

O processo de trabalho em um ambulatório de oncologia na percepção dos técnicos de enfermagem

The process of working in an oncology outpatient clinic in the perception of the nursing technical team

El proceso de trabajo en un ambulatorio oncología en la percepción del personal de enfermería

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ABSTRACT

Objective: To describe how the technical nursing staff perceives and describes the work process in an Oncology Clinic. **Method:** A qualitative study. Data was obtained through the use of focus groups and analyzed using content analysis method **Result:** From the analysis of the participant's reports emerged the following category: (re)organization of team work. The units of analysis were established to organize and sequence discussions: Barriers in health care network; Work organization focused on professional; Assistance provided to the patient as the central character; Difficulty in linking the micro processes carried out at the clinic. **Conclusion:** It is concluded that the work is exercised in a fragmented way and that the work process reorganizes, changing its components, but maintaining the same product.

Descriptors: Work process in health; Nursing work; Work.

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RESUMO

Objetivo: Descrever como a equipe técnica de enfermagem percebe e relata o processo de trabalho em um ambulatório de oncologia. **Método:** Estudo qualitativo. Os dados foram obtidos por meio da utilização de grupo focal e analisados através da modalidade de Análise de Conteúdo. **Resultado:** A partir da análise dos relatos das participantes emergiu a seguinte categoria: (re)organização do trabalho em equipe. Foram estabelecidas as unidades de análise para organizar e sequenciar as discussões: Entraves na rede de atenção à saúde; Organização do trabalho centrado no profissional; Assistência fornecida ao paciente como personagem central; Dificuldade na articulação entre os microprocessos realizados no ambulatório. **Conclusão:** Conclui-se que o trabalho é exercido de forma fragmentada e que o processo de trabalho se reorganiza, alterando seus componentes, porém mantendo o mesmo produto.

Descritores: Processo de trabalho em saúde; Trabalho em enfermagem; Trabalho.

RESUMEN

Objetivo: Describir cómo la técnica del personal de enfermería percibe y describe el proceso de trabajo en una Clínica de Oncología. **Método:** Estudio cualitativo. Los datos fueron obtenidos por medio del uso de grupos de enfoque y analizados a través del Análisis del Contenido. **Resultado:** A partir del análisis de los informes de los participantes surgieron las siguientes categorías: (re)organización del trabajo en equipo. Se establecieron las unidades de análisis para organizar y secuenciar discusiones: Barreras en la red de atención de la salud; La organización del trabajo se centró en profesional; La asistencia prestada al paciente como el personaje central; Dificultad en la vinculación de los procesos micro realizadas en la Clínica. **Conclusión:** Se concluye el trabajo que se lleva a cabo de una manera gradual y que el proceso de trabajo se reorganiza cambiando sus componentes, manteniendo al mismo tiempo el mismo producto.

Descritores: Proceso de trabajo en salud; Trabajo en enfermería; Trabajo.

INTRODUCTION

In the capitalist world, the characteristic work of the taylorist/fordist model, meaning, qualified, fragmented, repetitive, routine and lapsed, is substituted by the standard of accumulative flexible capitalism or toyotistic standard, which translates to competitiveness, productivity, agility, rationalization of costs, characterized for a multipurpose work, integrated, in team, with more flexibility and autonomy.¹

These characteristics had been absorbed by the management in the health area leading to a scenario of users dissatisfaction, mainly to those that use the SUS. This dissatisfaction occurs daily due to impasses lived in the reality of management, characterized due to financial resources, flexibilization of bonds, actions of health with low impact on the real problems of population's health, dehumanization and the present media, further demoralizing the management in this area and informing it to all social classes.²

Work in health presents characteristics that are distinguished from other processes of work, since the consumption of the generated product occurs simultaneously to the production of the action, becoming a component of

non material production, because not only is it essential for human life, it is also part of the sector of services and its final product is indispensable for the process that produces it.³

In the health area, this work is disciplinarily organized. Where the workers respect their physical environment and each product generated in its corresponding environment. Therefore, this type of work organization will only reach a final quality product if all stages are linked, thus, the worker will be able to identify the existing impediments in the routines and the impact of the problems in other sectors.⁴

The health worker has a certain level of self-government where it determines the characteristic of their work process within their place of work. Thus, these multiple and complex workspaces, composed of the process actors working directly with the subjects, are termed as micropolitical places. Therefore, micropolitics is the art of governing that each worker has within its due space, therefore, its comprehension is necessary for a possible intervention to take effect.⁵

The unveiling of the existing micro processes within the health institutions is fundamental to the development of intervention proposals.²

For the work process to elapse successfully, attention should be paid to the intra and inter institutional characters, which will include all those who participate in relations signed in the existing micropolitics within that process. Thus, it is possible to get to the root cause of the problem that impacts the micro decision-making processes of everyday health services.⁵

Faced with a setting of uncertainty of information on the procedures along the subjectivity of the work, the workers begin to carry out their work activities in a partially singular form, which is in their own way.⁶

Therefore, it is imperative that the discussion on the working process and its implementation difficulties transcend the personal aspect and takes place in a systematic manner, observing and knowing all existing micro processes in the hidden interior work. The justification of the error cannot be related only to the way of doing the work, but the analysis of real work situations with the rationality of the worker.⁴

Within study settings and health institutions, the nursing team is distinguished by large numbers of personnel that integrates it and by the fact that it is in various locations of the institution and establishes interactions with virtually all services.⁷ Thus, it holds extensive knowledge about how the work process is carried out, being able to describe it and analyze it.

Considering the assumptions described above, the present study aimed to describe how the nursing team perceives and reports the work process in the Oncology Clinic.

METHODS

Descriptive research with a qualitative approach. The study setting was the Ylza Bianco Oncology Clinic belonging

to the Hospital Santa Rita of Cassia (HSRC), located in the city of Vitoria in Espírito Santo state.

Participated in this study 10 nursing technicians. Were excluded from the study workers who were not present at the time scheduled for the meeting. Giving voice to nursing technicians as participants in this study took place because they account for the majority of the nursing team members in the health service and they are directly involved in assisting the user, and have contact with all other health team workers, experiencing, therefore, all the implications of the work process in health services.

To collect data it was decided to use the focus group technique (FG), for being this a search mode that is derived from group interviews that gather information through group interactions.⁸ This proposal allows the use of the lines of the group directly at the time of reporting their experiences for the benefit of a topic of collective interest.⁹ It was used as a reflective inquiry on the subject: "How Nursing Technic professionals perceive the work within the Ylza Bianco Clinic?"

The duration of the sessions of the FG was about 1 hour and 30 minutes, being properly prepared for the reception of participants, with appropriate location and use of group techniques that allows the wide exposure of ideas on the subject discussed.

The statements were recorded in electronic material and, later, fully transcribed. Data were analyzed using the method of content analysis. Content analysis has three chronological poles that are pre-analysis, exploration of the material and treatment of the material. The first stage is the stage of organization, where the initial reading and the development of indicators for the interpretation was used. In the second stage, the data was encoded from the registration units. The last step was made categorization consisting of the classification of elements according to their similarities and differentiation, grouping them according to common characteristics.¹⁰

As it regards human beings, this study was submitted to the Ethics Committee of the Federal University of Espírito Santo (UFES) in order to comply with the guidelines set out in the Resolution 196/96 of the National Health Council and it was approved by the CAAE Resolution nº 33283814 / 8.0000.5060. To ensure the confidentiality and the anonymity of the participants in the presentation of the results, the statements were coded as follows: P1, P2 and so forth.

RESULTS AND DISCUSSION

After finishing the transcript of the statements obtained by the focus group, we made the initial reading of this material, which emerged towards units (subjects) that led to the structuring of the category called (re)organization of work.

The speeches of the participants carried over from the way the work process of the clinic is carried out to whether if it is centered on the professional or the patient. Also

described the facilities and difficulties existing in the access at entry and post-entry of the patient to the service.

To sequence the discussion, we organized the participant's lines according to the units of analysis related to the subject.

Obstacles in the network of public health:

The discussion began with P2 and P3 describing the difficulties encountered in the transit of patients with suspected or confirmed cancer diagnosis within the public health system until the correct routing for the referral service to this demand.

"[...] Unfortunately, it is the difficulty that the NHS itself has, because when the result of the examination comes to it, sometimes the delay is in the health post. But what will the government want, when the result comes out here, it does not want to know the time that has already passed, the time runs, right, there comes the need for screening to expedite this, there comes the matter that there are many people to meet, to operate, then the schedules are huge, because time is running and the NHS will charge the Hospital." (P2)

The law that imposes the deadline for cancer treatment is number 12,732, of November 2012, which states: "Patients with malignant neoplasias have the right to undergo the first treatment in the Unified Health System (SUS), within sixty (60) days from the day the diagnosis is signed in pathology report or an even shorter period, according to the therapeutic need of the case registered in single medical record".¹¹ The participant P3 criticizes the law, suggesting that the deadline for the start of treatment should be counted from the date in which the patient is enrolled in the institutions, since the responsibility is of the reference service. "There should be counted 60 days of the day the patient got here" (P3).

This difficulty is evident in our study setting, the Ylza Bianco Clinic since patients often access the service with the deadline already expired in law. The search for treatment becomes emergent and the offer shall not meet this repressed demand, resulting in the burden of health care in secondary and tertiary levels that are penalized by the charging without criteria of the legislation and the failure of the health care model. We found authors who claim that access to the public health network that makes up SUS has not yet managed to consolidate in an organized and active way, respecting the imposed legislation for the regulation of performed services.¹²

Humanized access to health is an ethical and political challenge of constitution of care networks both in macro and micro, due to the services fragmentation scenario, lack of quality in the care provided and the inconsistency between the system of supply and quota demand.¹²

This demand is closely linked to chronic situations, acuter during the search for access to health. The author stresses the importance of following the basic care, because when there is

worsening, the system becomes reactive to these situations, resulting in the depletion of the present system.¹³

The difficulty of appointment scheduling is a major obstacle to entry primary care and pent-up demand of emergency situations that appear seeking care in primary care culminates in emergency care overburdening these places with situations considered simple that could be resolved in primary care.¹⁴ This aspect is highlighted as P3 talks about the various routes of access that the patient seeks to get treatment at a referral service, whether it is by Primary Care, via State Regulatory Consultations, private consultations and even directly in the institution.

“It is usually via CRE or Health Post or can be referred by private practice for any particular query that forwards it straight here. We know that there are patients who arrive routed wrong, sometimes the case doesn't fit here [...]”
(P3)

Work organization focused on professional:

The report of P1 just below emphasizes the organization of work aimed at the professional, he talks about the number of patients seen depending on the medical schedule parameterization.

“The amount of the first medical patients depends on the schedule.” (P1)

This statement lights up again the discussion on the public health system barriers and responsibilities of government agencies as the establishment of this organization, because even with the service, sometimes developing its work plan focused on professional, it is definitely impossible to attend to and solve all the demand that seeks a reference center directly.

Regarding the possibility of reducing the barriers of access to health and that the health services start to respond to the problems demanded by users it is necessary to consolidate the “gateway” at the basic level of attention. The regulation of consultations is responsible for ensuring the flow according to social, epidemiological and sanitary demands, regardless of the level of complexity. This reference and counter reference network should seek to facilitate user access, taking into account the geographical limits of demands.¹⁵

At the clinic, it is a demand that searches for service with illegible medical referrals without priority information, but with the urgency criteria described in virtually all of them. These users arrive desperate for treatment and for being “lost” in the network, they do not accept a deadline for the consultation schedule.

Assistance provided to the patient as the central character:

The description of the work process in the user oriented clinic starts and is analyzed by P5 that has it as its central

character “We think that everything begins with the patient because he comes here with the diagnosis or with some suspicion” (P5).

Studies have been presented on the health work process that faces the patient, ie, user-centered, seeking the satisfaction and resolution of existing barriers based on the walk of the user's health-disease process.³

The work process in health is beyond the tools present in hard technology and in the knowledge simultaneous to protocols and standardization, characterized in hard light technology. The light technology present in the relationship of users and employees is regarded as a living work and culminates in areas of speech, listening and interpretations with users expectation about the problem that will be faced, relationship of complicity and trust, finally approaching the health worker with the patient.³

When working with processes and procedures described, technology present in order to solve most problems, the user is not often perceived by workers as the main focus of attention. It is a fact that health services need to be provided the three types of technologies for the completeness of the quality of care, but the relational technology must occupy a prominent place in the existing processes.¹⁶

Difficulty in articulating the micro processes carried out at the clinic:

According to the statements below, the discussion again refers to the organization of work unit of analysis aimed at the professional and the difficulty in linking the micro processes carried out at the clinic.

“The nurse goes to the office and shows the case before opening records for the first time and then the doctor states if it can be opened or not.” (P4)

“But the information should have someone from nursing, to see which is the issue of screening, is the dressing, as you may overload the screening to authorize a bandage, which is not something that would need to go to Triage.” (P2)

The P7 participant speaks objectively on this (re) organization flow that is made by the professional as the work takes place. “It's very relative, there are doctors who make their own order, you can place according to schedule and he says it will meet so and so first” (P7). This (re)organization can happen by changing the components of work, provided you do not modify the final product.

The flow of patient care is already standardized by the institution and is frequently revised and reorganized by managers and supervisors as new routines are implemented in the sector. Regarding the speech of P7, the organization of work is evidenced by the medical professional, that is, consultations of patients are arranged according to the

parameterization of the agenda of each doctor, established by the institution.

In contrast, P3 talks about the routine adopted by the institution of pre-established hours for the operation of some locations within the study setting, but turning to patient dissatisfaction. "There would have to be office hours at the clinic because I find it sad, the patient who comes here for the first time, he does not know the screening schedule, sometimes coming from far away, then people say, 'Oh, the screening is over, now it's only at 2:00 p.m.'" (P3).

In proceedings related to changes within companies, various organizational factors can interfere positively or negatively so that they occur. The policy adopted by the company, the information flow and existing communication within the company, autonomy and the work of groups, bureaucracy and managerial expertise are some of the factors that may directly affect the implementation of change processes towards improvements.¹⁷

The Taylorized method still prevails in the health work processes and does not allow spaces of dialogue between workers to a possible overhaul of practices established by the rules, since the work is regarded as a strict adherence to standards and rules.¹⁸

Managers facing change processes within health institutions need to be aware of factors that can influence and modify directly this process, especially the people involved before, during and after implantation.¹⁶

According to a study carried out, the rigidity of existing rules in business mediated by protocols and excessive bureaucracy stops the workers from realizing the occurrence and effect of changes in the organizational environment.¹⁷ The following participant reports on how the consequences from the flow of the established bureaucratized care can affect the patient, characterizing the difficulty in linking the micro processes performed within the clinic.

"If the patient undergoes stress at the front desk, it comes in already stressed, the person comes for the first time then gets the screening password, then picks up the password to open the chart, then it gets here and wants to enter the medical room immediately, then we say 'sir, you have to wait a little' there it is, then he is already stressed." (P6)

The micropolitics network in health work processes contributes to the connection environment with the ability to operate with a high degree of creativity, provided there is a hegemony of living labor, ie, the high level of governance of the care production. Living labor suffers from these steps by which the patient goes through in the ambulatory, they often are necessary and extremely important for the security of information produced in consultation, such as the opening of a record. However, to minimize any problems that might occur in patient care, it is necessary that all stages of their care are interconnected, that the

barriers are unraveled with concrete solutions and mainly in order to facilitate access and patient flow within this network service, called micro network.

Normalization and standardization prevail in health services, but at the same time, it has an ability to create escape routes, working in their own way, according to the production environment, innovating all the pre-existing process.¹⁹

CONCLUSION

It was noticed in the study the influence of Taylorism in the processes related to health, characterized by a lack of communication between the teams, the rigidity of standards and protocols, lack of space for listening to workers, constituting a work defined by managers and run in a verticalized way by workers.

The survey also reveals the micro-network within the existing health institutions, which without its unveiling is practically impossible to solve routine problems. The worker is placed as the primary means for the knowledge of this network that exists within the work processes.

It was also explicit in discussing the difficulty that health services have to maintain user satisfaction and quality of care in their range, since there are gaps in the network of public health, which this study did not examine in its fullness, requiring a better approach to this issue.

However, the research points to a category of (re) organization of work, which identifies the changing of working components, but not the modifying of the final product. Therefore the adequacy of working with protocols is needed as workers, as part of the work process, can reformulate them towards a common goal with the institution, health.

We conclude also that the statements of the participants present contents that demonstrate an understanding of the need to a (re)organization of work, demystifying, thus, the idea that the practice of this professional category has strong technical features.

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