conscience and becomes more human. The relations man establishes with production means construct matter and human relations, which are the base for the movement of life and the collective. Work constitutes the basic principle through which man produces/and reproduces his history, turning himself a co-participant in the world and the relations that permeate it: "In sum, man should be conceived as a series of active relations (a process), in which, if individuality is of paramount importance, it is however not the only element to be taken into account... Moreover, these relations are not mechanical. They are active and conscious, that is, they correspond to the greater or lesser extent to which individual men understand them. Hence, we may say that each man transforms and modifies an entire set of relations in which he is the central point"[5].

We observe that the health-disease-care process, which permits theoretical-practical knowledge about the logic of health production at the ICU, could become a tool for the production of life inside the constituted social relations. Work, in this sense, corresponds to the basic and fundamental condition of all human life. It is capable of modifying both nature and itself before nature[6]. Hence, the discourse and professional practice developed in the intensive care setting are part of a reality filled with contradictions, influencing them and being, in the same way, influenced by them.

RESULTS AND DISCUSSION

We consider that nursing work contemplates the conditions of people, the work environment itself, their duties and needs at a given moment in time. We believe that, in assuming these characteristics, professional work joins them in the sphere of social effort, represented by the production of individuals' subjectivities in the conditions offered by the objective context. The production of material life rests in the production of the means that make it possible to attend to the individual's needs related to the conditions offered by nature: "The production of life... emerges as a double relation: on the one hand as a natural relation and, on the other, as a social relation – social in the sense of a joint action by different individuals, no matter its conditions, way or goal[4].

We observe that, with respect to health production at the ICU, nursing knowledge and social practice permeate its constitution itself, based on its formation as a group of people, who interrelate in order to implement and manage the occupational care promotion activities. Nurses believe, in their discourse, that this care promotion occurs within the establishment of a multiprofessional team at the ICU. The reports below demonstrate this observation:

I think that teamwork, I think that is different from group work, because it is more cohesive, a more common goal, the group interrelates better, I think it's a great facility [...] I had the opportunity to get to know all work shifts, knowing each employee, difficulties, all realities. I think that not all of them have the same characteristic, right? Some of them work in group and others in a team. I think that teamwork means one helping the other, you know? So, as we don't work with integral care, it's very divided, everyone has to help. (E_3)

... the medical team too, it's easy to work with most of them, a good relation, we face difficulties with only few, but we interact well with a large majority, I think there exists quite a lot of confidence. The leaders, the heads consult nursing a lot [...] they don't feel like they are the star that much. (E_4)

The transformations in modern society have influenced health because the latter is part of the former, in terms of its study object – the health-disease-care process – and using theoretical-practical tools that allow for the organization of work processes and services. The health sector needs to correspond to multiple demands, which lack a differentiated look in order to provide a healthier living condition. Within an integral care perspective, an interdisciplinary dialogue is important, seeking to understand the

relations among these subjects and between these subjects and the environment they live in[7].

The ICU is a closed environment with a reduced number of beds, which attends to a part of the population that needs intensive health care. The ICU represents a limiting physical space, surrounded by the gravity of the cases and requiring constant and continuous care. Thus, the multiprofessional team is limited to daily relations. This demands a policy of good interpersonal relations within the team, in order to promote a calm joint life and the promotion of better health care[8].

Accompanying family members and patients receiving care seem to perceive that the movement of people at the unit is part of the strategy not to particularize care in terms of specialization areas. A large majority refers to the diversity of professionals who are part of the health team, which interacts so as to promote the best possible care in the care context. The statement below summarizes this reality:

... it attracted my attention that there is a very great diversity in there: there are technicians, there are aids, there are nurses, there are physicians, there are physiotherapists, there were people from psychology asking if we needed accompaniment, something, that they could help with. I think they try different kinds of approaches, not just the person's physical part... (F_1)

We observe in F_1's statement that the constitution of a health team at the ICU is an interventionist strategy that does not just focus on medical knowledge, but aims to deliver care to the other in order to promote the complementariness of health actions. According to F_1, the multifocal view of ICU care does not seem to reproduce a reductionist practice that is frequent at intensive care units and dissociates body, mind and social relations. The objective is to consider the being as a whole, ranging from his/her biological constitution to his/her subjectivities, suffering, expectations and, mainly, interpersonal bonds.

The multiprofessional aspect of care is part of the appropriation process of the work object, centered in distinct practices, although with a common objective in the integral care sphere of health services. Multiprofessional practices are appointed as a privileged strategy to improve care and the quality of care delivery. However, practices centered in multiprofessional activity also have a limiting component when they refer to the reproduction itself and to the organization of health services, besides care actions focused on biomedical and fragmentary care[9].

Work organization in Brazil is considered to be directly related to the social transformations implicit and explicit in the production context. The Fordist-Taylorist* productivity inheritance includes, until today, a structural component that is manifested in the control of production modes and the labor force, reflected in the presence/absence of routine activities and of precarious work conditions. In this sense, "efficiency" and "control" concepts would be the rules that influence production, when it starts to focus on the repetition of tasks instead of the introduction of discussions that would create actual organizational changes in the production context[10].

Taylorism and Fordism created a production process logic centered in partial activity, that is, fragmented in terms of the existence of concentrated and verticalized poles. Fordism also contributed to a separation among management, conception, control and execution, constructing a culture and a specific way of life, which is adjusted to the reproduction of work and the rationality of production. With respect to health production, it is considered that this reality still permeates professionals' daily work, who should understand it as a complexity, in which the formation and social/technical division could not be ignored, nor could activities be resumed to their parts and fragments[11]. Nurses believe that the relations established among teams, the institutions and the ICU environment are important in the continuous search for work "efficiency" by guaranteeing staff to perform functions satisfactorily. This also presupposes their commitment to reality, and that reality will allow them to make decisions autonomously:

As the head, I always try to maintain a satisfactory quantity of material and staff at the unit, previewing the coverage of shifts, statements, good materials, because the UH works with good materials [...] As a care professionals, one promotes quality by calling upon the staff to really work, maintaining a good relation with them, because the ICU is a closed unit and conflicts have to be solved [...] otherwise it turns into a snowball. (E_3)

... No restriction whatsoever is put up against your work, neither medical nor from the nursing head, from nobody. I feel very free, that is very good, I have an enormous autonomy... you do not depend on anybody. The assessment is yours, you're the one who decides, if you have to apply a dressing or not. You're

* The Taylorist-Fordist inheritance represents a production standard in the capitalist age which was developed in the past century and focused on mass production, on concentrated and verticalized production, besides the control of time and movements in the execution of activities(10)

going to do things in accordance with the pre-established routine, but you decide outside that. (E_7)

Nurses' autonomy to decide on what care should be implemented exerts an important influence on the flow and management of ICU activities. The relations established among professionals at this sector and the greater flexibility of nursing prescription activities seem to improve potential conditions to promote/recover people's health. Nurses are also responsible for maintaining the team's interest focused on cooperative activity, in the attempt to make them co-responsible for care efficacy.

However, this is not always true, mainly when what is at stake are the relations among people and institutional policy as a whole, besides the (lack of) interest that may be implicit or explicit in professionals' attitudes. In some cases, some professionals interact well with their colleagues, helping them with patient activities. In others, this does not occur, and is perceived by some accompanying relatives:

I think that they really aren't very integrated, there are kind of "small groups", you know, and some people make more efforts. We see that some people are always moving around with the patients, always doing something, and others aren't, they keep on calling to get a coffee [...]I don't know if that is so because I only stay for one hour, I don't know if it's because of their schedule, but I think that some of them interact more and are more dedicated [...] We know that this causes stress, that if one wants to leave a bit, go for a walk, that this is considered negatively. Why do that exactly during visiting hours? It is when the relative is in doubt, they want to know if the patient is being treated well, it is seen negatively. I think that they do not neglect, but it is seen negatively, it seems like public service stuff. (F_5)

Hospital workers are hired by launching a call for candidates to fill in places. Exam calls tend to be released every two years, involving tests about specific and practical knowledge. After passing the tests and being hired, their public service contract is ruled by the Unified Legal Regime of Federal Public Servants (RJU – Law 8112/1990). The RJU has been constantly modified through the issuing of Provisional Executive Decrees (MP). MP 1595-14/1997 led to one of the most significant changes, related to the nomination and constitution of public exams. Through this system, the employee starts to accumulate personal advantages, as well as differentiated duties in the work environment.

The RJU admits the employee as a public servant, guaranteeing employment stability, which is rare in the private sector, after this same servant's approval on a training assessment (normally after two years). After that phase, (s)he returns to the original function (s)he was hired for, maintaining the job and salary for life. According to the RJU, public servants with a stable contract can only lose their job through a final legal sentence or a disciplinary administrative process, during which their right to a full defense is guaranteed[12].

This fact in particular concentrates one of the main nursing complaints, with direct consequences for the logic of health/care production at the ICU. The RJU is clear about penalties, but they are not always applied and, when they are, they are very bureaucratic, and it takes years before they are actually recognized:

In terms of the team, of course we have absences, statements, in general, and these absences are directly related to care quality and to the quality of clients' satisfaction. Because, as soon as someone's absent, the rest of the team has to get organized differently and work more, mainly when this absence is a justification that is not plausible in the staff's opinion, so then the level of dissatisfaction increases. And then there's gossip, discussions, intrigues. (E_6)

... public service difficulties, for example, when the employee is absent, there is no adequate punishment for that, it's not effective. I face difficulties to adapt to the hospital, you know? Damn, the guy doesn't show up for work and invents an apology. That happens frequently here and I get quite upset, because it impairs care. That's complicated, Leandro, the worker is absent, he's absent, his absence is deducted, but follow-up does not always occur, there is a way during the training period, but once he's stable there is no way of following up. (E_4)

... the difficulties we face here are labor problems. The greatest difficulty we see is the staff's dissatisfaction, related to wages, we've passed a long time without a raise, you know? It's bad when you manage a dissatisfied person. (E_7)

The public sector has a long tradition of administrative reforms, which are generally initiated at the beginning of a new public management mandate as a possibility to adapt the public apparatus to government plans. These reforms seem to mark a process of successive remodeling of the State and were implemented in the Vargas age, in the 1930's. They even continued under the military dictatorship, in order to realign administrative structures to exercise power in a centralized way that organizes society's interests. Besides the administrative apparatus, such as the Department of Public Service Administration and career plans, important structures were created

to make possible social policies in the fields of social insurance, work, economy, taxes, among others[13].

From the international economic crisis in the 1970's onwards, attempts were made to restructure the economy, making it globally disseminated and inserting it into the globalization process. The latter, in turn, produced effects during that period in order to stimulate competition among markets, in an increasing capital accumulation period. In that phase, beyond facing conjunctural difficulties, Brazil had to deal with the bonds of urbanization and industrialization, besides trying to undo the growing fragility of its economy through global crises. However, the country, with its growing deficit, ended up being incapable of making the investments needed for its growth, both in terms of the definition of public policies and the functioning of the administrative apparatus, becoming a refugee of international funding bodies for this sake[14].

During the 1990's, the restructuring process of the public apparatus was expanded to insert the country into the external market, as a new form of redirecting the public spheres and adapt them to the international tendencies of a new political economy. This entire reality was accompanied, in practice, by a profound privatization process, in combination with the greater flexibility of work relations, which was not always practiced with good sense. The financial-administrative autonomy management achieved could put an end to the stability granted by the RJU, making possible hiring and resignations for the benefit of greater efficiency. But it was during the Collor government that disbelief in public service reached its height, which neutralized the professionals themselves in the search for their rights and devalued their demands for better wages and labor conditions[13].

With respect to the hospital and health policies, the hospital is affiliated with the Single Health System - SUS and employees experience precarious work conditions on a daily basis, besides labor issues, which are very bureaucratic and do not always correspond to the agility that seems to prevail in the private care sector. Although they work in a care reality in which all possible measures are taken to avoid lack of supplies and not to impair the quality of intensive care, nursing care management difficulties seem to be closely linked with public policies to bureaucratize the public service, as well as with social policies that do not always pay attention to the employees' concerns.

The theoretical framework for the restructuring process of the State and its implications for health was the constitution of the Single Health System. Disseminated through the 1988 Constitution, the SUS has gone through constant reforms in terms of service funding and management decentralization. The ideology that attempted to integrate the State and civil society in the conquest of a control exercised through the mobilization of all would not be a source of fight against inequalities, as budget restrictions for public intervention and service offering destined a part of funds to policies directed at the poorest social segments, such as the Community Health Agent program and the Family Health Program[15].

Public service activity is essential for the functioning of the State and for the redefinition of public policies, for any goal. Within the reality of health promotion in care services, we consider that nursing praxis is inserted in a complex social locus, mediated by the state structure, by work conditions, by economic policy and even by the power relations established among the professionals themselves. However, the possible "discouragement" of ICU professionals seems to be closely related with the origins of the federal public service and its constant discrediting by subsequent governments.

Moreover, we believe that this context of "discredit" in public servants' work is accompanied *pari passu* by increasing unhealthy work conditions, revealed in insufficient administrative investments, as well as in wage readjustment policies that often give little attention to workers' interests, besides instabilities in the Brazilian economic policy that interfere in these interests. In the work context of the hospital ICU, one example of this concerning reality is the fight to adopt the 30-hour work journey, as shown below:

... I have required the 30 hours because, actually, although not officially, other areas do it inside the ICU and we who fight for the 30 hours do not manage to. I really require it, also because other areas with lesser demands, such as nursing in a hospital institution, work 30 hours [...] I think management is ill-willed and the current management is extremely rigid in this sense. Because there already exists a decree, provided that we manage to get organized. That's life, that's politics, while we see other employees working even less, who are sometimes not so directly involved with the patient [...] that injustice bothers me a lot. (E_3)

The State is be the apparatus that controls man's production modes, besides consisting of a legal-

ethical-economic apparatus that is manifested in material life, in interpersonal relations, in politics and in the economy. It would also inhibit manifestations through social coercion mechanisms. However, man, no matter how suffocated by the regulatory conditions promoted by the State, should never give up fighting. He should always relativize his world, his history, seeking his life philosophy in it, with a view to finding his individuality, his ethical-moral conscience and his conception of the world[5].

We consider that, no matter how much we think about a discredited civil service, which is also discouraged by the federal government's constant impositions on the investment policy, and about a career plan that has not considered the professional's valuation, there seems to exist, in E_3's discourse, a mobilizing feeling that is translated in the constant search for his rights and advantages. E_3's discourse seems to be a tendency whose ideology goes against the conformist policy which nursing, throughout its history, has learned to live with – and to accept, definitely fighting little for the transformation of reality. This feeling of struggle by E_3 is important as a mechanism to cope with the inertia and as an alternative to recover a new hegemonic relation, within a political practice of involvement with the dignity of the value of work in the public sphere.

In this sense, the multiprofessional team, which can be a way of emancipating its constituent subjects and an instrument to revitalize the work process, needs to adopt a frontline that is capable of recognizing the course to construct health and care practices. Even if the intent to constitute an environment positively affects the sphere of the care objective, it is not enough just to think about ICU activities as totalizing health actions. It is important to continuously and collectively mobilize all professionals, considering that the health-disease-care process, as we could perceive, also involves politics, institutional organization and relations among different professions. The transformation of care goes through an intriguing dialectics, which is often intermediated by a tortuous course, but this transformation should be a source of permanent struggle, highlighting the right to a dignified life, to adequate work conditions, to political rights, as well as to the value of the human being, as a caregiver and as a being that receives care, in this complexity.

FINAL CONSIDERATIONS

It could be perceived that the work and logic of health production at the ICU are mixed up in a complex network that involves human, professional, institutional and political relations, which directly or indirectly influence the care the health team delivers to patients and accompanying family members who experience the health-disease process at the ICU.

We consider that the relations established between workers and organizational institutions seem to influence, to a greater or lesser extent, the quality of care delivery, as well as the professionals' knowledge about health and illness at the ICU. We believe that unveiling this reality is interesting to promote constant reflection and transformation of the intensive care context by the health team and accompanying family members.

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