Federal University of Rio de Janeiro State
Journal of Research Fundamental Care Online
ISSN 2175-5361
DOI: 10.9789/2175-5361

REVIEW

Sofrimento e precarização do trabalho em enfermagem

Suffering and precarious ness at work in nursing

Sufrimiento y precariedad del trabajo en enfermería

Marilei de Melo Tavares e Souza [1] , Joanir Pereira Passos [2] , Cláudia Mara Melo Tavares [3]

ABSTRACT

Objective: This present theoretical essay aims at analyzing the work of nursing in a double-sided way: that which produces pleasure because it allows creating and transforming reality, and that which produces suffering in capitalist societies because it limits the human possibilities of choice, creation, and enjoyment. **Method:** This study uses a reflexive and theoretical critical perspective about what is specific in the work of caring in nursing. **Results:** Generally, workers have their possibilities constrained by the capitalist mode of production, especially those in the private sector; however, the work in nursing has its specificities. The act of caring is inseparable from its consumption by users of health services. **Conclusion:** The contradictions and difficulties that permeate the process of nursing work in contemporary times are understood as part of a larger context in the world of work today. To understand the precariousness at work in nursing. **Descriptors:** Nursing, Occupational health, Attention to health.

RESUMO

Objetivo: O presente ensaio teórico visa analisar o trabalho de enfermagem em sua dupla face: a que produz prazer, porque permite criar e transformar a realidade, e, nas sociedades capitalistas, a que produz sofrimento, porque limita as possibilidades humanas de escolha, criação e prazer. **Método:** Utiliza-se uma perspectiva crítica e reflexiva teórica sobre o que há de específico no trabalho de cuidar em enfermagem. **Resultados:** De forma geral, os trabalhadores têm suas possibilidades constrangidas pelo modo de produção capitalista, especialmente os do setor privado, também é verdade que o trabalho em enfermagem tem suas especificidades. O ato de cuidar é inseparável do seu consumo por usuários dos serviços de saúde. **Conclusão:** As contradições e dificuldades que permeiam o processo de trabalho em enfermagem na contemporaneidade, compreendidas como parte de um contexto maior em que se insere o mundo do trabalho hoje. Para compreendermos a precarização do trabalho na enfermagem. **Descritores**: Enfermagem, Saúde do trabalhador, Atenção à saúde.

RESUMEN

Objetivo: El actual análisis teórico tiene como objetivo analizar el trabajo del cuidado en su doble función: el que produce placer, porque permite crear y transformar la realidad, y, en las sociedades capitalista, el que produce el sufrimiento, porque limita las posibilidades humanas de de elección, creación y placer. **Método:** Se utiliza una perspectiva crítica y teórica reflexiva en lo que tiene de específico en el trabajo de cuidar en enfermería. **Resultados:** De forma general, los trabajadores tienen sus posibilidades constreñidas de las posibilidades por la manera de la producción capitalista, especialmente del sector privado, también son verdad que el trabajo en enfermería tiene sus especificidades. El acto de cuidar es inseparable de su consumición para los usuarios de los servicios médicos. **Conclusión:** Las contradicciones y las dificultades que perpasan el proceso del trabajo en el cuidado en la contemporaneidad se entiende como parte de un contexto más grande en que se inserta el mundo del trabajo hoy. Para entender la precariedad del trabajo en el enfermería. **Descriptores**: Enfermería, Salud laboral, Atención a la salud.

[1]PhD student at the Nursing and Biosciences Graduate School Program – PPGENFBIO at the Rio de Janeiro Federal State University/ UNIRIO. Assistant Professor at the Severino Sombra University – USS. Professor at the Nursing in Labor Graduate School Program at the Fluminense Federal University – UFF. E-mail: marileimts@hotmail.com. [2]PhD in Nursing by the São Paulo University. Associate Professor at the Alfredo Pinto Nursing School at the Rio de Janeiro Federal State University. Coordinator of the Academic Master Degree program in Nursing – PPGENF/UNIRIO, and advisor in the Nursing and Biosciences Graduate School Program (PhD program) – PPGENFBIO/UNIRIO. Email: joppassos@hotmail.com. [3]Cláudia Mara Melo Tavares. Postdoctoral fellow at USP-SP. PhD in Nursing. Full Professor at the Fluminense Federal University, Coordinator of the Professional Master degree program in Health Teaching and advisor in the Sciences of Health Care Graduate School Program (Master and PhD degrees) – UFF. E-mail: claudiamarauff@gmail.com.

INTRODUCTION

Problems related to the health working process seem to accumulate. Such problems relate not only to the precariousness of the labor contracting modalities, typical of the neoliberal model[1], but also the exploitation of suffering[2], position of health professions and their social roles[3], process of capitalist accumulation in health and organization of work[4], organization of public and private health care[5], dominance and submission of the worker to the capital, but similarly to resistance, constitution, and the historical making[6], relativity and diversity in the humanization of problems, tension between the individual and collective in the process of social change, and variations in reach of management functions in the performance of actions of the component of education and work[7] and current work, which under the empire of commodity fetish turns it into a forced, imposed, and exterior activity.[8]

When it comes to work in the health sector, there is a fundamental aspect to be considered: health care is the provision of a service. This means that work in health belongs to the sphere of non-material production, which is completed in the act of its performance. Thus, it does not have a product material as a result (independent of the production process) that is tradable in the market. The product is inseparable from the process that produces it; it is the very performance of the activity.[9] While the work within the capitalist system is considered productive to the extent that produces capital, it enters the production of goods, achieves capital gains, goes into circulation, and produces more value.[10]

However, generally speaking, workers have abilities that are constrained by the capitalist mode of production, especially the private sector; the nursing worker also suffers these influences, and features these and other specifics.

Considering care as the nurse's craft, we can say that the act of caring is inseparable from its consumption by users of health services. Caregiving has missing specifics in the production of objects such as chairs, shoes, or computers in which the fact that certain current features are present in the production of goods has weight such as the precariousness of work relations being also incorporated to work in the area of services. Different from the work of those producing material objects, the non-material work production of health care depends directly on the relationships built with other subjects being users, managers, or other employees. Such relationships is to say, can be expressed on a daily basis, both by indifference or respect and commitment for those involved and their effective needs and rights. This specificity gives great power to the work of caring for others.

The nurse's daily practice, in virtue of the knowledge-power that it produces that are not neutral, brings itself possibilities to mediate the interests of users and health teams. But it may also reiterate the existing subordination in these services, or give in to

the market's pressures for a quick service, which ensures more immediate gains to those who sell health services.

The nurse's work can be identified with the interests of different classes. Technical and social division of work in nursing.

In this article we will examine the work of nursing in its double-sided way: that which produces pleasure, because it allows you to create and transform reality and that which, in capitalist societies produces suffering because it limits the human possibilities of choice, creation, and enjoyment. Furthermore, we reflect about what is specific in the work of caring in nursing.

THE STORY OF THE NURSES' STRUGGLE

Modern nursing in Brazil was born under the aegis of public health. The first school in Brazil to provide systematic education in nursing – Ana Neri School (1923) - privileged its curriculum with disciplines featuring preventive approaches in line with that time's policy. After the 50s, a strong tendency towards the hospital field took place.

The struggle for health during the decades of 1970 and 1980 was also a struggle for democracy against dictatorship. This fight took various forms and extended into various spaces. In the 70s, as a result of economy monopolization, health practices and medicine and nursing suffered a sharp process of privatization and excessive specialization. This privatization concerns the growing organization of business that provides medical care.[11]

Health taken by the biology standpoint, centered on the disease, in medical hegemony, on individual attention, and intensive use of technology, care, in the inter-sector action, and growing autonomy of populations in relation to health is put into question.

The VIII National Conference of Health aimed at the Health Reform, proposing changes to the traditional model of health care and requiring changes in the training and practices of health professionals proposing an integral service for the promotion, protection, and recovery of health. In this perspective, the role of the nurse is not limited to the provision of direct care or supervision of technicians and assistants. The nurse shall exercise functions of coordination, teaching, and supervision in the field of health and should therefore be prepared to operate various models that will qualify them to perform multiple functions, contributing to the quality of care at all levels in health care.[12]

The nurse's training model instructed by technical pedagogy was questioned by the social set of the profession from the late 80's. Exhaustive debates, seminars, and discussions in the national scope, in the context of nursing, culminated with Ordinance MEC1721/94, which aimed at correcting distortions that are essential to the process of a nurse's formation adapting the process to changes in the profession in health care, education, and labor market areas and mainly to the needs and demands of health by the population, expressed by the significant change in demographic and epidemiological profiles.

However, according to Deluiz[13], the curriculum model predicted in the said Ordinance relates with the perspective and contemporary approach of training, which are linked to the globalization of economy, of exacerbation of markets competition, and demands for improvement of product quality and flexibility of production processes and at

work, where learning is action-oriented and the assessment of competences that seek to adapt the professional to the new requirements of the labor market.

To guarantee an integral formation of nurses implies the deepening of knowledge required in its scientific and historical dimension shared in experiments with collective practices, covering the citizenship dimension, in order to definitively overcome the professional instrumentalist, technical, and uncritical practice. However, the change in the model of nurse's formation passes by the need for transformation of the health system itself. Today, although we can observe signs of reorientation in the assistential model, represented by the experiences of the SUS in some municipalities and of the Family Health Program (PSF), which seek to break away from the productivity logic of services and implemented practices based on more comprehensive concept of health, we note in the current system, qualitative and quantitative deficits of attention to health. We still predominantly live with assistance founded on a biological dimension and in the medical act.[14]

Currently, the tendency of nurses-forming institutions in recognizing that it is part of the professional role of nurses to think about social responsibility in the allocation of resources; ensure the right to health of the population and promote participatory processes that stimulate popular organization. However, the professional practice of nursing is still marked by a hospital centered performance and intensive use of technology.

THE WORK OF NURSES IN THE CONTEXT OF THE SUS

Such as what occurs with the work in the area of education, the work in health is marked by directionality. There is always a result to be achieved. The result is the production of use-values and, therefore, it is essential to analyze the work in nursing not only as an activity that seeks people's health, but also as an important market in which several capitals try to achieve reproduced expansion, and therefore, compete at all times for the purpose of health acts.

The ideology that pervades the nursing profession since its origin is selflessness, obedience, and dedication. The conflict for these workers is evident because motivation, characterized by idealized feelings in the profession, conflicts with the reality determined by the capitalist labor market.[15]

The precariousness work in nursing in terms of hiring modalities, typical of the neoliberal model, is currently at odds with the speech of construction of the Health Unified System (SUS). Thus, to understand the world of work today is a precondition for articulated reading of Work and Health. Accordingly, we will seek support in the work of Ricardo Antunes to understand what the world of work is today.

For Antunes[16], the reordering of work relations in recent decades is due to a restructuring in the technical base in the productive sector and a reorganization of international economic relations associated with the globalization process. The author states that it is impossible to speak about the end of work. As an argument, he brings the discussion on globalization of capital and strengthens the rules and challenges of the work world are transnational.

The intensification of labor is a characteristic trait of the current phase of capitalism and has led to the uncontrolled consumption of physical and spiritual energies from workers. The insecurity generated by fear of unemployment makes people submit to regimes and precarious employment contracts, receiving low wages and risking their lives and health in unhealthy environments with high risks.

We are facing a new phase of deconstruction of work, unprecedented in the whole modern era, expanding the various ways of being in informality and precarious work. Advancing in the formulation, in the current context of structural crisis of capital, it seems that we are entering a new era of structural precarization of work.[17]

Therefore, when analyzing the precariousness at work in nursing, it is necessary to learn and understand the relationships, symbolic power, and forces at play in the very structure of the field in which the relations produced are legitimized. Thus, the concept of habitus proposed by Bourdieu contributes to the analysis. *It is in the various symbolic struggles developed in different fields and in which its own representation of the social world is at stake, especially the hierarchy within each of the fields and among the different fields.*[18] In addition to imposing meanings, it makes them legitimate, shaping individuals, composing habitus and information baggage, all in the social environment, featuring a learned, long-lasting, and transferable knowledge. The maintenance of this habitus involves individual interaction with the field, demanding a symbolic continuous fight[19]. However, if the power only had the function of repressing, acting only through censorship, of exclusion, of prevention of repression as a super-ego, if only was exercised in a negative way, it would be very fragile. If it is strong, it is because it produces positive effects in terms of desire and also of knowledge.[20]

Discussing about integrality, work, health, and professional training in health, Mattos[21] based on the design of critical reflexion of Boaventura Santos, who assumes the possibilities of transformation, contained in all realities, and examines the strategies of transformation of work and training in health by means of the social care practice. This practice involves power relations and emancipation within the relationships of care, in the health sector, which is possible for the author, to refocus on everyday care practices towards emancipatory relations. Therefore, he reaffirms the commitment to a fight that involves the adoption of an ethical-political perspective guiding the work in health and in education of health professions.

On one hand, we have the proposal for a health care model characterized by centralized public services that employ mainly medical specialists, who take biomedically defined diseases as health problems, who buy large part of procedures from the private sector that covers the population excluded from the market, but give space for those who can afford, to buy in the private system. Conversely, a proposal based on decentralized public services taking the health needs of individuals and collectivities as health problems, involving various professions in the health care, which predict the community participation in the management of services, and who aspire universal access, even if it means reducing the private sector.

Merhy[22] says that the health working process is specifically configured as techno-assistential actions, i.e. actions that, on the other hand, express a given construction of

what the health-disease object is, and to actualize, mobilize a set of technological knowledge (such as the medical sciences, psychology, epidemiology, and etc.); on the other hand, express a particular way of organizing the production of these actions as services, i.e. it requires a particular institutional-assistance design.

SUFFERING IN THE PROCESS OF WORK IN NURSING

When referring to the relationship between psychodynamics of work and the language, Dejours would be establishing another kind of rationality related to the subjectivity lived by the subject. The psychodynamics of work aims at the study of the relations between conduct, behaviors, and experiences of sufferings and joys experienced by the organization and achievements of work. Research is on the other side allowing the highlighting of a gap between prescribed work organization and actual work organization. And it is through the language that the subject could express how he lives the work, how he suffers at work, how he builds and rebuilds the work, and how he relates to the work. Language is the means by which it is possible to build a survey in the psychodynamics of work. The methodology in psychodynamics of work is based on the subject, in relation to the group, when it is possible to express their experiences and draw up a reflexion between suffering and pleasure at work.[23]

The field of health considers this condition of the worker as a social phenomenon of high significance in the health-disease process. The degradation of life by an exclusively economic sense, due to labor activity, with the generation of waste such as exposure to risks, the brutal awareness of our slavery at work, no bargaining power over wages and uncertain future originate a human deficit in health and in life itself.

According to the highlights by Moreira[24], the logic of capital accumulation leads to a clash of antagonistic interests between the working class and the capitalist class. This generates a drop in quality of life that consequently causing losses of psycho-social order such as insecurity about the future, possibility of unemployment, cultural interferences, lack of perspectives in life, and etc.

The production of affective relations and its disruption to work are sources of suffering. Dejours observes that the frustration and anxiety are experienced in isolation and affective loneliness, which causes it to increase even more. The author classifies anxiety in different components, which are: anxiety concerning the degradation of mental functioning and psycho-affective balance, anxiety concerning the degradation of the body, and anxiety generated by the 'hunger discipline'.[25]

Poor working conditions generate anxiety, dissatisfaction, and suffering in the worker, who inherently in his will, becomes fragile. This susceptibility throughout the process of work can be a strong ally injuring health. For Dejours[26], this suffering cannot be eliminated; the only possibility is to transform it. Therefore, the work process has powerful effects over the suffering psychic or contributes to exacerbate it or contributes to transform it.

The nurse coexists with a strong work fragmentation resulting from historical social and technical divisions' indifference expressed by other professionals, and also may have

accustomed to “superficial” definitions with no chance of participation. However, they may also participate in environments in which solidarity and collective work are the keynote.

If they work in major urban centers, they may be burdened with the effects of violence and impoverishment. Despite this, they may have deep sensitivity about the rights of users and importance of their work. They can also, by virtue of their personal religious beliefs, feel that working in health is giving to the poorest.

They can be bothered with complaints from users, become perplexed, have solidarity, and feel restless in the search for solutions, but they can also be naturalized with injustice or be waiting for a magic solution to their problems.

Silva Júnior[27] states that the health care model that emerges along with scientific medicine presents some characteristics that are directly related to their way of understanding the health-disease process: specialization/fragmentation, a mechanistic understanding of disease and a deepening of scientific knowledge in the direction of specific parts.

The historical process of the 20th century, as we have seen, shows that this is an integrated model and useful not only to the development of expanded productive health capital but to the reproduction of society as it is, i.e. without questioning the social order.

This complex relationship between health market, health conceptions, medicalization of life, scientific production in the area, and care practices can be illustrated from a specific example: the relationship between the pharmaceutical industry and the knowledge of the area and the prescription and consumption of medicines.

Therefore, health is a business and, as such, should enable the greatest possible return in terms of profit to shareholders' investments. For this to occur, its market needs to be expanded. People should consume medicines massively, needed or not.

However, some specific needs of certain classes or social groups are elevated to the condition of all society’s issues, becoming the object of public policies developed by the State. This process is always amidst the struggle between subjects and social forces that competed for this action of the State and, as a consequence of this action, we will always have relocations and changes in power between these subjects as well as interests met and thwarted.

For Aguiar[28], social classes are always a tangible reality, where the extraction of surplus value constitutes the central nerve of contemporary societies. The author defines itself as a historical process, to the extent that the relative stability of relations of capitalist exploitation does not automatically add the working class. Thus, it is important to note that the fights between classes and social groups do not occur only in the State (three powers, legal order and military-police repressive apparatus). There is a powerful process of struggle in the economic institutions of the State (central banks and investments, economic regulation, state-owned enterprises, etc.) and, also, in the so-called civil society.

THE WORK IN NURSING AND ITS SPECIFICITIES

On health care, one can understand the concern about the customer’s humanization in the Federal Constitution[29], which guarantees access to all healthcare in full and in an

egalitarian way. Similarly, through the Joint Commission for Accreditation of Hospitals for Latin America and the Caribbean[30], the Patient's Bill of Rights - Permanent Forum of clinical pathology - and more recently, the National Program for the Humanization of Hospital Care. These documents are the first steps to determine the mode and the field of action of health professionals seeking humanization of assistance.

Nursing care is sustained in human and social interaction, in the dialogical relationship of reciprocal interaction between the nurse and the cared subject in which an exchange of life processes unfolds in a particular way of understanding health, illness, and death. This intersection subject-care is where the communication in its verbal and gestural form, attitudes and affection are the backdrop for the meeting with the other, where the deciding process results in a fundamental element for care.

The notion of "human subject" emerged for the first time in the discourses and practices that established modern science. The conception of subject, founded on reason, was constituted in the Western world with the philosophy of Descartes, who also formulated the discourse of modern science in the seventeenth century.[31]

The conception of the Cartesian philosophy allowed the representation of the subject as the founder of the world for its reason. The discourse of reason came to be identified as the discourse of science.

Descartes described the universe, dividing it in two: one that refers to the objective knowledge, scientific - the world of objects; and another, intuitive and reflexive - the world of subjects. According to this understanding, an opposition between philosophy and science was created.[32]

Modern science and the concept of subject contained therein have become critical reflexion objects grown by philosophers, sociologists, and historians in the course of the 20th century. Michel Foucault is among the thinkers who have undertaken reviews of the scientific canons of modern science and approached the question of the subject.

Foucault[33] discussed the idea of subject in the modern philosophical thought and criticized the idea that science would allow the progress of society. For him, the social organization, far from being governed by technical rationality, is conducted by the exercise of power.

He considered that there is an ambiguity in the notion of subject in modern science. He highlighted the disciplinary authority as a new type of power that unfolded throughout the 19th century and reached its full legitimacy in the early 20th century, based on concerns for the regulation and monitoring of the human species, the individual, and the body when making a type of genealogy of the modern subject.

Today, for the implementation of care with humanizing actions, it becomes indispensable to value the subjective and social dimension in all practices of care and management in the SUS, strengthening multidisciplinary teamwork, promoting the construction of autonomy and importance of the subject, strengthening social control with participatory nature in all instances that manage the SUS, democratizing labor relations and enhancing health professionals. In presenting this proposal, the National Hospital Assistance Program inserts the human and subjective dimension at the base of every health

intervention, from the simplest to the most complex, influencing the effectiveness of services provided by hospitals.[34]

The conduct of nursing professionals is a determining factor and concern for many scholars of humanization processes in health. The mode-of-being in nursing is considered as a new ethics that articulates a new sense of acting based on the mode-to-be-cared for proposed by Boff in which the relationship is of coexistence and interaction, thinking about the nursing care as an attitude of concern, responsibility, and affective commitment to each other. The instrumental reason makes room for the sensitive reason and profound meaning. Hence, the nurse can better understand the dimension of otherness, embracement, and reciprocity. The big challenge for nursing, however, is to reconcile and find just the right amount of modes-of-being-in-world and in society.

Conversely, we must remember the characteristics of the work in nursing. The nursing staff performs its work applying characteristics of partial division of labor, in which lies the fragmentation of tasks under the managerial control of top-level professionals.

The work of nursing is compartmentalized, within the professional scope itself. Each component of the professional nursing staff (nurses, technicians, and assistants) provides part of the health care separate from others, often duplicating efforts and even taking contradictory attitudes. Significant proportion of nursing professionals performs delegated activities, maintaining limited space of decision, creation, and mastery of knowledge, typical of a dominated professional work.

CONCLUSION

The working conditions in health and nursing in Brazil deteriorate by the influence of the neoliberal policy, where the healthcare industry is subjected to strict cost containment, which imposes increasingly demeaning wages to nursing workers.

Although the values proposed by the SUS represent a political progress when favoring building a historic-critical landmark for training nursing professionals seeking integrality of attention in health and considering the struggles for health as a dimension of acting in nursing. It is known that a policy directed at improving working conditions and wages for its workers was neglected.

Therefore, it is essential that the contradictions and difficulties that permeate the process of nursing work in contemporary times are understood as part of a larger context in the world of work today. In summary, to overcome this framework it is essential that nursing workers join the social struggles that seek to rescue the most essential values of humanity, opposing the force that operates in favor of the de-socialization of mankind under the aegis of the capital.

REFERENCES

1. Antunes, R. Adeus ao trabalho? São Paulo (SP): Cortez/EDUNICAMP; 1995.

2. Dejours C. A loucura do trabalho: estudo de psicopatologia do trabalho. 5ªed. ampliada. São Paulo: Cortez-Oboré, 1992.

3. Scharaiber LB. O médico e seu trabalho. São Paulo: Ed. Hucitec, 1993.

4. Eibenschtz CH. Atención a la salud y poder ciudadano: elementos clave en la articulación público/privado. In: EIBENSCHUTZ, C.H. (org.) Política de Saúde: o público e o privado. Rio de Janeiro: Ed. Fiocruz, 1995.

5. Mendes EV. Uma ajuda para a saúde. São Paulo: Ed. Hucitec, 1996.

6. Mendes R, Dias EC. Da medicina do trabalho à Saúde do trabalhador. Rev.Saúde Pública., São Paulo, 25(5): 341-9, 1991. Disponível em: http://www.scielosp.org/pdf/rsp/v25n5/03.pdf

7. Pierantoni CR, Varella TC, Santos MR, França T, Garcia, AC. Gestão do trabalho e da educação em saúde: recursos humanos em duas décadas do SUS. Physis: Revista de Saúde Coletiva, Rio de Janeiro, 18 [4]: 685-704, 2008. Disponível em: http://www.scielo.br/scielo.php?pid=S0103-73312008000400005&script=sci_arttext

8. Antunes R. O caracol e sua concha: ensaios sobre a nova morfologia do Trabalho. São Paulo: Boitempo, 2005.

9. Pires D. Novas formas de organização do trabalho em saúde e enfermagem. Revista Baiana de Enfermagem, Salvador, v.13, p. 83-92, 2000.

10. Marx K. Posfácio da 2ª edição. In O capital (livro 1, vol. 1). Rio de Janeiro: Civilização Brasileira, 1980.

11. Germano RM. Educação e ideologia da enfermagem no Brasil. 2ª. Ed. São Paulo: Cortez, 1985.

12. Almeida MCP. A Formação do Enfermeiro frente à Reforma Sanitária. Cadernos de Saúde Pública, RJ, 2(4): 505-510, out/dez, 1986. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X1986000400010

13. Deluiz N. Qualificação, competência e certificação: visão do mundo do trabalho. In: Ministério da Saúde. Formação: Projeto de profissionalização dos trabalhadores da área de enfermagem. Brasília: Ministério da Saúde, v.1,n.2, p.5-15, 2001.

14. Tavares CMM. Paradigmas das diretrizes curriculares e a enfermagem. Cad CE ; 4: 121-127, 2002.

15. Melo C. Divisão social do trabalho e enfermagem. São Paulo (SP): Cortez Ed.; 1986.

16. Antunes R. A dialética do trabalho. São Paulo (SP): Expressão Popular, 2004.

17. Antunes R. Os modos de ser da informalidade: rumo a uma nova era da precarização estrutural do trabalho? Revista PRAIAVERMELHA . Rio de Janeiro. v. 20 nº 1, p. 11-20, Jan-Jun, 2010. Disponível em: http://web.intranet.ess.ufrj.br/ejornal/index.php/praiavermalha/article/viewFile/139/90

18. Bourdieu P. O poder simbólico. Rio de Janeiro: Bertrand Brasil, 1989.

19. Bourdieu P. A economia das trocas simbólicas. São Paulo: Perspectiva, 1987.

20. Foucault M. Microfísica do Poder. Rio de Janeiro: Graal, 1979.

21. Mattos R A. Integridade, Trabalho, Saúde e Formação Profissional: algumas reflexões críticas feitas com base na defesa de alguns valores. In: Estado, Sociedade e formação profissional em saúde: contradições e desafios em 20 anos de SUS. / organizado por Gustavo Corrêa Matta e Júlio César França Lima. – Rio de Janeiro: Editora Fiocruz/ EPSJV, 2008.

22. Merhy EE. A saúde publica como política. São Paulo: HICITEC, 1992.

23. Dejours C. Travail: Usure mentale. Essai de psychopathologie du travail, Paris, Editions du Centurion, 1980.

24. Moreira RJ. Agricultura familiar: processos sociais e competitividade. Rio de Janeiro: Mauad; Seropédica, UERRJ, 1999.

25. Dejours, C. A loucura do trabalho: estudo de psicopatologia do trabalho. 5ªed. ampliada. São Paulo: Cortez-Oboré, 1992.

26. Dejours C. A banalização da Injustiça Social. 4ªed. - Rio de Janeiro: Ed. Fundação Getúlio Vargas, p.127-145, 2000.

27. Silva Junior AG. Modelos tecnoassistenciais em saúde: o debate no campo da saúde coletiva. 2.ed. São Paulo: HUCITEC, 2006.

28. Aguiar JV. Cultura e dominação de classe: o projecto ideológico pós-modernista e a retracção identitária e política das classes trabalhadoras centrais. Revista PRAIAVERMELHA, Rio de Janeiro / v. 20 nº 1 / p. 95-108 / Jan-Jun 2010. Disponível em: http://www.ess.ufrj.br/praiavermelha/index.php/praiavermalha/article/viewPDFInterstitial/144/96

29. Brasil. Constituição de 1988. Constituição da República Federativa do Brasil. Brasília, DF: Senado, 1988.

30. Novaes H M, Paganini JM. Direitos do Paciente. In: Garantia de qualidade: acreditação de hospitais para América Latina e o Caribe. Organização Pan-americana de Saúde; Organização Mundial da Saúde; Federação Latino-americana de Hospitais; Federação Brasileira de Hospitais. SÉRIE/SILOS, n. 13, 1992.

31. Birman J. Psicanálise, ciência e cultura. Rio de Janeiro: Jorge Zahar, 1994.

32. Morin E. A noção de sujeito. In: Schnitman, DF. (Org.). Novos paradigmas, cultura e subjetividade. Porto Alegre: Artes Médicas; p. 43-55, 1996.

33. Foucault M. Vigiar e punir: nascimento da prisão. Petrópolis, RJ: Vozes, 1977.

34. Oliveira BRG, Collet N, Vieira CS. A humanização na assistência à saúde. Rev. Latino-am Enfermagem, março-abril; 14(2): 277-84, 2006. Disponível em: http://www.scielo.br/pdf/rlae/v14n2/v14n2a19.pdf

Received on: 29/05/2011
Required for review: No
Approved on: 22/11/2011
Published on: 01/01/2015

Contact of the corresponding author:
Marilei de Melo Tavares e Souza
PPGENFBIO/UNIRIO
Rua Xavier Sigaud, n. 290 - 2º andar, Urca, Rio de Janeiro – RJ. CEP 22290-180 Tel. (21) 2542-6479. Brasil. E-mail: marileimts@hotmail.com