NURSES' PRODUCTION OF SUBJECTIVITY FOR DECISION-MAKING: ECOSYSTEM APPROACH[1]

Josefine Busanello*
Nalú Pereira da Costa Kerber**
Wilson Danilo Lunardi Filho***
Valéria Lerch Lunardi****

ABSTRACT

The objective was the analysis of the macro-political and micro-political factors of the nurse's production of subjectivity that permeate the decision-making process in Nursing care. We adopted qualitative research design. The scenario was a philanthropic hospital in the State of Rio Grande do Sul. The study participants were twelve nurses that work in this institution. For data collection, the focus group technique was used, with three focal meetings conducted in December, 2011. We adopted the content analysis. Macro and micro-political factors of production of subjectivity that support decision-making were identified. These factors are associated with environments that involve the academic institution of the nurse, the hospital and inpatient units. Conclusion: These results provide an approximation of the production process of subjectivity of the nurse with an ecosystem approach of the practice of care.

Keywords: Nursing. Nursing care. Decision making. Focus groups.

INTRODUCTION

Subjectivity is characterized in two hemispheres. On the one hand, infrapessoal processes, which define the micro-political dimension of subjectivity, that is, the modes of expression that pass through the relational and the dimensions of desire. On the other hand, the macro-political dimension of subjectivity, essentially at the level of social, cultural and economic determinations. Micro and macro politics make up an ecosystem in which subjectivity is produced[1].

In nursing, nursing practices and all actions and behaviors of nurses represent the ecosystem interactions of these professionals with clients, with the work process and with the social and environmental context. Thus, the term ecosystem can be used as an alternative to broaden the concept of environment, representing a more comprehensive view of the relationships between organisms and physical and non-physical factors, which are linked by a network of direct and indirect interactions[2].

The ecosystem approach in nursing allows integrating the environment, health and nursing care actions. The ecosystem approach allows, above all, reconnecting knowledge, allowing fluctuations in several fields of knowledge, promoting self-organization and promoting the sustainability of existing systems[3].

Thus, it is possible to articulate the concepts of ecosystems and the production of subjectivity, in the macro and micro-political perspectives, as a set of environments, in which human subjectivity is produced and consumed. Nurses' decisions can elucidate important manifestations of their subjectivity, since their choices determine behaviors, care relationships, interactions with the health team and, above all, guide care practices.

Considering the complexity of situations and contexts that involve nursing care, and which may influence nurses' decision-making, the following research question was elaborated: What are the macro and micro-political factors of nurses' subjectivity production that subsidize Decision-making process in nursing care? Thus, the objective of this study was to: To analyze the macro and micro-political factors of nurses' subjectivity production that subsidize decision making in the nursing care process.

METHODOLOGY

We adopted a qualitative research design, of the exploratory and explanatory type. For the data collection, held in December 2011, the focal group technique was used, which proposes the investigation with depth, the construction of new ideas and the answers about the theme in focus[3].

The study was carried out in a philanthropic hospital in the State of Rio Grande do Sul, with twelve nurses who work in this institution. The criterion for the selection of the participants was to be active, during the period of the research, that is, not to be away from the institution for vacations or health leave.

Considering the thematic universe of the research, three focal meetings were held, lasting approximately two hours. The focus meetings were conducted from topic guides, containing meeting objectives and triggering issues.

The research project was submitted to the Ethics Committee in Research, being approved with the protocol number 008/2011. The participation of the nurses in the focus group was formalized from the signing of the Informed Consent Term. The confidentiality of the information was also guaranteed, without disclosing the name of the participants at any stage of the study. For the identification of the nurses' statements, the code "ENF." was used, followed by the ordering number of the participants.

For the treatment of the data, initially, the literal transcription of the audio recordings was carried out, associated to the information described in the field diary. The data set was submitted to the content analysis of three major steps: pre-analysis; exploitation of the material; and treatment of results and interpretation. The data were structured in thematic categories, based on the theoretical framework adopted[1] to approach the production of subjectivity, based on macro and micro-political factors.

RESULTS AND DISCUSSION

Macro and micropolitical factors related to nurses' training environment

The institution of academic formation is an environment influenced by macro and micro-political factors that interfere in the production of subjectivity for the decision making of the Nurses. The subjectivity produced during the training of nurses points to the importance and necessity of this professional to assume the role of decision maker in the actions and practices of care. However, nursing teaching and learning practices do not always guarantee the skills to make decisions regarding the reality of care situations.

> At graduation, the importance of the nurse as a decision maker was always shown. (ENF 4)

> During graduation, you have that view that the Nurse has to decide. The Nurse must behave in a decisive way. But once we are in practice, we see that the way we are prepared sometimes is not in accordance with reality (ENF 10).

> This is important. But academic practice does not place you in decision-making situations [...]. In practice, the nurse becomes involved in decisions all the time [...]. He has to be aware of the decisions. I do not know if that is the difference of the student. In training, the need for decision making is not well developed (ENF 8).

> We are there as a trainee, volunteer, or with our own compulsory internships. You can never be and take the role of decision maker (ENF 2).

The training institutions are the main environments that determine the macro and micro-political factors of nurses' subjectivity production. Instrumentalizing and developing skills and competencies for nurses' decision-making mean producing modes of subjectivation. Everything that is produced by subjectivation, whether by language and/or technology, is not just a matter of ideas or significations, by means of statements, nor is it reduced to models of identity. These are systems of direct connection between the productive institutions of social control and the psychic instances that define the way each individual perceives the world[1].

According to the nurses, the practical activities and internships do not provide situations in which the students are provoked and stimulated to assume a behavior of decision maker. The teaching and learning methodologies in nursing involve activities exclusively in groups of students and are

focused on the manual skills, the harms the incorporation of more decisive and integral behaviors.

> In the practice of internships, we are in groups and with other colleagues. We cannot feel that we are deciding about care (ENF 2).

> It's everything done in group. That's different when you are alone. You are in a group internship; it's you and four more to get a patient [...]. I think the teacher does not make an opportunity for the student to make the decisions (ENF 3).

> That's because the current training system prepares the professional for the technical skills. [...] Now, in relation to the decision, in the relation of the team, it is complicated (ENF 12).

Academic activities in groups of students are important as they develop the perception about the interrelationships between the macro and micro-political environments of care practices. Nonetheless, the unique space of learning, territory in which internalized instances favor self-perception, facing the reality, needs to be preserved. It is these symbolic determinations that determine the singularization of the subjectivity of the individual[1], a process that allows nurses to develop a differentiated, critical, meticulous, sensitive and broad thinking for decision making.

The nursing training environment, as well as other higher education institutions, undergoes significant transformations: globalization, the information society and public health and education policies in Brazil. However, the model of health education in which higher education has been structured, and in particular Nursing, has not been able to prepare the professional to respond to these complex transformations of society. In general, educational institutions find it difficult to incorporate proposals to increase changes in the training of professionals, especially those related to the acquisition, development and evaluation of skills and abilities, essential contents, practices, internships and activities[5].

In addition, nursing academic practices are generally restricted to care from a micro perspective, studying and practicing caring for a person or group of people, not engaging with macro issues such as institutional policies and their interrelations. Thus, nursing higher education is marked by the mismatch between what is proposed in academic practices and what will be experienced in care practice, as it is much more complex, involving conflictual relations, political struggles, economic and cultural assemblages[6-7].

At the end of the 1990s, it was pointed out that a predominant way of training nurses favored the construction of productive and economically useful subjects, however, politically fragile, more molded to obedience, passivity and docility, and not to resist institutional determinations[9]. Thus, teaching and learning methodologies emerge to rescue academics from passivity, making them more active in the process of knowledge construction, in a dynamic and fruitful context of opportunities, in order to experience real situations of practice[6,8].

There is still no clear definition on competencies for nurses' training for decision making in the practice of care. A survey conducted with North American nursing students has shown that critical thinking and clinical reasoning are fundamental skills for decision making[10].

Macro and micro-political factors related to the environment of hospital institution

Some aspects associated with the organizational structure of the hospital environment are the main macro-political factors that determine the decision maker behavior of the nurses. The participants highlighted: the demands for care, the availability of material and professional resources, the physical structure of the institution and working conditions

> You are in an institution where the number of patients looking for services is great. So we work at the limit, always crowded. And this, of course, interferes with the care we offer, because our decisions need to take account of the demand, which influences our decisions (ENF 4).
> Our decisions are also influenced by something even bigger, in which our hospital, our unit, we as professionals and patients are inserted, which is the health system as a whole. [...] And, for all that, it is that our decision (ENF 7).

> It's something bigger, it's part of the economy and politics, too. And we make our decisions of

care with what the system offers for us. And that is very clear. Nursing care, which needs adequate human resources, time, materials and spaces, leaves our decisions limited (ENF 8).

The macro-political dimension of the production of subjectivity also involves everything that characterizes capitalistic modes of production. The current health system agencies the social, economic and political elements of health institutions, determining the hospital organizational structure. Thus, the ecosystem perspective emerges from the understanding of the health system as a set of services and actions that interact with each other. The constituent elements of this system are interdependent; they have influenced and are influenced by the interactions of the various levels of action, defining the social, cultural and economic structures of care settings[11]. The physical structure, the working conditions and the demand for care are aspects that determine the conditions of hospital care. These factors can influence all stages of the decision-making process, delimiting the behavior of nurses in care practices.

To understand the hospital environment from an ecosystem perspective, it is necessary to consider it as a social and dynamic system, composed of a diversity of interrelated elements. Hospital institutions can be considered as open systems, in which there is interaction and dependence on public policies, departments, areas, productive units, workers, patients and other individuals who share this environment[11].

In this sense, the notion of subjectivity totally renounces the idea that society and the phenomena of social expression are the result of a single cluster or sum of individual subjectivities. On the contrary, it is individual subjectivity that results from a criss-crossing of collective determinations of various species, not only social, but economic, technological, media, and so many other processes of the collective constitution that are results of confrontation with the ways in which, On a planetary scale today, subjectivity is produced[1].

The relationship between the nurse and the patient is presented as a micro-political factor of the production of subjectivity. The professionals emphasize that the behavior of the patient interferes directly in the decision-making behavior of the nurse. If, on the one hand, the patient's involvement and interest, based on questions and suggestions, make it possible for the nurse to participate in the decisions of the care actions, on the other hand, the patient's passive and alienated behavior causes the nurses to exclude themselves from sharing decisions.

> Sometimes the patient is very passive. You're the professional who knows him. He does not stand or question. And for us, it's so comfortable. [...] You do what you have to do. When you are faced with that patient that causes you to question yourself, then the decision-making process is different, because you can think about it (ENF 5).

> The behavior, in front of our decisions, is also influenced by the socioeconomic and even intellectual level of the patient. The decisions are different, not in the sense of privileging one or the other. Our position, for example, with the patient who has economic difficulty... He usually does not question anything, he has no doubts, he accepts everything. So our care decisions are being made without her involvement (ENF 10).

> I worked on the health insurance plans. And there, it's a very different decision-making. First, in general, it is the intellectual level of the patient and that patient of the SUS. In the SUS, I have a posture: if they ask me or are interested I try to inform. But in the health plan, the patients are more interested and demanding and this differentiates their posture, interfering in our decisions (ENF 11).

The alienation of the patient may be associated with their socioeconomic and intellectual level. According to the nurses, the patients belonging to the most favored social classes, economically and/or intellectually, present demands, in relation to the care received and, thus, greater possibility of participation in the decisions.

In many situations, professionals are resistant to share the care plan[12]. A Brazilian study, whose objective was to analyze the roles of nurses and patients in the decision making process, focused on three fundamental concepts: health, autonomy and shared clinical decision. As a result, the perspective of opposition to the paternalistic model of health care, still in force at the national

level, that neglects information and the consent of the clients to the implementation of health care has emerged[13].

Those who have been called "social workers" act in some way in the production of subjectivity. All those who occupy a position in the field of social work find a fundamental micro-political crossroads[1]. An example of this is the normativity that is placed on the conception of health, a set of rules and lifestyles that prevent the subject from acting autonomously on his body.

Throughout history, nurses have been involved in the governance of individual bodies through the production and idealization of subjectivities, from the establishment of norms for the "good patient" and the "healthy citizen"[14] However, the characteristics and singular desires allow the nurse to produce care relationships and to create ways of caring, modes of reference and their own cartographies[1].

The relations between nurses, nursing technicians, physicians and other health professionals determine the micro-political factors of the production of subjectivity. The sharing of the environment and care actions with other professionals is represented as a relational system in which the nurse is influenced and also becomes a vector that focuses on the decision-making processes of other professionals.

> Everyone brings their own knowledge. But we, as a nurse, influence the attitudes and behaviors of team and the team will influence our decision process [...] (EN 7).

> The professionals who work in the unit also influence. We cannot say that the medical part does not influence our decisions (ENF 2).

> Yes. There are two ways to influence our decisions. I feel that, specifically, the medical professional exerts a certain power over us ... The second way of influencing, which are other professionals, such as physiotherapists, who are in the same line of power as we are [...] Other professionals, pharmacists, Nursing technicians, hygienists and maintenance, in the sense that we exercise power and more influence over them. And all this changes our way of acting. And we are, rather, influenced in our decisions by these professionals (ENF 5).

In the discussion among nurses, it is possible to identify that power relations among professionals constitute the main micro-political factor of the production of subjectivity for decision making. The medical category exerts power over the nurse's decision-making, while the nurse exerts power over the behaviors and decisions of the other professionals who share the care environment.

In decisions of an interdisciplinary nature, most of the time, the nurse appears as a passive subject, without considering that all the therapeutic behaviors are, intimately, linked to the practice of care. This subjectivity, shaped by obedience and productivity, does not only affect the body, but the soul of these subjects, in a pretended uniformization of their way of being, feeling, perceiving, desiring, and finally, wanting to be a nurse[9].

When they do not exercise resistance against the use of power, nurses participate in their own oppression, exhibiting a tendency to perceive themselves and to feel extremely dependent on their superiors or on those who psychologically project some of their better parts and more competent. Thus, it is perceived that some subjective characteristics of submission and obedience are still absorbed by professionals[14].

Macro and micro-political factors that prevail in the intensive care unit

In the hospital environment, the intensive care unit presents specific organizational aspects that determine the decision-making behavior of nurses. In the debate among the participants it was evident that the intensive care unit is an environment in which the organization of work allows a constant interaction among health professionals; materials and technological resources are available; and the professional dimension is always adequate for the care demands.

> The environment and the physical space influence. There are some spaces that influence you to decide all the time, mainly, those who work in the ICU (ENF 1).

> This context constantly requires me to decide. I may have a patient in a critical situation and this may have a need or more that is not critical. But in general, in this context, it is always decided what to do (ENF 11).

> Within the ICU, care will cause you to take

attitudes and behaviors that need decision making, continuously. It is the closest to the patient, you see him. You're not at the nursing station with that hall around you. You have that close environment, which is characteristic of the ICU and you will directly see your patient. This forces you to have a greater perception (ENF 2).

In the ICU, you have all these stimuli: you are closer to the patient and you can organize yourself. And, on the unit, you do not have it (ENF 6).

This makes sense because after going to the ICU, I feel like another professional. I learned to question myself, to position myself and to seek more knowledge because, there, I needed to take and put into practice my decisions (ENF 10).

These characteristics of the intensive care unit subsidize the production of subjectivity, in which the nurse develops the capacity for accurate perception in all stages of decision making. Different perspectives are pointed out in relation to the other hospital units, which present the configuration of "open" units.

In open units, you cannot have continuous contact with patients. Routine does not allow you to do it. [...] Even though it is a priority, sometimes decisions about nursing actions are not prioritized (ENF 5).

In the open unity, I see myself in this way: I get involved in many other things that would not be specifically to do them. Another professional could do it, because I, as a Nurse, would not have to get involved. And I could do other things like receiving the patient, otherwise, at least to do the anamnesis. So, because of these other things, I quickly get the patient, I see what he has, where he came from and where he goes (ENF 4).

In the hospitalization units, there is decision making, but in a smaller perception, because there is too much that is left for me to do, it goes beyond care. And this decision is not surrounded by questioning (ENF 2).

The unit of therapy is an environment that presents some characteristics differentiated, in relation to the other units of the hospital institution. Other hospitalization and care units are given characteristics that, according to the nurses, do not provide sufficient stimuli for the development of an accurate perception for

decision making. In these "open" units, the involvement in other managerial activities does not allow nurses' decisions to be, prioritized, directed toward caregiving actions.

The units or sectors also form a set of open systems, which are part of the hospital institutional system; however, they present specific characteristics, in relation to the purpose, physical structure, health workers and patients, factors that shape the organization of these environments. In addition, the proximity to the patient in a critical situation of life in the intensive care unit becomes a factor that sensitizes and stimulates the development of the perceptive sense of the nurse, about the problems and needs of care[14].

Specifically, the intensive care environment presents some characteristics that may influence the production of a singularized subjectivity of the nurse. The professional who works in intensive care experiences a set of practices of governability, which establish ways of being a nurse and caring, favoring the incorporation of autonomy and the capacity to choose. In this way, the nurse is no longer just a task-taker and starts to have a position of equality with the other components of the health team[15-16].

Thus, considering the macro and micro-political factors of the subjectivity production, the question is: How to produce subjectivity for nurses' decision-making in care practices? The answers to this question may emerge from the ecosystemic perspective of nurses' subjectivity production, with the understanding that the organization of human behavior is linked to a set of production systems that configure identity, ego, and code compliance of a micro-society and the laws of a society.

In addition, it is necessary to understand the creative and respectful relationships that allow the organization of a division of labor and produce, both materially and subjectively, the conditions of a collective life and, at the same time, singling out[1].

FINAL CONSIDERATIONS

The macro and micro-political factors of nurses' subjectivity production are conditioned by environments, and their physical and relational structures, in constant interaction and

interdependence. Thus, it can be affirmed that nursing care has an ecosystemic perspective. And, it is in this set of environments that the nurses' subjectivity is produced.

From the installation of new modes of production of subjectivity, nurses will be more instrumental to refuse all the pre-established modes for decision making. Regarding this aspect, nurses who participated in the study expressed the need to consolidate political spaces for professional meetings and discussions in hospital institutions.

Linkage and participation in trade unions and professional councils are important mechanisms to guarantee the rights and the expansion of the space of nursing action. The focal meetings allowed reflection, self-knowledge, self-perception, perception of the other, and the hospital institution. A perspective which is not (self) proportionate in the daily work of the nurse.

PRODUÇÃO DE SUBJETIVIDADE DO ENFERMEIRO PARA TOMADA DE DECISÕES: PERSPECTIVA ECOSSISTÊMICA

RESUMO

Objetivou-se analisar os fatores macro e micropolíticos da produção de subjetividade do Enfermeiro que subsidiam a tomada de decisões no processo de cuidar da Enfermagem. Foi adotado o delineamento qualitativo de pesquisa. O cenário investigativo foi um hospital filantrópico do Estado do Rio Grande do Sul. Os participantes do estudo foram doze Enfermeiros atuantes nessa instituição. Para a coleta de dados, foi utilizada a técnica do grupo focal, com três encontros focais, realizados em dezembro de 2011. Adotou-se a análise de conteúdo. Foram identificados fatores macro e micropolíticos da produção de subjetividade que subsidiam a tomada de decisões. Esses fatores estão associados aos ambientes que envolvem a instituição de formação acadêmica do Enfermeiro, a instituição hospitalar e as unidades de internação. Esses resultados permitem uma aproximação do processo de produção de subjetividade do Enfermeiro com uma perspectiva ecossistêmica da prática de cuidados.

Palavras-chave: ursing. Nursing care. Decision making. Focus groups.

PRODUCCIÓN DE SUBJETIVIDAD DEL ENFERMERO PARA TOMA DE DECISIONES: ENFOQUE ECOSISTÉMICO

RESUMEN

El objetivo fue analizar factores macro y micro políticos de la producción de la subjetividad del Enfermero en su toma de decisiones en el proceso del cuidado de la Enfermería. Se adoptó un diseño de investigación cualitativa. El escenario de la investigación fue un hospital filantrópico en el estado de Rio Grande do Sul, Brasil. Los participantes del estudio fueron doce Enfermeros que trabajan en esta institución. Para la recolección de datos, se utilizó la técnica de los grupos focales, con tres reuniones realizadas en diciembre de 2011. Se adoptó el análisis de contenido. Fueron identificados factores macro y micro políticos de la producción de la subjetividad que apoyaron la toma de decisión. Estos factores están asociados a los ambientes que involucran la institución de formación académica del Enfermero; la institución hospitalaria y las unidades de internación. Estos resultados proporcionan una aproximación al proceso de producción de la subjetividad del Enfermero con un enfoque ecosistémico de la práctica de la atención.

Palabras clave: Enfermería. Atencíon de enfermería. Tomada de decisione. Grupos focales.

REFERENCES

1. Guattari F, Rolnik S. Micropolítica cartografias do desejo. Petrópolis, RJ: Vozes; 2010.

2. Lausten G. Enviroment, Ecosystems, and Ecological Behavior – dialogue toward developing nursing ecological theory. ANS. 2006; 29(1):43-54.

3. Zamberlan C, Medeiros AC, Svaldi JD, Siqueira HCH. Ambiente, saúde e enfermagem no contexto ecossistêmico. Rev Bras Enferm. 2013; 66(4):603-6.

4. Dall'Agnol CM, Magalhães AMM, Mano GCM, Olschowsky A, Silva FP. A noção de tarefa nos grupos focais. Rev Gaúcha Enferm. 2012;33(1):186-90.

5. Colenci R, Berti HW. Professional development and entering the labor market: the perceptions of nursing graduates. Rev Esc Enferm USP. 2012; 46(1):158-66.

6. Trevisan DD, Minzon DT, Testi CV, Ramos NA, Carmona EV, Silva EM. Formação de enfermeiros: distanciamento entre a graduação e a prática profissional. Cienc Cuid Saude. 2013; 12(2):331-7.

7. Trevisan DD, Minzon DT, Testi CV, Ramos NA, Carmona EV, Silva EM. Formação de enfermeiros: distanciamento entre a graduação e a prática profissional. Cienc Cuid Saude. 2013; 12(2):331-7.

8. Chiamenti C, Fonseca AD, Fernandes GFM, Vaghetti HH. Tendências tecnológicas na práxis educativa da enfermagem e sua interface com a organização do trabalho. Cienc Cuid Saude. 2012; 11(4):832-7.

9. Lunardi VL. História da enfermagem: rupturas e continuidades. Pelotas: Ed. Universitária; 1998.

10. Campbel ET. Gaining Insight into Student Nurses' Clinical Decision making. Process. Aquichan.2008; 8(1):19-32.

11. Svaldi JDS, Siqueira HCH. Ambiente hospitalar saudável e sustentável na perspectiva Ecossistêmica: contribuições da enfermagem. Esc Anna Nery. 2012; 14(3):599-604.

12. Kavanaugh K, Moro TT, Savage T, Reyes M, Wydra M. Supporting Parents' Decision Making Surrounding the Anticipated Birth of Extremely Premature Infant. J Perinat Neonatal Nurs. 2009; 23(2):159-70.

13. Campos DCF, Graveto JMGN. The role of nurses and patients' envolvement in the clinical decision-making process. Rev Latino-am Enferm.2009; 17(6):139-45.

14. Busanello J, Lunardi Filho WD, Kerber NPC, Lunardi VL. Modos de produção de subjetividade do enfermeiro para a tomada de decisões. Rev Bras Enferm. 2014;67(3):422-9.

15. Busanello J, Lunardi Filho WD, Kerber NPC. Produção da subjetividade do enfermeiro e a tomada de decisão no processo de cuidar. Rev Gaúcha Enferm. 2013;34(2):140-7.

16. Silveira RS, Martins CR, Lunardi VL, Vargas MAO, Lunardi Filho WD, Avila LI. A dimensão moral do cuidado em terapia intensiva. Cienc Cuid Saude. 2014; 13(2):327-34.

Corresponding author: Josefine Busanello. Rua Dr. Maria, Nº 1921, Bela Vista, CEP: 97501768, Uruguaiana/RS. E-mail: josefinebusanello@unipampa.edu.br