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CARELESSNESS IN HEALTH AND IN NURSING

DESCUIDADO EM SAÚDE E EM ENFERMAGEM

DESCUIDO EN LA ATENCIÓN A LA SALUD Y ENFERMERÍA

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Objective: reflect on the meaning and the consequences of carelessness in health care and in nursing. Method: reflective study. Results: the carelessness is a product of the biomedical care model, which privileges the body as an object of work, fragments the work process in health, requires service provision on a large scale with cost containment and does not guarantee access to universal, comprehensive and egalitarian care. The user suffers because the right to life is not guaranteed, due to the destitution of one's identity and the deprival from satisfaction in the interaction with health workers. Consequences for the nursing workers include linking professional identity to an ideology, loss of meaning and invisibility of the work and mental suffering. Conclusion: the reconstruction of the practices in nursing and health, from the perspective fighting the neglect, presupposes the assumption of care as the core of education and practice in this field, besides investments in the funding of SUS, so that its project can achieve the expected practical success potential.

Descriptors: Nursing. Care. Health Care.

Objetivo: refletir sobre o significado e as consequências do descuidado na atenção à saúde e em enfermagem. Método: estudo de reflexão. Resultados: o descuidado é produto do modelo assistencial biomédico, que privilegia o corpo como objeto de trabalho, fragmenta o processo de trabalho em saúde, exige prestação de serviços em larga escala com contenção de custos e não garante acesso ao atendimento universal, integral e igualitário. O usuário sofre por não ter assegurado o direito à vida, pela destituição da identidade e privação da satisfação na interação com trabalhadores em saúde. Consequências às trabalhadoras da enfermagem incluem identidade profissional ideologizada, perda do sentido e invisibilidade do trabalho e sofrimento psíquico. Conclusão: a reconstrução das práticas em enfermagem e na saúde, na perspectiva de combater o descuidado, pressupõe assumir o cuidado como cerne da formação e da prática nesse campo, além de investimentos no financiamento do SUS, para que seu projeto tenha o sucesso prático possível e esperado.

Descritores: Enfermagem. Cuidado. Atenção à Saúde.

Objetivo: reflexionar sobre el significado y las consecuencias del descuido en la atención a la salud y enfermería. Método: estudio de reflexión. Resultados: la desatención es producto del modelo asistencial biomédico, que privilegia el cuerpo como objeto de trabajo, fragmenta el proceso de trabajo en salud, exige prestación de servicios a gran escala con contención de costos y no garantiza acceso a la atención universal, integral e igualitaria. El usuario sufre por no haber asegurado el derecho a la vida, por la destitución de la identidad y privación de la satisfacción en la interacción con trabajadores en salud. Consecuencias a las trabajadoras de la enfermería incluyen identidad profesional ideologizada, pérdida del sentido e invisibilidad del trabajo y sufrimiento psíquico. Conclusión: la

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reconstrucción de las prácticas en enfermería y en la salud, en la perspectiva de combatir el descuidado, presupone asumir la atención como núcleo de la formación y de la práctica en ese campo, además de inversiones en el financiamiento del Sistema Único de Salud, para que su proyecto tenga el éxito práctico posible y esperado.

Descriptores: Enfermería. Cuidado. Atención a la Salud.

Introduction

Professional health care consists of "[...] health care immediately interested in the existential sense of the experience of physical or mental illness and therefore also of health promotion, protection or recovery practices"[1:4]. Therefore, care is not reducible to technical reasons and actions. Professional care consists of "[...] humanized conformation of the care that aims at the extension and flexible regulation of the technosciences of health in the therapeutic application"[1:22]. Thus, care is related to the intersubjective interaction between human beings, permitting an authentic encounter between who provides care and who receives care, transcending the physical and material world. Professional care should put the excellence of technologies at the disposal of the subject's need and will with a view to ensuring life with dignity.

In the act of caring, the therapeutic encounter between the health professional and the user should allow the instrumental sense of the techniques (technical success) to be at the service of the projects elaborated in common agreement with those who seek health care (their project of happiness). It is only in this sense that this therapeutic encounter will result in practical success[1]. In care, what matters is to permeate the technical rationality of care with the non-technical aspects that give practical meaning to its application. The possibility of articulating the practical and technical success produced in a therapeutic encounter takes place in the dialogical dimension, that is to say, by the opening of an authentic interest in hearing the person whom we wish to target with our good professional practices, and by whom wish to be heard[1]. Thus, professional care is the result of the professionals' practical wisdom, amalgamated in health care, whose challenge is to "[...] match every idea of practical success with an infinite search for technical control"[2:69].

The perspective of care taken in this reflection is a challenge to be achieved in the scenarios of health practices, given that the biomedical care model is based on a political, functional and economic rationality that does not permit universal access to the Unified Health System (SUS), but requires large-scale service provision with cost containment. This imposes the fragmented organization of the work process, as it is carried out by different health workers, including nursing professionals. This model also makes bonding between professionals and users difficult or impossible and interferes in the quality of actions and services provided. Therefore, in the daily reality of health services, carelessness is significantly the product of this model. This, in turn, is a product of the military order that reoriented the hospital organization in capitalism, and also of scientific and technological development at the service of this economic production mode, whose primary purpose is the recovery of the body as workforce. In this sense, it is necessary to put the hegemonic care model at stake again, reflecting on its implications in the expression of carelessness in health.

In view of the above, in this study, we aim to reflect on the meaning and consequences of carelessness in health care and in nursing.

Method

This theoretical reflective study is based on the literature consulted and on the authors' experience. We assume a theoretical conception of health/nursing care and reflect on the challenge of being reached in health care settings, due to the hegemonic care model, which can produce carelessness. We present the expression of carelessness in health care and nursing and we deduce its possible consequences for the nursing workers, the health service users and the Unified Health System itself.

The article presents the two elements of this reflection: Expression of carelessness in health care and nursing; Consequences of carelessness in health care and nursing.

Results and Discussion

In the following sections, carelessness in health care and nursing is discussed from two perspectives: as a product of the hegemonic biomedical model and its consequences for nursing workers, health service users/patients and the Unified Health System itself.

Expression of carelessness in health care and nursing: product of the hegemonic biomedical model

In the biomedical model, the ill body is the object of work in health and nursing. Thus, the human being attended is apprehended in a pathophysiological perspective, understood as a measurable body, an archetype of normal values, a set of apparatuses, a body separated from the psyche, emotion, knowledge, and history[3]. Hence, the use of work instruments prevails which meet the technical, rational, scientific and regulatory standard, measured based on the outcomes produced. Therefore, the health intervention is one-dimensional, imposing, and limited, constituting the opposite of care, which includes, but is not restricted to technical skills and tasks. It is clear that the merits of technical and scientific rationality for care should not be neglected, but its exclusivity as a regulatory criterion to achieve successful health practices should be reviewed[2].

Another element that reveals carelessness as a product of the biomedical model is the fragmentation of the work process in health and nursing. This fragmentation distances the worker from the care and reinforces the procedural intervention in the machine body, increasing the specialization and making the articulation of health work more difficult, whose nature is collective. In the health services, overall, work is developed in teams instead of groups, in which each professional has his specific technical knowledge as a necessary and sufficient tool to assist the body and its pathologies. The user is the receiver of the technical actions and the family member, when considered by the professionals, acts as a mediator and/or informant of the patient's physiopathological deviations[4] or as a subject capable of containing the actions that are considered undesirable and are practiced by the same professionals.

Another argument to show that carelessness is the product of the hegemonic care model is that the management of the biomedical model in the organization of the health and nursing work process distances the workers from care and brings them closer, in education and in practice, to the execution of fragmented technical procedures. We emphasize that the institutionalization of health practices in the capitalist production mode inserted the physician in the modern hospital with the function of curing, based on the dual professional-patient relationship. The nurse is inserted in this organizational context as the professional responsible for the organization and discipline in the provision of health services, aiming to monitor the patient's recovery and ensure the continuity of the therapy the physician prescribes[5].

In the early days of the nurse's work, both the actions of the lady nurse and the nurse are directed at a sick body, and their practice is characterized as a subsidiary of medical know-how, centered on a care routine. The nurse's activities are founded on the control of the environment,

lighting, hygiene and ventilation, control of people and times and movements – establishing work hours and rhythm – besides the control of the education process, of standards of moral conduct and professional performance[5].

Today, although nurses differ from this performance standard, because they find or create breaches that permit the rupture of the biomedical model, it is still common in the field of nursing education and practice. With the institutionalization of nursing practice, the care that used to be performed in the private sphere, as domestic work, is replaced by the care actions carried out in the public sphere, including the demands of capital, for bodies that are suitable for work. This purpose of the capital determined the organization of the hospital space, the work process and the nurse's place in health work.

With the development and increasing complexity of technical and scientific knowledge in the field of health, and the new demands of society for the hospital organization, other workers are added to the field of health. Consequently, the social and technical division of health work occurs, separating the work into actions considered as intellectual and so-called manual actions. In this division, the physician appropriated the intellectual work, which gave him a place of power over the other health workers. This, added to the advancement of diagnostic and therapeutic technologies and the increasing demand of users in health services, has led to the production of protocol-controlled procedures. This division between the intellectual and manual work also responded to the organization of the work process in the functional and economic logic, aiming for the large-scale production of medical services at a low cost.

The nurse, as the articulator and controller of the nursing work process, often develops a relationship of domination over the auxiliary nurses and nursing technicians through the social and technical division of labor, with powers that differentiate her from her subordinates. This technical division takes form in an enhanced division of health work and among the categories of workers. Nursing work can be focused on tasks and procedures (bathing, vital signs, dressings, change of position, surveys, consultations, material control, work process management, among others), distributed according to the skill and qualification of the worker, guided by the principles of scientific management, with the nurse acting as coordinator of the work process.

This process is revealed in the fragmentation of care practices, reducing the user to a passive object of the professionals' work, usually with a single professional in charge of multiple tasks directed to a large number of patients/users. In this organization model of the work process in nursing, intersubjective interactions are difficult or unfeasible and the workers and users are considered as things.

The nurses' role may be diverted from the care and management of the nursing work process, which represent fundamental attributions in the hospital setting and in basic care, to fulfil merely techno-bureaucratic functions. These do not require technical and scientific skill and interpersonal relationship and make their performance from the perspective of care more difficult. At other times, we observed that, due to the demands of the nature of nursing work and the small number of female workers, the nurse performs many functions on the same day.

Even today, there is a trend for the nurse to cover medical procedures, considering that these attributions are a form of power and professional recognition. Nurses contribute to maintaining the low value of their work and the invisibility of their profession by denying or ignoring that, by accepting this way of acting imposed by health organizations, they accentuate the technical division of health and nursing work.

In the field of nursing education and training, it is worth mentioning that there are schools, although based on national curricular guidelines and pedagogies described as active, that link or emphasize learning about the scientific, anatomical, biological and ill body. Especially in practice scenarios, teaching conveys the image and discourse of an ideal, normative body with a specific structure and mode of

operation, eliminating the desire-body, pleasure-body, aesthetic-body and so many others not authorized to show themselves and be shown[6]. Consequently, the instruments used in nursing education comply with a technical standard, while care is reduced to the humanized execution (meaning only polite, respectful, less distant or less "hard" care) of technical procedures.

Even when the development of knowledge and practices is identified in the teaching-learning process to combine technical success with practical success, the nurse entering the job market needs to adjust to the "care policy" dictated by the interests of the organizations, whether public or private, and their employers. By agreeing with this institutional policy, the nurse is also considered a thing and suffers from the impotence of her practice. The nurses who are aware of this reality also suffer because they are unable to transform the care into everyday actions.

Based on the above, the practice of the nurse may not be expressed through care, but rather through care and management procedures that, even when technically qualified and "humanized", do not always take into account the happiness project of the person/family/assisted groups. They are regulatory acts and procedures, devoid of a sensitive attitude of concern and radical responsibility for the human experience, accompanied by unique health needs and a dignified life project.

At the same time, we identified, in the process of nursing work, considering the psychological dimension, workers living with precarious, exhausting and frightening working conditions, among which we highlight: the direct impact of physical illness on the professionals; the patients' attempts to share feelings of depression, anxiety, fear and repulsion by the illness with the team; the contact with mutilated bodies, suffering and death, and the execution of tasks considered repulsive, exhausting and frightening[7]. In the field of primary health care, these professionals are exposed to social inequalities, institutional and gender violence, among other conditions. This scenario makes the nurses perform their work, approaching the control and framing of users and the nursing team in a coercive and authoritarian pattern.

The extremely anxiogenic nature of the nurses' care and management work ends up strengthening the technical division of the work as a mental defense strategy. Thus, the nurses prevent themselves from having direct contact with the patient and, consequently, with the resulting anxiety[7]. The nurses' rationalization of feelings is a form of perversion of reason. The technical division of work and its consequent mental defense mechanisms also promote the fragmentation of the nurse-patient/user relationship and of the relationship between nurses and other nursing workers, besides the depersonalization and denial of the subject's importance. As regards the patients/users, they start being treated not by their name, but by their bed number or disease or affected organ or, like in primary health care, by their social role as mother, grandmother etc.[7].

The standardization of conducts and patients may also occur. In this case, the way a user is treated is largely determined by his belonging to a patient category and minimally by his idiosyncratic desires and needs[7]. An example is hospital admission, in which users/patients are deprived of personal belongings, subject to hospital rhythms and times (hours for bathing, meals and controls) and limited access to the family due to strict visiting times, as well as to the information on the conduct of their treatment. This is not always ensured due to barriers in the regulation in the service network and limits on the offer of the treatment they want and need. When this occurs, users/patients practically become the property of the professionals and no longer have family, are no longer persons and do not longer have an identity. This can also be revealed in primary care, when the nurse's work predominates in the clinics or rooms of the health service, a traditional place of power, where standards and behaviors are sometimes dictated by the user's belonging to a category of patient (hypertensive, diabetic, with leprosy, AIDS, among others). When the nurse moves to

the territory of the community, school, home, she is exposed to the social reality with which she does not always want or is not always prepared to cope.

Another mental mechanism of defense occurs by distancing and denying feelings, using mechanisms of escape from work, means by which any possibility of continuity of an interpersonal interaction and, therefore, of care is made impossible.

The carelessness is also expressed by power relations evidenced in the ritual of the users/patients and their families' adjustment to the institutional standards and routines, considered as inviolable and incontestable, applied without discernment. This carelessness, which perpetuates the traditional relations of power, reveals itself: in the use of scientific language, which users are often unable to decode, representing a social filter capable of manipulating their will; in the absence of professionals' availability to listen; in the denial or postponement of the fulfillment of their requests; in the absence of agreement with the expectations, limits and possibilities of the therapeutic proposal[8-9].

The reflection still needs to return to the carelessness resulting from the conception of care dictated by the policies and the organization model of the health services. This carelessness is characterized by what we have previously called a political, functional and economic rationality, which requires the provision of large-scale and high-speed services with cost containment and which does not guarantee individuals access to universal, integral and egalitarian care[9]. Or, as is common in the SUS, by the lack of implementation of policies or by political choices in operating an excluding health service system.

At present, medical-scientific rationality is increasingly differentiated and subordinated to the administrative technological order of the health services, which dictates the policies of care according to market standards, even in the SUS[9]. One example is its financing model, based on the quantitative execution of procedures or programs and projects financially induced by the Ministry of Health. In private organizations, the care is considered a commodity. Market laws determine its consumption and its access is proportional to the consumers' purchasing power.

Inserted in the neoliberal macroeconomic logic, through the optimization of resources, downsizing of the machine, increasing flexibility of work and several other measures that should result in increased revenues, the health organizations provide another version of "care". Patients/users, when they are able to enter the health system, receive limited care due to the decay and abandonment of many of these organizations. Once again, the perspective that should guide any and all health-related activity is promoted: the promotion of the comfort and well-being of the human being[9].

In health services, the carelessness can be illustrated by the impersonality of care, the hours users/patients and companions lose queuing while seeking or waiting for care; barriers between users and professionals; the despair of perceiving one's own or family members' worsening, without having access to treatment and without understanding what is going on[10]. We emphasize that most SUS users, when they access the health service, submit to the relationship of the care providers and the treatment offered, with few possibilities of choosing professionals and, as a rule, do not have the information that enables them to a health conscience capable of judging the technical capacity of the attending professionals.

Consequences of carelessness in health care and nursing

Based on the above, we can derive the consequences of the carelessness for the nursing workers, for the health service users/patients and for the Unified Health System.

As consequences of the carelessness for the nursing workers, which contributes for these persons to feel at a loss, without control over their lives and their working lives, we can appointed the link between professional identity and ideology, with nurses occupying a hardly

visible and devalued place[11]; loss of meaning of the work, expressed in the illness and mental suffering of the workers and the lack of identity with the profession; multiple jobs; as well as the precarious work relations and conditions neoliberal capitalism establishes.

For users/patients, the consequences seem visible in the suffering to ensure the right to life, subject to the economic logic that prevents or hinders access to the system and health services. The carelessness resulting from the current welfare scenario produces fear, anxiety, disappointment and frustration of expectations. This is due to the uncertainty, waiting time or impossibility of access to health services and the uncertainty of being assured of the technical quality and the problem-solving ability of care. The disappointment can occur if the users/patients find that the access to the system has meant little to their quality of life. The suffering, then, exists due to the destitution of their identity, the disregard of the human, expressed in the depersonalization, denial and categorization of the importance of the people in the hegemonic care model; because the professionals do not value their participation in decisions; due to the deprival of positive satisfaction in the interaction with the female and male workers; due to the lack of feeling of consideration and desire for their well-being; the distancing and denying their needs; the constant manipulation of bodies considered as "docile and cold"[12].

For the SUS, the consequence of the carelessness points to the incompatibility of the biomedical model and the political, functional and economic rationality of health services with its principles. Insufficient funding, corruption in the management of the system, the slow fight against exclusion in our society and the predominance of neoliberal policies, even in health, prevent its project from achieving the expected practical success potential.

Conclusion

We recognize that there are several challenges for the reconstruction of health practices from the perspective of fighting the carelessness. We acknowledge the need for public investments in SUS funding and for its project to achieve the expected practical success potential. Even in the capitalist economic mode of production, and with the organization of the work process governed by the biomedical model, nurses can provide care and not only technical procedures, building gaps in the daily work and escaping from the devices generated by health institutions and organizations.

We recognize the driving force of the advance of nursing knowledge, associated with the conceptualization of care in theories and research that evidence the overcoming of clinical limits as fundamental knowledge. Nevertheless, we understand that we can still advance towards the theoretical construction in the field of nursing. Therefore, we defend the construction of professional identity, granting visibility to the three professions and their differences. We can start by appropriately appointing the professions of nurse, auxiliary nurse and nursing technician that, in the Brazilian theoretical production, are commonly called nursing. By doing so, we hide who we are, what we do and how each of these professions acts and the differences between them. This attitude further distances us from the practical construction of professional nursing care.

We understand that the reconstruction of nursing and health practices, with a view to fighting the carelessness, presupposes the assumption of care as the core of education and practice in this field. Betting on the possibility of a dialogue between technoscience in health and users/families' references on the practical success of health actions; seeking to know the value these actions gain for them in daily life, due to symbolic, relational and material implications; and considering them as protagonists of their own care requires broadening the horizons of the rationality that guides the technologies and agents of the practices. It also implies knowing the place our practices can occupy in the users and families' care project.

The challenge is to understand the difference between medical science and the art of caring and healing, which means distinguishing the difference between the knowledge of things in general and the concrete application of this knowledge to the singular case. This means building, along with the person receiving care, his/her care project and, consequently, the construction of nursing knowledge, including the experience of those who work and those who use the health services.

We conclude that the reconstruction of nursing and health practices, with a view to combating carelessness, presupposes the assumption of care as the core of education and practice in this field, as well as investments in the funding of the SUS, so that its project can achieve the expected practical success potential.

Collaborations:

1. conception, design, analysis and interpretation of data: Fernanda Carneiro Mussi and Cristina Maria Meira de Melo;

2. writing of the article and relevant critical review of the intellectual content: Fernanda Carneiro Mussi and Cristina Maria Meira de Melo;

3. final approval of the version to be published: Fernanda Carneiro Mussi and Cristina Maria Meira de Melo.

References

1. Ayres JRCM. Care, (the) human being and health practices. Saúde soc. 2004;13(3):16-9.

2. Ayres JRCM. Subject, intersubjectivity and health practice. Ciênc saúde coletiva. 2001;7(1):63-72.

3. Lucena AF, Paskulin LMG, Souza MF, Gutiérrez MGR. Health care models and the building of nursing knowledge and practice. Rev Esc Enferm USP. 2006;40(2):292-8.

4. Puschel VAA, Ide CAC, Chaves EC. Clinical and psychosocial models of attention to the individual and the family in home care – conceptual frameworks. Rev Esc Enferm USP. 2006;40(2):261-8.

5. Ide CAC. A coordenação do processo de cuidar. In: Ide CAC, Domenico EBL, editoras. Ensinando e aprendendo um novo estilo de cuidar. São Paulo: Atheneu; 2001. p. 153-64.

6. Rodrigues AM. Poder e cultura nas organizações. Rev Paul Enferm. 1991;10(2):67-72.

7. Menzies IEP. A case-study in the functioning of social systems as a defence against Anxiety: a report on a study of the nursing service of a general hospital. Human Relations [Internet]. 1960 [cited 2009 July 31];13:95-121. Available from: http://hum.sagepub.comDoi:10.1177/001872676001300201

8. Mussi FC. Desconforto, modelo biomédico e enfermagem: reflexões com base na experiência de homens infartado. Acta Paul Enferm. 2003;16(3):88-96.

9. Mussi FC. Comfort and hospital practice: an analysis from the historical perspective of the concept of comfort in nursing. Acta Paul Enferm. 2005;18(1):72-81.

10. Souza ECF, Vilar RLA, Rocha NSPD, Uchoa AC, Rocha PM. Primary health care access and receptivity to users: an analysis of perceptions by users and health professionals. Cad Saúde Pública. 2008;24(supl 1):S100-10.

11. Melo CM. Editorial. Desafios contemporâneos sobre trabalho e formação da enfermeira no Brasil. Rev baiana enfermagem. 2016;30(2):3-5.

12. Kruse MHL. Is it possible to view nursing education differently? Esc Anna Nery Rev Enferm. 2008;12(2):348-52.

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