Collegiate management in inpatient pediatric unit from health professionals' perspective#

Gestão colegiada em unidade de internação pediátrica na perspectiva de profissionais de saúde

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Abstract

The hospitals make up the tertiary level of Health Care Network, which include sets of procedures in the context of the Health System, it involves high technology and high cost and integrates other health care levels. Thus, the establishment of a network of services implies a new management model whose assumptions are focused on the quality of care at different levels of health care. One of management models that favor decentralization and participation of professionals is a model of collegiate management. Thus, the objective of the study was to know the collegiate management from the perspective of professionals in a pediatric unit of a university hospital. For this, a qualitative research, analytical and descriptive was conducted with 16 professionals from different categories of of a university hospital. The data collection took place through interviews with semi structured script, which were submitted to content analysis. It was noticed that professionals consider that the collegiate management has barriers they are lack of communication between professionals and between them and the directors; infrequent meetings; lack of transfer and sharing of information and the participation of the directors and difficulty of performing the teamwork. In contrast, the teamwork is effective in multidisciplinary projects. We conclude that the collegiate management happens in a corporatist and undemocratic means, demonstrating the need for transformation of the organizational culture for it to be participatory.

Keywords: Health Services Administration; Health Manpower; Hospital administration.

Resumo

Os hospitais compõem o nível terciário da Rede de Atenção à Saúde, os quais englobam conjuntos de procedimentos que, no contexto do Sistema Único de saúde, envolve alta tecnologia e alto custo e integra os demais níveis de atenção à saúde. Dessa forma, a constituição de uma rede de serviços implica um novo modelo de gestão cujos pressupostos estejam voltados para a qualidade da assistência nos diferentes níveis de atenção à saúde. Um dos modelos de gestão que favorece a descentralização e a participação dos profissionais é o modelo de gestão colegiada. Assim, o objetivo do estudo foi conhecer a gestão colegiada na perspectiva de profissionais de uma unidade de internação pediátrica de um hospital universitário. Para tal, foi realizada uma pesquisa qualitativa, analítico-descritiva com 16 profissionais de diferentes categorias de um Hospital Universitário em Minas Gerais. A coleta de dados deu-se por meio de entrevistas com roteiro semiestruturado, as quais foram submetidos à Análise de Conteúdo. Percebeu-se que os profissionais consideram que a gestão colegiada possui entraves, são eles: falha na comunicação entre os profissionais e entre eles e a diretoria; reuniões pouco frequentes; falta de repasse e compartilhamento das informações e de participação da diretoria e; dificuldade de realizar o trabalho em equipe. Em contrapartida, o trabalho em equipe é efetivo nos projetos multiprofissionais. Conclui-se que a gestão colegiada acontece em um meio corporativista e pouco democrático, demonstrando a necessidade de transformação da cultura organizacional para que ela seja participativa.

Palavras-chave: Administração de Serviços de Saúde. Recursos Humanos em Saúde. Administração hospitalar.

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INTRODUCTION

In the twenty-first century, market demands and the constant search for quality, efficiency and effectiveness in healthcare practices, both in public and in private spheres, have required innovations in health management models[1].

Hospitals, especially the public ones, have been reorganized in order to meet the requirements of the Health Care Network (HCN), establishing the integration of this level of care with other health services[2]. The tertiary level of the health care network has the hospital care as a reference for the health care of the population, which can be understood as a set of procedures that, in the context of SUS, involves high technology and high costs, aiming to provide population access to qualified services, integrating them to other health care levels[3].

Thus, the establishment of a network of services implies a new system, political, cultural, cognitive and technological changes in all services involved in SUS [1]. These changes are based in a practice focused in the quality of care at different levels of health care. In this sense, the integration between hospital care and other network services has contributed to a new configuration of hospitals as an open system, which suffers the action of the environment, being influenced by developments and changes in all social fields, becoming a multi-disciplinary space for interaction with society[4].

Regarding SUS, it is suggested that organizations as an open system to broaden the perspective of management models, encouraging the participation of workers in decisions related to the execution of their work[5], i.e., setting what is called collegiate management. However, the effectiveness of management models that focus on participation depends on the construction of democratic and integrated culture in the organization, involving changes in the forms of relationships of people, socialization of information, sharing of knowledge, power and integration among professionals.

These characteristics are contrary to hegemonic, centralist and corporatist culture, with the physicians prevailing and governing over the other professions[6], which is still a reality of Brazilian hospitals, either public or private.

The collegiate management is a management model that favors decentralization and participation of professionals and has been implemented in many health public organizations in Brazil. It changes the traditional pyramidal organization model, leveling it through the creation of production units with autonomy in their planning and more integrated with senior management[5]. Each production unit has a board with representatives from each professional category, searching for the planning and evaluation of services, integrated with senior management [8].

The first formulations of this management model were systematized by members of the Management and Health Planning Laboratory of the State University of Campinas and were implemented in many hospitals[7]. In the early formulations, the central concern was the participation of workers in the collegium, aiming to constitute collective spaces for discussion of better practices for the care of users, considering their different views and interests[8].

Despite evidence of improvements in management of hospitals that implemented the collegiate model, such as the speed of process, the integration of work teams and participation in management by the professional categories have not been identified[10]. Through these analyzes, it is highlighted that all management process should be dialogical, consider people and pursue specific strategies for a minimal consensus regarding the proposed change of organizational culture, and not only in structural change of the organization [10,9].

In this regard, these strategies must be built as a team, which demands multidisciplinary research, considering the various dimensions of organizational dynamics such as management practices, their communication mechanisms and symbols[11]. Moreover, there is the need to know the views of health professionals about their participation in decision-making in hospitals as permanent strategies for building a democratic culture, which reinforces the need for studies on the dynamics of relationships in the daily work management[9].

In view of the above considerations, authors of this study sought to answer the following guiding question: which is the professionals'

opinion of the implanted collegiate management model in the pediatric unit where they work? Thus, the aim of this study was to know the collegiate management from the perspective of professionals in a pediatric unit of a university hospital. This study may contribute to developing strategies and new studies for culture awareness in hospitals and to strengthen the collegiate management.

METHOD

This is a descriptive study of qualitative approach. Authors chose this type of study because of the dynamic, subjective and social aspects involved in the management of the daily work that go beyond the quantitative data. Such an approach not only seeks to highlight the data, but also analyze them in depth, understanding the dynamics of relationships and contributing to new discussions[12]. The qualitative method of health research seeks to understand the subjectivity of the problems that arise from everyday reality, which is portrayed by the meanings, beliefs, values and attitudes expressed by the subjects[12].

This study was conducted at the Pediatric Unit of a University Hospital. The University Hospital advocates the integration between care, education and research. These features, associated with the wide range of professional groups and experts, make the said hospital a reference in health care in the public service, which makes it complex to manage. Thus, it is a prime location for a deeper study of this object.

Participants were 16 professionals working in the pediatric unit, being: two psychologists; an occupational therapist; a social worker; a physical therapist; a speech therapist; a nutritionist; two physicians; two nurses and; five nursing technicians. The professionals were randomly selected, provided they met the following inclusion criteria: representing the different professional categories working in the unit, being working in the unit regardless of the work shift. Professionals who were on leave, on vacation or enjoying day off were excluded. The number of subjects was defined during the research according to the data saturation criterion[12].

Data collection occurred from July to September 2010 through interviews guided by semi-structured script, recorded and performed individually. The semi-structured script allows the interviewee to discuss the proposed theme without pre-established conditions by the researcher[12]. The interviews were identified by the acronym representing each professional category, so "N" for nurses; "NT" for nursing technician; "SW" for social workers; "P" for a psychologist; "OT" for occupational therapist; "PT" for physical therapists; "ST" for speech therapists; "NU" and to nutritionist; "PH" for physicians. Also, the number corresponding to the participant and to the interview order by professional category was added to the letters.

The data were subjected to content analysis[13], comprising the stages of pre-analysis, material exploration and treatment of results, inference and interpretation. The pre-analysis involved transcribing the interviews in full, the initial reading and the organization of the material. The material exploration involved the coding and categorization in which the raw data were transformed into data with meaning. And the treatment of results, inference and interpretation aimed to extract meaning from the data and to compare them with the literature.

After these phases, two themes emerged: challenges of participatory management in a collegiate management model and difficulties in building teamwork.

As for the ethical aspects of the research, the project was approved by the Ethics Committee of UFMG (0054.0.203.000-10) in accordance with the Resolution of the National Health Council 466/12 that discusses the regulatory guidelines and standards on research involving human beings of the Ministry of Health[14].

RESULTS AND DISCU SSION

The data were presented and discussed according to the themes defined in the data analysis.

Challenges of participatory management in a collegiate management model

It was observed by the speeches that collegiate management is a challenge to be faced by managers and professionals in the hospital context. One of the main barriers identified in the management process relates to failures in communication, with emphasis on the conduction of meetings and their interference in decision-making. It is noteworthy that gaps in information-sharing of processes hinder communication between the teams and generate disinterest in the professionals to participate effectively in the processes, which impacts the quality of healthcare and power relations among professionals, as in th**e** example below:

> *We do not have, for example, a biweekly meeting or something like that. Often we are the last to know about the preparation for discharge. I think this makes it difficult because they come with a request: "The patient will leave today and I need so and so." But we cannot solve it. If it was previously discussed, because we have a complete logistics to contribute for the patient to be discharged. (N-1)*
>
> *In any case I go until the end working alone; we have a discussion at the beginning when we take the case, with the nutritionist with the physical therapist. The meetings are here in the pediatric unit. There is no scheduled meeting, this is rare. These are informal meetings where the speech therapy is included, right. (ST)*

With respect to management performance, other aspects reported by respondents interfere with the quality of health care, namely: the lack of people prepared to give information to users, the shift changes in written and non-verbal form, the lack of transfer of information from coordinators to professionals, the difficulty of directors in discussing the proposals of the senior management with unit managers:

> *Some decisions come from the board and there is no way to change it. We also think it is not that way, the girls complain, but as it is a decision from the board of directors, there is no way to argue, even more so because sometimes orders come from there to the entire hospital. (N-1)*
>
> *I think that there is lack of information, for example, we used to have here the shift change, now we do not have it anymore, it is written, it used to be spoken and written, you know? Sometimes, for example I forget to read, so I go to the infirmary and then there is a complication and the mother is the person who tells me, you know? So I think it would be interesting to do that spoken shift change. (NT-4)*

This report presents a contradiction in the behavior of managers and senior management with respect to what is expected in a collegiate management model, where the production units should have autonomy for their planning and management, which effective decentralization of management[9].

Furthermore, another contradictory aspect refers to the fact that the sharing of information depends on personal interests, especially of managers, and there is no culture of sharing in the organization. Moreover, it is noteworthy the fact that the transfer of information is not set up as an everyday activity in the management dynamics.

> *Information here is much discussed at the management and coordination level. If you work with a coordinator or a manager who is interested in sharing information, you have access to it, if not, you stay in the technical information level of what you have to do and what you do not have to do. (SW)*
>
> *Eventually there are meetings, but this is not a routine thing, but when there is a need, for example, there was a physician on duty here and two there in the ICU, so they changed things so that the physician could work there and here too. So these decisions were all discussed. So when there is a need in this sense, of something that will interfere with the work of everybody, then yes there are meetings, but these are random things, right? (PH-1)*

These contradictions on managers, coordinators and senior management's behavior toward expected in a collegiate management model also reflects in the behavior of some professionals who reported not being interested in participating in these meetings. Thus, it is clear that participatory culture is not yet part of

organizational dynamics. Such participation and positioning of workers in meetings also impacts on organizational communication.

Management must be considered not only as administration, but as dealing with life and with people, and must be committed not only with the care to users and democratic processes, but with the production of subjects[10]. In this sense, the training of managers and professionals for the realization of a democratic culture in the organization is fundamental.

In view of the collegiate management, one of the strategies is the strengthening of organizational communication in organizational arrangements with the decentralized and horizontal boards in order to expand the organizational democracy, with emphasis on the pursuit of participation and democratization of management focused on sharing power[4]. But this "participatory and democratic" doing requires a "break" with the classic management models and this makes the adaptation process slow and complex[15].

Miscommunication interferes directly in the management of organizations, so it is necessary to implement mechanisms to improve the dissemination of information, negotiation, cooperation and teamwork among health professionals. To this end, the horizontal and more flexible management models provide improved communication inside and between the units[16]. However, it is essential to implement a humanization policy in relationships and a culture of communication for its effectiveness. Communicative management models would be able to stimulate the work of collective participatory workers in favor of the analysis of health care quality[17].

Another aspect noticed in interviews that hinders the collegiate management refers to the occurrence of separate meetings according to professional categories, favoring the adoption of isolated decision without interaction, reflecting weaknesses in the organization of health care and teamwork. This fact occurs not only due to the existence of separate meetings, but mainly due to the lack of meetings with professionals from different categories.

> *We have meetings that are mostly made more with our category, right? Social work with social work, and sometimes in the pediatric unit there are management meetings, in which the collegium members participate and when needed, the manager calls us for the meeting, for passing information or to build some protocol, but it is not as regular, it depends on the need of the unit (SW).*

The lack of discussion, analysis and team planning harms the health care for the sake of completeness and shared management. Thus, it is a paradox in a collegiate management model, which in addition to leveling the organizational chart of the hospital and giving more autonomy to the production units and agility to work processes, it is organized by boards in the units for analysis and planning with representatives of each professional category.

However, it was noted that the functioning of the formal organization proposed by the collegiate management, without a strategy for the formation of a culture of information-sharing and decision-making, reproduces the fragmentation of management and health care[17].

In this sense, management strategies are actions that redirect work processes in more democratic and interdependent directions. Work management in health cannot be considered only in formal and technical perspective, as it mainly involves changes in relationships, processes and people[18]. Permanent education is a strategy for the reorganization of work processes and development of new relationships and behaviors of workers [18].

It is understood that the challenge to establish a collegial management model is involving subject in changes and producing changes in their behavior, i.e., new forms of intrapersonal and interpersonal relationship among them. One of the strategies for the involvement of people is creating space for expression and discussion, such as meetings between teams and collegiate managers[6].

Difficulties in building teamwork

IIn this category we point out the obstacles for the establishment of teamwork. The lack of meetings between teams of different professions in the unit under study intensifies the fragmentation of care, the corporatism of

professional categories and the weaknesses of the adopted participatory management. The difficulties pointed to teamwork are: difficulty in the relationship between professionals, the lack of recognition between different professional categories and the lack of a team composed of professionals from different categories.

Failures in teamwork, as exposed in the statements, point to difficulties in the relationships between the different categories, which are related to health care grounded in the biomedical model, which emphasizes the cure of organic diseases and medicalization. In this perspective, some respondents reported lack of recognition for the work of certain professional categories:

> *I think there are professionals who still have prejudice against psychology, which they do not yet. There are, for example, physicians here who do not know what the occupational therapy does, and also do not seek to know, right?! So, it is difficult to make a referral. (P-2)*
> *What makes it difficult is the lack of recognition for my category, occupational therapy, by some professionals, so I have to always be proving, proving. (OT)*

Professionals believe that without teamwork the service is not performed with the necessary promptness. The greatest conflict between professional categories was between the nursing and the medical staffs.

Regarding the rivalry between doctors and nurses, since the emergence of nursing, a predominantly female profession, these professionals have had to face the challenge of demarcating their territory of decision and acting in order to disentangle the "delegating power" of the medical profession, that is, the culture of traditionalism of the medical profession[19]. This constant search of nursing for autonomy as opposed to historical and cultural hegemony occupied by doctors hinders the relationship between these two categories, which impairs communication between them.

An example of the measures adopted by nurses before the medical hegemony was the creation of nursing records, separate from the other records, to facilitate the work process of nurses in face of the difficulty of negotiating with doctors due to the withdrawal of medical records by residents to study with their professors, resulting in delays and slowness in the work process of other professionals:

> *I think that the big problem here are the records, that is why we have separated the medical records from nursing records, because as there are many students, they get the record and take them to another place and then the patient needs to do an exam, we need to check something in the patient's record and we cannot do this. (N-1)*
> *In the medical record there is all the information, but there is this problem, we do not always find the records there before making the procedure because they are taken by a resident to discuss the case. (PT)*

The separation of records and the lack of meeting in multi-professional team is a throwback to the health management model with a view to comprehensiveness and humanization.

On the other hand, some professionals reported the existence of teamwork in the development of specific projects, among which there are: Adolescent Care, Palliative Care and Homecare, which are getting progress with regard to planning and therapeutic projects with teamwork. These reports were related to multidisciplinary projects that are developed with the following professional categories: Psychology, Social Work, Occupational Therapy, Medicine, Nursing, Physical therapy and Speech Therapy. These projects are considered special:

> *We have meetings, but most of the meetings and discussions are focused on the support [multi-professional] team, composed of psychologists, occupational therapists, social workers, nutritionists, nurses, administrative coordinators and managers. (SW)*
> *I think the multi-professional issue is well developed. There is an opening by physicians and other professionals too, we see that the speech therapists seek a lot for our help, we seek them a lot; we have good relationship with psychologists, with occupational therapists and generally with physicians. (NU)*

Considering the temporality of this research,

such projects are recent and respondents reported that they consider that the team is multi-professional and not inter-professional, since there is need for more integration between the professional categories so that it is considered inter-professional. Professionals also considered that the possibility of building an interdisciplinary work depends on the disposition of each professional to reformulate knowledge, which requires selflessness and openness to new knowledge.

The multi-professional work is one in which different professionals complement each other in favor of a common goal[20]. The performance should be non-systematic, independent and without functional connection between them, which can cause communication problems and contradictions with respect to the work plan. In contrast, the inter-professional work takes place simultaneously and in a coordinated manner, the work is connected, there is communication, mix of knowledge and transfer of concepts from one specialty to another. So, it prioritizes teamwork so that different professionals recognize and respect each profession. Thus, the multi-professsional work takes place so that professionals are more independent of each other, as opposed to inter-professional work, in which interconnection is essential.

Thus, with regard to work in inter-professional team, one of the goals of the collegiate management model is to end the "body of professions" in the hospital, that is, with the corporations[7]. However, corporations, with their power struggles, resist to changes in daily work by the difficulty in sharing power [9].

From the foregoing, it is understood that the biomedical model culture in hospitals brings up the roots of a hegemonic model permeated by relations of domination that determine complex, stressful and power relationships among health professionals, demarcating permanent spaces of negotiations and conflicts of interests[21].

Regarding the formation of corporatism, the unique characteristics of work processes between professional categories reinforce corporations and resistance to change[9]. This is due to aversion to power-sharing that is necessary to build flattered relationships that would enable effective work in inter-professional team.

Thus, it is noted that the effectiveness of collegiate management requires strategies for involvement and permanent training of professionals and managers for changes in culture and organizational structure and especially in people.

FINAL CONSIDERATIONS

Knowledge of collegiate management in the perspective of professionals in a pediatric unit of a university hospital led authors to realize that the dynamics of a multi-professional work has been a barrier to a democratic work process, especially with regard to the dominance of the biomedical model that divides the work organization according to the professional category. Therefore, there is priority of formal meetings separated by professional category at the expense of meetings with the multi-professional team for the preparation of therapeutic projects.

In this sense, it is understood that even with the hospital's investment over many years in the improvement of labor management, including improvements in management after the implementation of the collegiate management model, it is still observed a corporatist and undemocratic culture.

Professionals' behavior within the institution of both the staff and managers is still not consistent with what is expected in the collegiate management model, showing the need for transformation of the organizational culture from the knowledge of local culture and strategies for training of professionals and managers.

This study also enabled an analysis of the researched inpatient unit and raises questions for further studies, such as the creation of devices for intervention in the organizational culture in favor of the team's integration and participation in management, considering the power relations between health professionals, among others. Authors also emphasize the relevance of new investigations in other scenarios, considering the diversity in the nature of hospitals and their regional contexts.

REFERÊNCIAS

1. Brito MJM, Alves M, Montenegro LC. Relational Experiences of Power and Gender for Nurse-Managers of Private Hospitals. Rev Latino-am Enfermagem 2010; 18(5): 952-959.
2. Mendes EV. As redes de atenção à saúde. Brasília: Organização Pan-Americana da Saúde; 2011.
3. Costa PRB, Panozzo VM. Assistência à saúde nos serviços de alta complexidade no brasil: uma experiência de trabalho do assistente social. Revista ampliar 2015. 2(2): 1-21.
4. Bonato VL. Gestão da qualidade em saúde: melhorando assistência ao cliente. O Mundo da Saúde 2011; 35(5): 319-331.
5. Alessandra Bassalobre Garcia 1 , Vanessa Gomes Maziero 2 , Fernanda Ludmilla Rossi Rocha 3 , Andrea Bernardes 4 , Carmen Silvia Gabriel 5. Influência da cultura organizacional na gestão participativa em organizações de saúde. J. res.: fundam. care. online 2015. abr./jun. 7(2):2615-2627
6. Campos GWS. Cogestão e neoartesanato: elementos conceituais para repensar o trabalho em saúde combinando responsabilidade e autonomia. Ciênc Saúde Coletiva 2010; 15(5):2337-2344.
7. Campos GWS, Rates SMM. Segredos e impasses na gestão de um hospital público. Rev Médica de Minas Gerais 2008;18(4): 279-283.
8. Bernardes A, Cecílio LCO, Évora YDM, Gabriel CS, Carvalho MB. Modelo de gestão colegiada e descentralizada em hospital público: a ótica da equipe de enfermagem. Rev. Latino-am Enfermagem 2011; 19(4):1003-1010.
9. Cecílio, LCO. Colegiados de gestão em serviços de saúde: um estudo empírico. Cad. Saúde Pública 2010; 26(3): 557-566.
10. Campos GWS. Saúde, Sociedade e o SUS: o imperativo do sujeito. Saúde e Sociedade 2009; 18 Supl 2:24:34.
11. Fleury MTL. O desvendar a cultura de uma organização: uma discussão metodológica. In: Fleury MTL, Fischer RM. Cultura e poder nas organizações, 2.ed. São Paulo: Atlas; 2009.
12. Minayo MCS. O desafio do conhecimento; pesquisa qualitativa em saúde. 13 ed. São Paulo: Hucitec; 2013
13. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2011.
14. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Resolução nº. 466 de 12 de dezembro de 2012. Brasília: Ministério da Saúde; 2012.
15. Bernardes A, Cecílio LCO, Nakao JRS, Évora YDM. Os ruídos encontrados na construção de um modelo democrático e participativo de gestão hospitalar. Ciênc Saúde Coletiva 2007; 12(4):861-70.
16. Santos MC, Bernardes, A. Comunicação da equipe de enfermagem e a relação com a gerência nas instituições de saúde. Rev. Gaúcha Enferm 2010; 31(2):359-66.
17. Rivera FJU, Artmann E. Planejamento e gestão em saúde: histórico e tendências com base numa visão comunicativa. Ciênc Saúde Coletiva 2010; 15(5):355-65.
18. Medeiros AC, Pereira QLC, Siqueira HCH, Cecagno D, Moraes CL. Gestão participativa na educação permanente em saúde: olhar das enfermeiras. Rev.bras.enferm. Brasília. 2010; 63(1):38-42.
19. Faria L, Santos LAC. Saúde e enfermagem na primeira república. In: Anais do IV Encontro de Professores e Pesquisadores de História da Enfermagem no Rio de Janeiro: IV Mostra da Produção Científica da História da Enfermagem no Rio de Janeiro; Rio de Janeiro: UNIRIO, PPGENF, Laphe. 2006.
20. Nogueira JWS, Rodrigues MCS. Comunicação efetiva no trabalho em equipe em saúde: desafio para a segurança do paciente. Cogitare Enferm 2015; 20(3): 636-640.
21. Cecilia LCO, Carapinheiro G, Andreazza R. Os mapas do cuidado: o agir leigo na saúde. São Paulo: Hucitec; 2014.

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