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The opacity of nursing work and configurations of risk

La opacidad del trabajo de enfermería y las configuraciones del riesgo

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ABSTRACT The article aims to reveal the invisibility of nursing work and the individual and collective strategies established to face the labor risks of attending psychiatric patients in situations of crisis. The theoretical-methodological approach combined ergonomic analysis with ergology contributions, examining in 2012 a team from an emergency unit of a Brazilian public psychiatric hospital composed of 17 nurses and two doctors (the director and medical coordinator of the unit). The results revealed that user care is strongly characterized by teamwork, especially in the confrontation of the knowledge of doctors and nurses, and is often mediated by other professionals such as social workers, administrative staff, and entrance guards. In this way, the health team extends beyond the care staff to include support services as well. It was also evidenced that this construction is effective in day-to-day work and requires skills for cooperation as well as the development of collective abilities.

KEY WORDS Psychiatric Nursing; Occupational Risks; Occupational Exposure; Brazil.

RESUMEN El artículo tiene por objetivo revelar la invisibilidad del trabajo de enfermería y las estrategias individuales y colectivas instauradas como posibilidades de regulación del personal de enfermería frente al riesgo laboral de asistir al paciente psiquiátrico en situación de crisis. Desde un enfoque teórico metodológico que combinó el análisis ergonómico del trabajo con aportes de la ergología, se investigó y analizó, en 2012, a un equipo del centro de atención de crisis de un hospital público psiquiátrico brasileño, compuesto por 17 enfermeros y dos médicos (director y coordinador del sector). Los resultados revelaron que la asistencia a los usuarios está fuertemente caracterizada por el trabajo en equipo, especialmente en la confrontación de saberes del personal médico y de enfermería, mediada, muchas veces, por la intervención de otros trabajadores como los asistentes sociales, el personal administrativo y el portero. Es decir, el equipo se extiende más allá del cuerpo asistencial involucrando también al servicio de apoyo. Se evidenció también que esa construcción se efectúa en el día a día del trabajo y requiere competencias para la cooperación, además del desarrollo de habilidades colectivas.

PALABRAS CLAVES Enfermería Psiquiátrica; Riesgos Laborales; Exposición Profesional; Brasil.

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INTRODUCTION

This article is based on a larger research study titled *O agir competente como estratégia de gestão do risco de violencia no trabalho: o ponto de vista da atividade humana de trabalho dos técnicos de enfermagem de uma instituição pública psiquiátrica*,[1] which was conducted in the psychiatric emergency unit of a public hospital and focused on the risks and grievances experienced by psychiatric patients while being assisted in situations of crisis. This research study is based on the field of knowledge production for the development of ergonomic and ergologic criteria aimed at the design and management of work systems in the health sector, including work performance conditions and the impact of work execution conditions on the health of the working population involved in mental health care, whose space and technique are undergoing a thorough structural transformation.

The paradox of rules: between necessity and insufficiency

According to Maciel and Telles,[2] the practice of risk avoidance has always been associated with the possible occurrence of unwanted events. However, "risk" is a very recent term and its conceptual definition is far from reaching a consensus.[3,4] Living forces us to inevitably bear risks in mind. Protecting ourselves from death, disease, turmoils, and business failure is not a recent strategy.[3] It is a genuinely modern concept which is involved in the reorientation of the relationships that individuals and communities establish with the events that may occur, with the aim of controlling the future. This notion arises in contrast to the concept of fate and destiny, which is related to specific contingency or ambiguity resulting from the different dynamics of the social world.

According to Mazet and Guilhermain,[5] "…risk characterizes the contingency of an unwanted (or feared) event (or situation) and its effects and consequences." Risk is the measurement of the level of danger – a qualitative concept expressing potentiality, a physical condition or situation with the potential to have unwanted consequences, such as death or physical injuries, due to their probability of occurrence, severity, and acceptability.[6]

Therefore, the concept of risk has three main components: 1) its potential for loss and damage; 2) the uncertainty of loss and damage; 3) the importance of loss and damage. Thus, risk equals the probability of damage multiplied by the magnitude of the consequences in terms of time.[7] Technological and scientific breakthroughs as well as the advances in the productive standard have contributed to this new perception of risk associated with the changes in the very nature of the resulting risks.

In order to characterize the subject matter of this research study, in this context, nursing is considered to be a historically structured practice, involving different ways of providing health care determined by the social relations established in each historical moment.[8]

At present, nursing is part of the collective work in health care, is specialized in nature, and is divided and hierarchically organized into assistants, nursing technicians, and nurses depending on the complexity of conception and execution. Although nursing has relative autonomy in relation to the other professionals, it is subordinated to the management of healthcare activities performed by doctors.[8,9]

According to Almeida,[10] nursing is part of the care process and medical work, and its performance represents an instrument of this work which will "care for" or "ensure the proper care of" the sick patient's body. Nursing observation, data survey, planning, revolution and evaluation of patients, healthcare systems, technical procedures, methods for the communication, and integration not only among patients and nurses but also among different professionals, among others, are a few of the work instruments used in this "caring" process, which shares the same purpose of the medical work: "to cure individual

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bodies." The author also mentions, as a historical and social result, the existence of another type of nursing activity, namely "management" — an activity which is not performed by all the other types of nursing workers, only by nurses. The management instruments are the patterns and methods of administration that are inherent to this activity: rules and routines, nursing labor force (assistants), permanent equipment and materials, and those used for the manipulation and administration of drugs and solutions.

In the nursing field, work is characterized by grouping factors that may pose a risk to the workers' health. Different research studies[11,12,13] have shown that the exposure to mechanical[14] and environmental risk factors, night work shifts,[15] manipulation of chemical products,[16] long working hours linked to working double shifts,[17] ionizing radiation, carrying heavy weight while attending to patients,[18] and direct contact with infected materials are further worsened due to insufficient and inadequate material resources, causing unsafe working conditions.[8]

In addition, there are psychosocial factors in nursing work that cause an increase in the rate of absenteeism and ailments suffered by the workers. According to Manetti,[20] the psychosocial factors in nursing work are related to the changes and innovations in work organization (autonomy, organizational climate, opportunities of professional growth) and violence which leads to stress, lower job satisfaction, physical and mental burnout, suffering, absenteeism, and rotation.[21]

Normalization is associated with the increasing bureaucratization of different social activities and has shown to be effective, despite criticism that the bureaucratic model does not always reflect progress and unforeseen situations at the organizational level. Rules attempt to control the ordinary procedures, and the emotion itself is rationalized from a perspective that makes subjects cling to prescribed procedures. The distance between bureaucratization and the reality of work is also a fact. The central role played by technical rationality — in this compelling and sometimes dangerous path — always combines scientific methods and procedures. Therefore, normalization forces us to be alert and vigilant in search of constant commitment to rules and regulations.

Rules and procedures are essential for the running of a modern organization and are also necessary for the management of safety when trying to track, control, and anticipate social activities. Normalization includes two entirely built-in stages: on the one hand, control and, on the other hand, explicitness. It is nothing new that written procedures not only state how tasks should be done, but also limit and control workers with regard to the tasks to be done and how they are being performed. In addition, these procedures enable the formal expression of work practices to materialize, spread, and open the debate from its foundations to, for instance, the organization levels, external collaborators, and those who control the practices.

According to Bourrier,[22] sociologists and ergonomists have long demonstrated that procedures and rules impose restrictions, but they also serve as safety and control elements against unsafe practices, insufficient rules, and inconsistent management. According to the author, "rules can bring people comfort and reduce anxieties of newness and uncertainty. It is often necessary to go beyond rules to achieve goals [...], yet they also serve as [...] guidelines when the course of action is not easy to find or too controversial." Normalization legitimizes technical rationality.[6]

From this perspective, there are insufficient rules to account for the existing unpredictability and variability of nursing work activities in the psychiatric hospital subject matter of this research study. Both the tasks themselves and the way they are carried out are invisibilized and unknown to the system managers, despite being essential for the construction of local safety (not only for workers, but also for the patients under treatment). Thus, the individual and collective skills that are developed and valued in this context need to emerge through methods which will enable these micro regulations to arise so that they may be harnessed to develop rules and provide safety.

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Boyé and Robert[23] define skills as "sets of know-how required by the tasks, which are linked to the people who implement them, recognized as such by the setting in which they are performed, and directly dependent on the sociotechnical and cultural context in which they are applied." Leplat and Montmollin,[24] in an attempt to conceptualize the term *skills*, define it as "stabilized collection of knowledge and know-how, standardized behaviors and procedures, and types of reasoning which may be applied without acquiring new knowledge." According to the authors, skills settle and organize the acquisitions of professional history and help anticipate phenomena, the implicit nature of instructions, and the variability of tasks.

Skills help to develop and use strategies to explore knowledge or cognitive and social resources in order to perform a particular action. This exploration consists of planning the action, that is, combining all the knowledge acquired, selecting and guiding the action (planning, distribution, execution, control), as well as combining knowledge derived from past experience with rational expectations about future events.[25] These interventions reinforce the idea that such actions are performed by living human beings acting in settings affected by multiple (micro)-variabilities.[26]

According to Schwartz,[27] "work is a place of complex events," that is, a problematic unit involving human activity, real working conditions, and the effective results obtained. In this sense, from an ergologic perspective, activity is always considered "an encounter [...] of a reality that is always unique,"[28] a debate about norms (preceding norms and renormalizations) driven by values and translated as the operational synthesis including the different inseparable dimensions of life. These dimensions arise in specific situations and globally visibilize the drama of human action, in which the activity is a general anthropological dimension.[29,30]

According to Schwartz,[31] it is necessary to address work as the constant movement between objectifiable environmental conditions, which expose workers to foreseeable risks that the author called "professional risks," and an enigmatic dimension, which partly reshapes human action in the workplace leading to what the author calls "occupational risks." According to Echternacht,[32] "working means managing oneself in a setting restricted by rules of a technical, organizational, and managerial nature, among production frameworks which hetero-determine the aims of human work, its tools, time, and space." However, those levels of heterodetermination do not exclude human activity in the mobilization of knowledge and values incorporated into the practices, a condition to act appropriately.

Starting from the ergonomic assumption that real work is different from prescribed work, ergology also states that completely reproducing rules is not only impossible, but also "makes life unbearable."[33] Therefore, in order to manage variabilities, one must "make use of oneself, one's abilities, resources, and choices," which are shaped into the "drama of the use of oneself." According to Schwartz and Durrive, working means taking risks and making "use of oneself."[33] According to Cunha,[26] "even obeying preexisting rules is already a way of choosing. In addition, by working in the interstices of preexisting rules, humankind makes history." These choices determine "the relationship with others or the world we want to live in."[33] If, on the one hand, working is always part of a singularization and resingularization process, on the other hand, choices are always marked by a collective dimension, an entity with a variable structure which is spontaneously established "with regard to, or in relation to the organization."[33]

If in the activity there is a melting pot of patrimonies mainly made up of skills and "know-how," renormalization is a process of invention of localized solutions that are then consolidated and transmitted for efficacy and health.[34] According to Nouroudine,[34] the areas of development of action, activity, representations, memory, consciousness, and unconsciousness may be linked among them in an instance called body-self. According to Schwartz[35]:

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> The body-self is history, history as a sedimented memory, organized in the myriad of circuits of a person, but also history as a matrix, energy producing the unknown: as long as the renormalizing ambition is simultaneously *imposed on* the self [...] and also *demanded* as a life requirement, as its own plea for health, relentlessly implementing it to attempt to transform what is objectively a medium [...] into what it may constitute *its* medium. [Own translation]

In this regard, human activities are the place of commitment of those who execute such activities. According to Echternacht,[32] to arbitrate between "one's use by oneself and by others" implies renormalizations, in which the preexisting rules will be reinterpreted with the aim of readjusting them to the individuals' needs and to the current situation.

METHODOLOGICAL ASPECTS

The methodological approach used in this research study is based on the ergonomic[36] and ergologic[37] analysis of work. A qualitative-descriptive method was used, along with analysis methodology and tools suitable to identify the main technical and organizational factors which intervene in the management of health in contextualized work and to manage, jointly with the petitioners, suggestions for the preventive adequacy of the current socio-technical and organizational systems that we applied in the analysis of hospital work.

The methodological procedures used in this research study were set up in accordance with Resolution No. 466/2012 issued by the National Health Council and approved by the Research Ethics Committees of the Universidade Federal de Minas Gerais (CAAE: 0492.0.203.287-11) and the Fundação Hospitalar de Minas Gerais (096-B/2011).

The aim of this article is to evidence the invisibility of the nursing work and the individual and collective strategies established as a possibility to control the work of nurse technicians who face occupational risks while attending to psychiatric patients, and to discuss the role played by rules in the analyzed context.

Survey and analysis of data

The collection of data in the field was conducted in 2012, at different times and situations, covering a total of 244 hours. At first, the demand and technical organizational aspects of the hospital were analyzed and the sector was defined. The selection was done through observation and self-confrontation interviews with the assistants and nurse technicians from the sector and the flowchart analysis of the patient's admission to the system, revealing that this sector is a key place for the configuration of the work process and management of risks in the remaining sectors of the institution.

At this stage, the involved doctors (the chief medical officer of the hospital and coordinator of the analyzed sector) participated, researchers mapped the demands and related them to the work systems, aiming to understand the singularity of the targeted productive contexts. Using this method, the sector and the population to be analyzed were defined. The criteria used for this choice were: 1) severity, with regard to the potential risk; 2) centrality, in terms of the conditions for the global performance of the system; and 3) accessibility, concerning the conditions for the analysis.

The participants in this research study were 19 workers: 17 assistants and nurse technicians of an emergency unit and 2 doctors (director and medical coordinator) of the Crisis Care Center in a public psychiatric hospital. Open and semi structured interviews were conducted, along with the general observation of work activities through the method of ergonomic analysis of work and data collection related to the temporal and spatial distribution of activities. Once the delimitation and focus of the study were established, researchers began a detailed analysis

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of the identified critical situations, conducted a survey of tasks (production aims, methods, productivity, and quality rules), and of the operational, interaction, communication, and cooperation demands. After the tasks were surveyed, systematic observations of the activities performed in real work situations were made and verbalizations (simultaneous and consecutive) were recorded through self-confrontation interviews and the method of ergonomic analysis of work.

The observations and validations conducted during the ergonomic analysis of work revealed the main elements that restricted and modified the operating modes and values in the hospital setting. These elements may often facilitate or hinder the collective configurations of risk management strategies or the learning procedures and their necessary updates to manage risks in specific situations. After analyzing the data and the diagnostic conclusions, the criteria for the preventive transformation of these situations were established.

Given that the aim was not to impose the analysis, the knowledge gained while working was discussed at different times and situations. Many discussions were held individually with several participants, and others in groups. The confrontation material, which was collected while observing situations, filming, or conducting the interviews, prompted a series of questions about actions and communications, bringing to light the knowledge, the values in the context, the intentionalities, and the restrictions inherent to the (im)possibility of complying with the rules.

Group discussions with the nurse technicians were held at the nursing station, at times when assistance was less needed, so that they could participate and simultaneously manage the work process. There was an attempt to hold these discussions at other times and places, but with low participation. The results were also presented, discussed, and validated with the local managers (medical coordination and nursing supervision) by giving feedback and discussing the surveyed data and submitting the written material. Once the written material was sent to the director and to the other managers to be read, it was found that not many people had participated or provided answers. A more efficient approach was that in which the data were presented orally.

The validation of the work analysis was organized in order to help build the trajectories, establish and direct the focus of observation, and confirm/reject the hypothesis formulated until then. The results of the work analysis are, therefore, the raw material of the commitments to be assumed by the actors involved who, in turn, are the authors of this process and play a part in the construction of the story.

In order to understand the activity, which is more comprehensive than the action, the act of performing a task is not enough, it is necessary to also articulate meaning, limit the perception, and focus, because the activity also includes the setting that cannot be seen. Thus, canceled, questioned, or hampered activities and their counter-activities[7] were accepted in this analysis. This stance led to the joint reflection of the researcher analyst and the actors that participated and helped reconstruct the meanings for the performance of the activity.

The work analysis along with its collective validation modifies the level and nature of the contribution of the different actors involved and enables joint decision-making while destabilizing the positions in which the different actors are isolated.

In the results and validation analysis it was observed that much of what is done in this productive environment is "invisible" to the system managers, although certain "expertise" to deal with the patient in the Crisis Care Center has been recognized. In this regard, the knowledge acquired through the analysis of specific situations cannot be detached from the use that those who contribute to the development of this knowledge can make of it, especially, because based on this stance, another form of regulation and new types of rules are made possible, which can provide a new perspective about the organization of work. This space for the restitution of results and validation may be a possible

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field to establish the different perspectives of the work relationships and their regulation, and to clarify the different "points of view" observed in the research studies about work.

ANALYSIS OF THE NURSING ACTIVITY PERFORMED WITHIN THE CONTEXT OF THE CRISIS CARE CENTER: FINDINGS

The Crisis Care Center plays a key role in this institution; it is the crucial and necessary *locus* for the management of beds and violence risks in the hospital. The role played by the Crisis Care Center in the organizational structure of the hospital, shared by different professional groups (doctors, nurses, assistants, nurse technicians, and so on) is to admit, assess, treat, and transfer to the wards (in cases requiring a more prolonged stay) those patients in situations of crisis, and to establish links with the alternative services of the mental health network, once the patient is discharged from the hospital.

When treatment must be continued after staying in the Crisis Care Center, the patient is hospitalized in the ward. There are four hospital wards, the first and second are for women, with 21 beds each, and the third and fourth are for men, with 30 beds each. The Intermediate Care Unit (IMCU) has 6 beds for clinically unstable patients. Beds in the IMCU are supplementary, when they are used, a place in the ward is reserved. In the hospital there are, therefore, 6 beds in the Crisis Care Center, 42 in the women wards, 60 in the men wards and 6 in the Intermediate Care Unit, that is, a total of 108 beds.

The flow of patients in situations of crisis, based on the organizational structure described in Figure 1, and their necessary stay in the hospital in order to stabilize their clinical conditions is extremely important, therefore, the Crisis Care Center is a strategic sector for the management of beds, the risks faced by the patients and third parties, and for the making of a diagnosis and treatment decisions. However, an increasing demand of compulsory hospitalizations was observed in this hospital and, thus, the strategies of bed and risk management were compromised.

Social transformations and significant changes in the patients' profile: risk issues

Social transformations significantly changed the patients' profile. At the time this research study was conducted, "drug addicts" accounted for 65% of the hospital demand. The patients admitted to this service were mostly dismissed as "difficult" by other institutions and, therefore, were not related to other services. Most patients were admitted involuntarily or in situations of crisis, which substantially increased the risk, mainly of physical and psychological violence, at the hospital entrance.

The violence surrounding the psychiatric patient, which has been culturally established and associated with the entire social fabric, brings about consequences regarding the way this population is seen. The psychiatric patient is stigmatized, treated as a criminal or tramp, which includes drug users and their resulting social exclusion. Violence related to hospitalization is justified as a claim demanded by the State to psychiatry and legitimized by the patient's families. Violence is established and refers to an end that lies in the future: a therapeutic perspective which is aimed at the "benefit" of the subject or that objectifies a social harmonization.

Foucault, in *Madness and Civilization: A History of Insanity in the Age of Reason,*[38] already warned about the categorization of "madness," the classifications and "scientific" therapeutics, and the resulting submission of singularity to the rules of reason and truth of the psychiatric view. According to Foucault, a network of biopowers and disciplines that constitute the social control of the mentally ill is organized.

Many times, psychiatrists are under pressure (from the State, the Courts, the police, the society, the family) to hospitalize patients, as told by a hospital psychiatrist who was interviewed:

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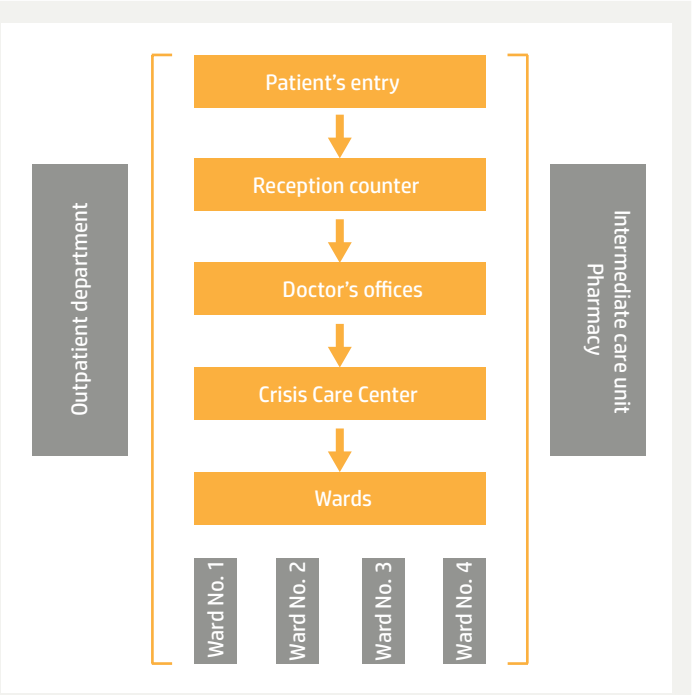

Figure 1. Healthcare structure of a public psychiatric hospital in Minas Gerais, Brazil.

Source: Own elaboration.

The Government intends to hide this population of drug users, especially crack users. As long as these patients are not a nuisance to society, they are left out there, being hidden in psychiatric hospitals. But, this is becoming a public calamity, isn't it? For instance, we are here today in our CCC [Crisis Care Center] *with a patient whose name I will not mention to keep him safe, but the claim is that besides being a crack user, he has also been stealing stuff from his own mother and threatening his family… This is a patient that has already been through the healthcare center and therapeutic units for a long time, right?, voluntarily or involuntarily. The voluntary commitment, if real, only works when the patient has been admitted to the CCC, despite having decided to leave about an hour ago, because it wasn't necessary for him to stay here with us for more than 24 hours. In order to monitor this withdrawal, the patient must stay for more than 24, 48, 72 hours. Right?, for his own safety. And he has been here since the beginning of our shift, confronting us and the social services staff hoping that he would be discharged today and that his mother would come. She had already been here yesterday and talked about how difficult it is to handle him and about other people's advice, "why don't you give up?" "It's hard for me," she said. Even though she is the victim, you see? He treats her like an object in those situations. Because that is what being a mother means, isn't it? Being supportive. So, her life project is to leave the house where other relatives live and rent a place where she can live alone with him, although he is the kind of son who steals stuff from their own house to get drugs. The family puts*

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> *pressure on her to hospitalize him, to be free once and for all. But at the same time, in addition to dealing with the situation, she wants to take care of him, to turn the situation around, while the patient wants to get out, violence erupts, and he even escapes*.

In this hospital, the main criterion for the patients involuntary or compulsory hospitalization is the notion of the risk of violence against themselves and others. The patients who are admitted bring along the badge of social stigma: "*patients who are upset, aggressive, intoxicated, dangerous, convicts, and those who have already killed or are potential killers,*" (Nurse technician 5, Crisis Care Center). The violence is also perceived in the control techniques exerted by the police, the Emergency Medical Service (EMS), and the patient's family.

Social violence against the patient has an impact on the worker's care and establishes a condition of violence risk for the working population at the psychiatric hospital, which represents the *locus* (the gateway) of the manifestation of violence. The "difficult" patient, who has been compulsory or involuntarily hospitalized, is potentially a risk to themselves and will expose other people to this risk condition. It is the working population's responsibility, especially of the nurse technicians, to manage the formative objectives (violence and the care provided to the subject/patient). As mentioned by a psychiatrist:

> ...these patients are brought to the hospital at a breaking point. They are completely broken-down, aggressive, lost. Most of the time, they are brought in by the police. The family cannot stand it anymore. They have already infringed many laws due to their disruptive behavior in the city, they have stolen from their family, and been aggressive. Very aggressive indeed. We, the assistant staff, have also suffered many aggressions and physical and psychological violence (threats to "catch" us outside). We must take care of the suffering subject and of ourselves because we do suffer as well.

It was observed that the decisions allegedly diagnosed respond to a social demand for control and normalization, in which psychiatry handles the population. It is in this symbolic set that psychiatric practice and knowledge become visible in the psychiatric hospital, which materializes the metaphor of exclusion in terms of the differences taking place in modernity.

Opacity and density of nurse technicians' work

The care work provided to users in the Crisis Care Center is strongly characterized by team work, especially in the confrontation of the knowledge of doctors and nurse technicians, often mediated by other professionals, such as nurses, social workers, administrative staff, and entrance guards, therefore, the team extends beyond the care staff to include support services as well.

The transformation of a population from different backgrounds, life stories, and realities into a unified team is not a quick and easy process. The construction of this team is achieved in day-to-day work and requires both cooperation skills and the development of collective abilities. Hence, it is important to learn from experience, not only from the daily reality of workers in the Crisis Care Center, but also from the exchange with the other members of the team, promoting a feedback of experiences and the strengthening of the group.

The observation of the nurse technicians' activities at the Crisis Care Center gave rise to various interactions which were necessary for the exchange of information, namely, the staff movements to search for medication and the transfer of patients to the wards, the survey of system data and spreadsheets of the wards, and also the different interruptions, such as answering the phone or attending to a newly admitted patient requiring urgent and immediate care. Therefore, an ongoing action is momentarily interrupted. Interactions are

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frequent, which leads to the affirmation that the activity exceeds the functionalist perspective of tasks and enables the management of the information flow in the service.

Figure 2 and table 1 show the results of the observation of a nurse technician's work in the Crisis Care Center, a professional who has 30 years of work experience in the institution. These findings also show the different activities undertaken for 84 minutes which are not officially known in the organizational structure: for the local managers those regulation strategies are "*invisible*."

Almost 51% of the time measured was used to discuss cases with the hospital's working group (doctors, nursing team, nurses and other technicians, social workers, and administrative staff in charge of admittances). The remaining time was used for the transfer of patients among sectors, patient care, data queries and recording of tasks, organization of medical records, and request of resources from other sectors. There is even a 12% of the activities which were allocated to the category "Others," due to the variety of actions performed, such as answering the phone, requesting the discharge of beds through the phone, verifying the vacancy spreadsheet, waiting, thinking, taking notes, and so on. It should be noted that 44% of the total time measured took place during the interactions between nurses and doctors – a meeting of experience-based knowledge from the day-to-day exchanges with patients in the ward (their progress, drug interactions, and risks) with the specialized knowledge of doctors and nurses.

Figure 2 aims to show the constant activity of nurse technicians in their daily routine of anticipations, transfers, and exchange of information in order to manage their own and others' activities in a permanent search for work efficiency. The collection of information shown in the graphic was conducted during the morning shift, at a peak time in their work, namely, bed management, group discussions of possible discharges, admittances, new decisions adopted, and referrals, while anticipating the new patient admittances in the afternoon shift. If beds were not

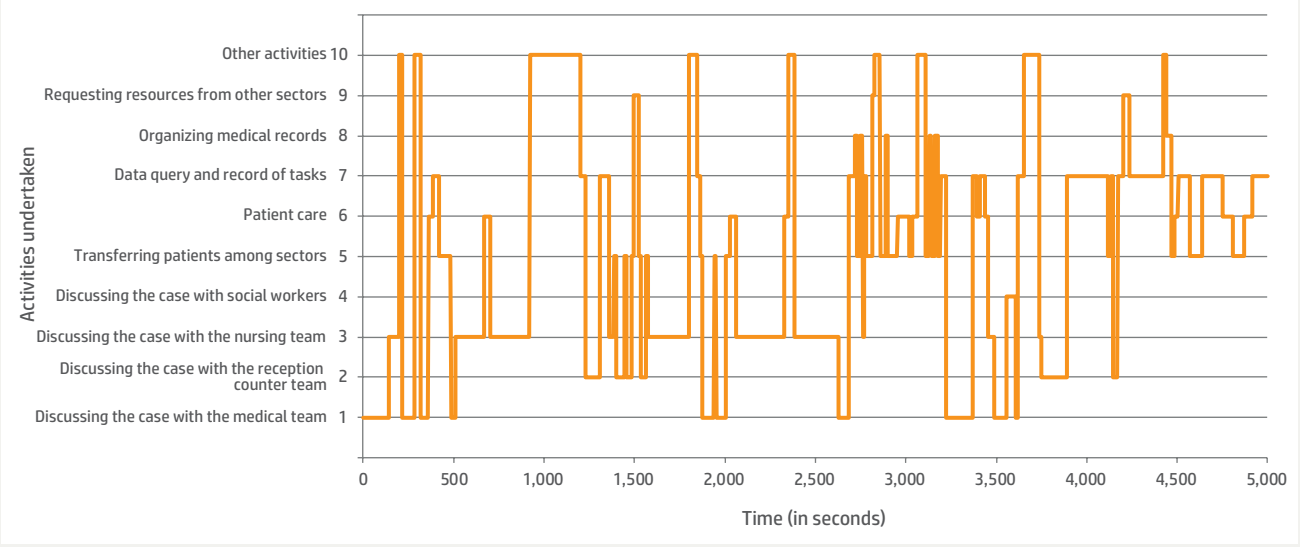

Figure 2. Activities undertaken for 84 minutes by a nurse technician from the Crisis Care Center. Minas Gerais, Brazil.

Source: own elaboration.

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Table 1. Activities undertaken by a nurse technician from the Crisis Care Center. Minas Gerais, Brazil.

Activities	Analyzed time		
	Seconds	Minutes	%
Discussing the case with the medical team	680	11.33	13.60
Discussing the case with the reception counter team	346	5.77	6.92
Discussing the case with the nursing team	1513	25.22	30.27
Discussing the case with social workers	54	0.9	1.08
Transferring patients among sectors	537	8.95	10.74
Patient care	376	6.27	7.52
Data query and record of tasks (nursing record, IHMS system, and vacancy spreadsheets)	736	12.27	14.72
Organizing medical records	94	1.57	1.88
Requesting resources from other sectors	70	1.17	1.40
Other activities	593	9.88	11.86
Total	4999	83.33	100.00

Source: own elaboration.

freed up by the time patients were potentially admitted in the afternoon, this would be a significant setback for the team and would increase the risk at the main entrance, because of the chances of a patient resisting admittance.

> A significant part of the time was primarily used to discuss cases with the nursing team, to record data and share information with the medical team as well as answering the phone. This management proved to be necessary for the regulation of the context and to reduce the workload, both individually and collectively, by expanding the possibilities of action and regulation fields, which can be observed in the following excerpt from the field notes:
>
> ... Regina, the nurse technician, tells Raúl that after having checked the Integrated Hospital Management System (IHMS), she did not see the patient's blood sugar levels in the medical record. In the nursing notes the patient's blood pressure (BP) is 160/100 mmHg. The doctor returns to the nursing station and the technicians discuss the patient's blood pressure with her. They suggest administering medication if the patient's blood pressure is still high. Nurse technician Raúl tells the doctor to "administer medication to the patient and notify the alternative service. They must follow the process. If the patient has high blood pressure and is coming from the alternative service, they should have received the medication there." The doctor listens and decides to give medication to the patient.

This situation revealed a competent performance as a work management strategy. Here the technicians and the doctor applied the preexisting rules associated with the history and singularity of the action based on measurable and non-measurable values. This management is not here portrayed individually, but is collectively established in partially relevant collective entities,[33] which evaluate the management of beds (the patient's entry and exit dynamics), the quality of care and the clinical services to be provided to the patient, and the management of health care and safety. The idea of working together for the common good is relevant and important. If the values discussed have enough adherence and power to create relevant entities, it can be inferred that the participation of these people in the debates and the fields of politics and values is coherent. Thus, there is a two-way local and global dialectic.

For a competent performance, certain ingredients must be articulated. These groups have a variable structure; they are both partially relevant and essential, and are established based on the work efficiency principle. This is a local creation of different leading

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actors in the situation, of a certain way of "life," of constructing life in the workplace.

When variations and contingencies are observed, even when many solutions fail, it may be understood that working in the Crisis Care Center is not enough to deal with problems. In order to benefit from the setting and act competently, it is necessary to leave the Center, search for and compare information, make phone calls, go to the hospital's reception counter, share practical and technical knowledge with other nurses and the medical team, conduct a survey of the system information and the spreadsheets with notes. Anticipating is necessary to manage activities, as seen in the following field note:

> *…technician Raúl grabs the phone and calls the Drug Addiction Treatment Center in Minas Gerais (CMT)* [Centro Mineiro de Toxicomania]. *He asks whether the ambulance has already picked up the patients. At the same time, he covers the phone and talks to the doctor about the need to make spaces available in the Crisis Care Center because, according to the technician, more patients would be admitted soon. "I went outside and saw many upset people demanding to enter," he said. He looks at the spreadsheet while speaking to the technicians (two of whom were in the sector) and the doctor. "All the ward beds are already reserved by the director," he continues. (Vacancies reserved by a court order). He resumes his conversation on the phone, speaks, takes notes, and tells another technician that the ambulance is coming and that they may take the patient to the CMT. He hangs up the phone, searches for the medical records, which he organizes in a sequence he himself chose, and hands them over to the doctor who goes back to the sector. Once the doctor has left, he says: "there are patients who are ready to be discharged, but as we cannot decide on that, we arrange the medical records in the order that we think the patients would be discharged. That way, the doctors will examine these patients first and beds are freed up faster. It is the only way this sector can be made known. Otherwise, imagine if the clinical record of the patient to be discharged was the last one? Many people would enter without going through the CCC. Experience helps us build our own paths…*

Both Figure 2 and the excerpts presented here show the specific, unpredictable, and indefeasible work of a *partially relevant collective entity*. If the working group did not work in harmony, whether because of the absences and/or rotation of workers, and there were "lack of synchronization" and mistakes, this would cause occupational risks, and the hospital, workers, and patients would pay the price. Constructing and updating skills are fundamentally needed for risk management in this context.

The source of the problems (delay of the ambulance to transfer patients, admittance of different new cases, and so on) and other types of difficulties may be the consequence of something very distant in time and space. According to Schwartz and Durrive,[33] "a collective entity also works this way: in order to perform an action at its own pace in almost the right conditions, that which is relevant as an area of exchange, of communication must never in advance be confined in time and space."

These actions collectively performed within the Crisis Care Center are in constant transformation. This is truly a symphony without a conductor, that is, everyone plays their own score (they know what they have to do) but, at the same time, the score must be synchronic and, thus, there should be markings so that every musician knows when to join as there is no conductor.

DISCUSSION

The hospital has also undergone transformations: it has reduced its role as a permanent place to stay and has increasingly become a

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place of transit mainly in the case of emergencies.[8] The patients who arrive in a situation of crisis are assisted, controlled, and referred to the alternative services of the mental health network for their follow-up.[21,39] Therefore, this hospital merges and reinforces this network.

According to the institution's manager "the CCC is essential for emergency care and to assess the possibility of hospitalization and/or referral of patients to the alternative services once the period of crisis has ended." The same manager argues that, in order to work at the Crisis Care Center, potential workers should have expertise or a body of historical knowledge to deal with the inherent risk of the activity in this context. He further stated that, "without the CCC and the assessment of risk at the hospital's entrance, the number and severity of the aggressions would absurdly increase in the hospital wards." This statement goes hand in hand with the notion of risk,[34] which is found within two types of verifications: "on the one hand, an excess of safety regulations defined in anticipation to the performance of an activity and, on the other hand, the discreet know-how that is established almost in the secrecy of the course of activities."

A nurse technician working in the institution describes the drama of dealing with a patient:

> *The main problem is the following: the patient is drugged when he arrives, he has smoked some kind of stuff. There is no chance the patient will accept to stay. So, we are forced to use violence. Do you get it? We are obliged to use physical force, there is no other way. Now, one of the biggest problems that comes up mainly between us and the patient is that the doctor examines the patient and recommends hospitalization. Many doctors do the right thing, they approach the patient and say, "you will be hospitalized," because whether we accept it or not, that's what we have to do, we will have to force him in. But other doctors don't speak clearly to the patient about their decision, they leave this task to the nursing staff, which I consider to be completely wrong. Do you get it?* (Nurse Technician No. 1, Crisis Care Center).

At work, there is a continuous debate between preexisting rules – sets of knowledge that are relatively stabilized and formal, and knowledge deriving from the worker's experience – and internal rules. Choices are made based on this debate about rules. These choices are not always consciously made or supported by values. Renormalization takes place when there is a break between the values within the organization and, consequently, the previous rules and workers' values.

Over the last decade, the institution under analysis has undergone a change in the patients' profile that caused a rise in the potential risk of aggressions at the hospital's entrance. A nurse technician explains:

> *...this became a jail, that's the truth! Most of our patients are "drug addicts," alcoholics, and there are many prosecuted patients; there are patients carrying the weight of death on their backs, patients who steal, patients who do atrocious things. So, here in the emergency room, the death threat is constant, do you get it? Constant indeed! Patients who threaten to kill us... Either we develop strategies to deal with it or we die. Another alternative is leaving the hospital sooner, which is very common here among the newbies.* (Nurse Technician No. 3, Crisis Care Center)

Within this context, the changes in the patients' profile demand a reconfiguration of practices and skills[40] in light of the specificity of the psychiatric care of drug users, which often entails violent reactions on the part of the patients.

Even when the decision is individual, these debates and negotiations are always collectively made. If the work management implies dealing with multiple managements, it should be highlighted that there is not an equal footing between this debate and the

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negotiation of efficacies. The established power and knowledge relationships directly influence decisions in a complex dispute field. The nurse technician shares knowledge with the group, anticipates, manages risks and care, discusses, gives opinions, and confronts their knowledge. However, the final decision and the behaviors undertaken depend on the doctor.

These methods of organizing the mental health services and teams that are still strongly focused on the figure of the doctor were also mentioned in the research study carried out by Ramminger and Brito[41] at a psychosocial attention center (CAPS) [*Centros de Atenção Psicossocial*] located in inner Rio de Janeiro. According to the authors, the doctor has a key role in this service, which is to medicalize. Faced with the impossibility of attending to patients in situations of crisis (psychotic breaks), doctors "administratively discharge patients," which is not a therapeutic measure in nature, but essentially punitive, with moral judgments disguised as medical argumentation. In addition, they contribute to the quick transfer of patients for hospitalization and "docilization" through chemical incarceration. Other research studies[42,43,44] also reveal a similar picture.

According to Foucault,[38] in light of the hypothesis that includes insanity within mental illness, the action of psychiatry is presented as the police for the mentally ill disguised as philanthropy. This same author,[45] who focused on the relationships between the subject and the practices of power, reinforces that "all the great reforms, not just of psychiatric practice but also of psychiatric thought, revolve around this power relation: they are so many attempts to shift it, conceal it, eliminate it and nullify it."[46]

According to Arendt,[47] the phenomena of violence and power are found in the political realm of human affairs. In a sense, it could be said that any organized action forces its actors to develop the potential of skill management, that is to say, to perceive and translate the elements of the situation — translation skills of the ongoing action — and to bring up the sets of knowledge for action/reaction.

Within the collective dynamics of work, the moment that the patient is admitted to the hospital inflow, the technicians' abilities of explicitness, intervention, and evaluation[25] associated with the skills of the specialized technical team are essential resources for the assessment of violence risk and the implementation of strategies to address imminent risks.

In this context, risk would be the logical answer to a double impossibility related to the nature of human activity, beyond the form and the historical organization that it may adopt: the impossibility of neutralizing singularities in human activities and the impossibility of total anticipation of the constitutive elements of the activity process.[34] In this sense, human activities are the place of commitment of those who perform them.

An example of this commitment is the following narrative of a nurse technician at the Crisis Care Center regarding the importance of the group and the necessary experience to perform tasks in that sector:

> *They contribute, contribute a lot. And when it is necessary for someone to come to the CCC from another unit because of a lack of professionals, or because something happened, for example, or someone had to leave, had to go to the doctor, one drastically feels how complicated the service becomes. Because that person has no experience at all! It's not that the professionals aren't dynamic, but the dynamics in the CCC are different. You know, as soon as the patient arrives, their vital signs are immediately monitored, or are sent to the toilets. The nurse who takes the patient to the toilet starts to grab the patient's belongings and puts them aside. Another professional enters the patient's admission data into the computer. It has to be that way, quick! Because if a nurse wants to do everything by themselves and another patient arrives, what then? Then comes the stir, you can't allow disruption in the service.* (Nurse Technician No. 4, Crisis Care Center)

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And, in regard to the violence risk, the nurse technician added:

> *I think that when we arrive in the morning we have to slow down. You already arrive expecting everything to be unpredictable, violent, and aggressive. Time goes by and these demands don't take place, and you start to slow down a bit more, you get to the CCC's setting with a certain unrest. Violence is intense. The working group must show up. You are always on demand, on the alert. When everything is quiet, you have to slow down, but that doesn't mean that this unpredictability won't take place, you already have that in mind. At any moment, this clockwork mechanism will be on and the demand of professionals will begin. It's a mechanism, isn't it? It will start to work and it's like a mechanism where all the pieces have to fit together, and everybody knows their place at that moment.* (Nurse Technician No. 7, Crisis Care Center)

When asked what "slowing down" meant, the nursing technician disclosed, "slowing down doesn't mean to stand still. It's being alert, attentive, anticipating in order to cope with the problems. It means to have a general picture of the situation. It's understanding what your coworker says without words. It's knowing which team will be in charge and whether the medical team is empathic or bossy. It's all about doing."

In order to reach a diagnosis of this setting, it was necessary to hold a rigorous and humble position in order to assess the workers' knowledge of their own activity and, at the same time, to set up a dialogue using the established sets of knowledge. In a sense, this led to the idea of "what is done and cannot be said. What is said that should be done but cannot be done."[48]

The construction and updating of skills are an essential necessity for the management of violence risks in the hospital. The possible solutions to the hospital malfunctions and violence risks do not lie in increasing the regulations and the means of local protection (that are often necessary for certain types of risk), but in the implementation of organizational methods that may give rise to the management ability of the main actors in the workplace during the course of the activity.

FINAL CONSIDERATIONS

The analyzed risk approach was limited to the occupational risks. However, the relationship between risk and human activity does not allow this approach to be restricted only to risk. There is an *enigmatic dimension* at work, thus, the local risks are related to the negotiations among individuals, working groups, and the "working conditions" which are always somewhat being reworked.

In the Crisis Care Center and, consequently, in the hospital, it was observed that there was, on the one hand, an excess of rules, even of safety rules, established before the activities, and, on the other hand, a know-how that was constructed and established almost clandestinely during the course of the activities: this violation was placed there as a necessary condition for the development of a sensible know-how, useful for occupational efficacy and health.

The implementation of the care dimensions established in the Crisis Care Center reinforces the approach used against potential risks. The expansion of potential risk management fields depends on the organizational conditions to update group skills, in which the nurse technicians play a key role. Therefore, the assessment of these technicians' work, which involves the stability of relationships and the equal workload and remuneration of this group are essential procedures.

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