

COMPLEMENTARY AND INTEGRATIVE THERAPIES IN NURSING CARE: AN ETHICAL FOCUS

Práticas integrativas e complementares no cuidado de enfermagem: um enfoque ético

Prácticas complementarias y de integración en el cuidado de enfermería: un enfoque ético

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ABSTRACT

Objective: The study's objectives were to characterize the participation of patients in nursing care and in choosing integrative and complementary therapies, and then to analyze this participation from the perspective of nursing care ethics. **Method:** Qualitative research conducted with patients receiving ICT in public health facilities where there are nurses to apply these therapies. Approved by the Institutional Review Boards of the facilities involved. The sensitive creative method and discourse analysis were used. **Results:** When the autonomy and participation of subjects were considered as citizenship issues, the discussion concerning their right to choose among services provided is resumed. The right as an ethical condition implies having appropriate access to information regarding different therapeutic possibilities; this depends on broadening the subjects' understanding and how they act upon the world and themselves. **Conclusion:** It is important not to lose sight of the ICT essence of integrality, its principles and purposes.

Keywords: Nursing Care; Ethics; Complementary therapies.

RESUMO

Os objetivos deste estudo foram caracterizar a participação de usuários na opção e no cuidado de enfermagem por meio de práticas integrativas e complementares de saúde (PICS); e analisar esta participação sob o enfoque ético do cuidado de enfermagem. **Métodos:** Pesquisa qualitativa, desenvolvida com usuários de PICS, em instituições públicas de saúde onde há enfermeiros que as aplicam; foi aprovada pelos Comitês de Ética em Pesquisa das instituições envolvidas. Utilizaram-se o Método Criativo Sensível e análise de discurso. **Resultados:** Ao considerar a autonomia e a participação dos sujeitos como questão cidadã, retoma-se a discussão sobre o seu direito de opção face aos serviços ofertados. Este direito como condição ética implica ter acesso adequado às informações sobre diferentes possibilidades terapêuticas; depende da ampliação da capacidade dos sujeitos de compreender e agir sobre o mundo e si mesmo. **Conclusão:** Há de se ter atenção para que seja preservada a essência da integralidade das PICS, seus princípios e finalidades.

Palavras-chave: Cuidado de Enfermagem; Ética; Terapias complementares.

RESUMEN

Objetivo: El estudio objetivó caracterizar la participación de los usuarios en la opción y en el cuidado de la enfermería a través de las Prácticas Integrativas y Complementarias de Salud (PICS) y examinar esta participación bajo el enfoque ético del cuidado. La investigación cualitativa fue realizada con usuarios de terapias aplicadas por enfermeras en las instituciones de salud pública; aprobados por los Comités de Ética. **Métodos:** Se utilizó el método creativo, sensible y el análisis del discurso. **Resultados:** Por considerar la independencia y la participación de los sujetos como cuestión de la ciudadanía, se retoma la discusión sobre los derechos frente a los servicios ofrecidos. La condición ética implica tener acceso adecuado a la información y depende de la expansión de la capacidad del sujeto para comprender y actuar sobre el mundo y consigo mismo. **Conclusión:** Hay que tener atención para que sea conservada la esencia de la totalidad de las PICS, sus principios y propósitos.

Palabras-clave: Cuidados de Enfermería; Ética; Terapias complementarias.

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INTRODUCTION

In recent years, users of health services have more strongly expressed their dislike for conventional medicine due to its increasingly more technical approach, to the morbidity that results from conventional treatments' side effects and to the lack of cure for some diseases. In this context, integrative and complementary therapies (ICT) have become an attractive alternative for many users of health services¹. ICT is an approach that seeks to stimulate natural preventive and health recovery mechanisms through efficient and safe technologies. As an approach, it emphasizes receptive listening, the development of therapeutic bonds, and the integration of the human being into the environment and society. Other points shared by diverse approaches covered in this field are a broadened view of the health-disease continuum and the global promotion of human care, especially self-care².

The Federal Council of Nursing, through Resolution COFEN-197/97, "Establishes and acknowledges Alternative Therapies as a specialty and/or qualification of the Nursing professional." The requirement to receive this title is that the Nursing professional must complete and be approved in a program offered by a recognized educational institution or counterpart entity, with a minimum workload of 360 hours. All this discussion is necessary for professionals and patients and should be the focus of the attention of researchers and scholars interested in the subject.

The inclusion of ICT in the SUS leads to ethical-legal discussions concerning professional practice in the implementation of these therapies in the health system. In this study, we highlight ethical issues in healthcare that involve the implementation of ICT by health professionals, more specifically, nurses. Among these issues, attention is focused on the patient's right to choose this care approach with the due respect and valorization of the individual's participation and autonomy in relation to the production of health. The right to choose, as an ethical condition, implies having appropriate access to information concerning different therapeutic possibilities. It is worth noting that this ethical condition grounds nursing care regardless of the therapeutic system used and also permeates the philosophical fundamentals of ICT.

The view of nursing care we share is that in which both nursing knowledge and patient knowledge are valued, acknowledging that care is the result of an exchange of knowledge. The patient, in the condition of a subject, is an active participant in the care process. In such a condition, patients reflect, criticize, refuse or accept what is presented to them in the context of care. We understand that nurses and patients are subjects who participate in the relationship of care with actions that are completed and redone; that is, they are transformed over the course of their trajectory³.

One exploratory study we conducted confirmed what some studies addressing the applicability of these therapies indicate: little is known about health institutions and the professionals who employ ICT, or about in what circumstances patients seek these therapies⁴. Additionally, ICT's use is often linked solely to the professional's interest rather than to an institutional policy with an understanding and valorization of ICT's importance among the health practices available to the population⁵. Also, the discontinuation of ICT in some institutions is justified due to a lack of human resources qualified to meet the different health services needs.

The results of the exploratory study enabled us to shed some light on the participation of users of public health services in the choice of ICT. Dialogue with the patients revealed that the use of these therapies was not a choice of patients or requested by them, but a choice of the nurse applying the therapy. That is, these therapies were applied without any previous introduction of their principles or purpose. Given the beneficial effects of these practices, however, the patients accepted the continuation of these therapies in the sphere of the care they received.

It is important to recognize that the problem concerning a lack of information on the part of patients regarding the therapies that are applied to them, as well as the need to acquire their consent or verify their interest in being cared for with one therapy or another, is not restricted to the universe of ICT. This issue is recurrent in the sphere of health services and needs to be considered when a humanized and integral care is to be offered, regardless of the therapeutic choice of either professionals or users.

In regard to the development of this study, the problem we intended to investigate is based on the fact that there are gaps in knowledge regarding how effectively patients participate in the discussion process and in the care itself that is provided through these practices. The reason is that these practices are in the process of being disseminated and legitimated by both patients and professionals. Therefore, discussions about these therapies need to be broadened.

With this in mind, this study's purpose was to discuss the participation of users of public health services in choosing care and in the nursing care provided through integrative and complementary therapies, which is the object of study. The objectives were: to characterize the participation of users in choosing therapies and in nursing care providing therapies; and to analyze this participation from the ethical perspective of nursing care.

It is important to reflect on and discuss the active and inquisitive attitude of people searching for therapeutic options able to act in favor of their own health interests, giving back to the patients the responsibility to maintain and recover their health⁵.

Considering the context in which holistic ideologies and health practices are disseminated, we inevitably move toward new health paradigms in which the conception is dynamic and totalizing. It is from this global perspective that patients should be cared for without, however, losing sight of their uniqueness when explaining their disease and health continuum. Such an approach helps these individuals to become co-responsible in these processes, which encourages the exercise of their citizenship. In this sense, the National Policy of Integrative and Complementary Therapies (NPICT) cooperates with integral health care, which also requires interaction among services existent within the SUS². It also interacts with the principles of the National Policy of Humanization (*Humaniza-SUS*), the theoretical-philosophical framework of which includes the valorization of subjective and social dimensions in all care and management practices, in addition to the construction of autonomy and an active role of the subjects and the collective⁶.

With the implementation of ICT in public services, these therapies became linked to various circumstances in the field of ethics and healthcare itself. It is an individual option and active choice that requires intimate adherence of people to values, principles and moral rules; it is linked to the notion of individual autonomy; it seeks out the inwardness of the human being; and requires convictions that cannot be imposed by outside sources. A reflection that is by necessity multidisciplinary requires the participation of philosophers, theologians, sociologists, anthropologists, jurists, religious people, etc. The theoretical option follows the autonomous and humanistic perspective, tending to see the human being in its wholeness. It uses the language of rights and intends to bring about the humanization of health services and the guarantee of the rights of citizens while users of health services^{7,8}.

Humanization is related to ethics, while the latter is one of the tools human beings use to ensure social cohesion. It is a critical reflection on human behavior that interprets, discusses, and problematizes values, principles and moral rules, in a search for the "good life" in society-the good social life. In this context, autonomy refers to self-determination, self-government, and decision-making power in the case of decisions that affect one's life, health, physical-psychological integrity, and social relations⁷.

In regard to the humanization of healthcare, we should note that every human being, when in the position of being a user, should be treated because of his/her health needs and not as a means to satisfy the interests of third parties. For this reason, the participation of users when choosing ICT or any other health therapy, is not only an issue of autonomy, but also of rights, of citizenship, thus the choice of developing this study with a focus on ethics.

The ethical view of care is consistent with the ICT principles regarding community development, solidarity, and social participation. Moreover, it is noteworthy that these same principles guide the National Humanization Policy, especially its reference to the concept of integrality, both in terms of actions and the care practices developed in these services. When nurses implement care practices from this perspective, they favor the exchange and construction of new knowledge, thus enabling patients to have the autonomy to mobilize their own resources in the production of health.

METHOD

Qualitative research is characterized as a way to systematically seek information and is usually described as holistic and naturalist, without any limitation or control imposed on the researcher. It does not strongly depend on statistical analysis for its inferences or closed instruments to collect data⁹.

This study was developed in three public health facilities in the city of Rio de Janeiro, RJ, Brazil: one Federal facility, one State facility and one municipal facility. The individuals were nine users cared for by nurses who apply at least one of the following: Reiki, Medicinal Plants or Bach Flower Remedies.

The project was submitted to and approved by three Institutional Review Boards: the Anna Nery Nursing School/São Francisco de Assis University Hospital (No. 031/2011); Rio de Janeiro Health Department (No. 311th /2011); and Pedro Ernesto University Hospital (No. 2414). Authorization was provided by the facilities that served as the study settings for data collection. After the participants received proper clarification about the study and consented to participate in the study, they signed free and informed consent forms. All identities remained confidential through the use of the following codes: Users of flower remedies (FR₁, FR₂, FR₃ and FR₄); of medicinal plants (MP1, MP2, MP3 and MP4); and Reiki (RC₁). The researchers were identified by the letter "R".

To study the conceptions held by the participants concerning ICT and how they participate in the care provided through these therapies, part of the data production was grounded in the Sensitive Creative Method (SCM), which uses the dynamics of creativity and sensitivity (DCS) as a space to produce data. It forms a triad together with group discussion, collective interview, and participant observation. The combination of the SCM techniques is justified because depending on the technique used, various and different responses may emerge to the same question¹⁰. The combination of techniques supports the critical-reflexive pedagogy of Paulo Freire in the scope of DCS and permits the researcher to be inserted into the context of the reality to be investigated. Hence, SCM values and enables the subject's active participation in the search for knowledge.

The artistic productions prepared those participating in the dynamics for dialogue, facilitating the organization of their thinking for the enunciation of discourse and guiding the analytical process, with interventions on the part of the researcher only as a mediator of the discussions, valuing everything that emerges from each subject's thought and perception, including what apparently has no immediate or direct relationship with the research. Individuality collectively shared through dialogue enables comprehensible coding and decoding, but never in the same way, because the study's subjects are not equal, which generates recoding and the construction of new meanings¹⁰.

In addition to the group discussions, individual and collective interviews were performed outside of the DCS sphere, given the subjects' particularities and the difficulties presented both in their participation in the group dynamics, using artistic production, or in integrating the groups, due to an incompatibility of schedules.

Operationalization of Dynamics of Creativity and Sensitivity: Calendar

The use of DCS requires the valorization of creativity and sensitivity with the purpose of avoiding a dichotomy between reason and emotion. The dynamics called "Calendar" has been applied by various authors who opt to use creativity and sensitivity to produce research data. It consists of participants cutting and pasting pictures, drawings, and words of diverse origins to create an Calendar that addresses a theme or central question.

The participants freely express their ideas and opinions, not only those of interest for the purposes of the study. A dialogical relationship requires sharing among subjects who produce the discourses; everyone is encouraged to talk and is listened to about what they desire and what concerns them. Therefore, in addition to these questions, the group's dialogical process brings other questions to light, which meet the objectives expected by the researcher to develop the dynamics and also the participants' interests.

The production of data occurred in five steps: 1) Organization and preparation of the environment; 2) The group was greeted and participants were introduced. The objectives of the group dynamics and activities that would be developed were presented; 3) Development of individual artistic production: each participant produced their own calendar. This production was guided by the central theme "Integrative and complementary therapies provided by nurses and the participation of patients in the care process"; 4) Presentation of individual works: each participant presented their artistic work to the group, based on which, a collective discussion was initiated; and 5) Collective analysis and validation of data: Based on the description of what was constructed we followed with analysis of data that emerged from the artistic work.

The calendars were photographed and the participants' testimonies were recorded in the Mp3 format and transcribed the following day to avoid losing the essence of what had been shared with the group. The transcriptions, calendars and records of participant observation during data production composed the report of data production, the study's primary source.

The corpus concerning the reports was analyzed according to French Discourse Analysis (DA). We adopted this analysis because it allows the researcher to grasp ideas embedded in the individuals' discourses, as well as allowing one to grasp how the components inherent to the individual and social components intertwine in the participants' statements. DA does not deal with language or grammar. Even though all these matter, DA focuses on the discourse. The empirical material that originated from the reports of data production was interpreted under the light of the following analytical devices: inter-textuality, inter-discourse, paraphrased processes, polysemy and discursive development¹¹.

RESULTS AND DISCUSSION

The results that originated from the individuals' data production are presented by separating the therapy groups, since the choice and participation of the subjects references the care provided by different nurses. The following guiding question was answered: "From the perspective of these users, how do they participate in the choosing process and in the care itself through the ICT applied by nurses?"

Choosing nursing care that provides ICT

The power to decide, to opt, to make choices is embedded in the principle of autonomy. In the health care field, it is a term that refers to the human being's ability to decide what "is good" means and what "wellness" is according to one's values and expectations, needs, priorities, and beliefs. It requires that the individual, whether healthy or sick, does not totally surrender to health professionals, nor renounce the larger portion of his/her freedom in exchange for a smaller portion of his/her own health. Autonomy is related to a perception of subjectivity on the part of each person, coupled with the principle of human nature's dignity^{7,8}. It appears, based on the paraphrastic speech of some participants, that the decision to use flower remedies is not safe or definitive cure, rather, these individuals have the desire to try something new that may somehow benefit their health and wellbeing:

(...) I've always noted people coming in and out, always like... you know (/) in a good mood... Then, I thought to myself: "I'm here sad, crying and there's always someone

leaving this place with a smile on her face, so I'm like, it came to my mind "the flower remedies..." So I asked the nurse for a referral for flower remedies (...) I'm very grateful for all, all these rich colors, the person who referred me, EX and E1, my thanks to them. (FR1)

Even though FR1 took the initiative to ask for a referral, she highlighted that she had no prior knowledge of flower remedies and for this reason she sought the flower therapist nurse in order to ask about it. It is worth noting that FR1's discourse was enunciated in the first person plural when she refers to the beginning of the flower therapy, "then we started...", thus indicating a joint action, in which healthcare is shared between patient and therapist. The choice for this complementary care approach was made based on this conversation:

"Then the woman talking in her office, then I encountered the flowers, many of them I couldn't imagine they existed. So I thought: Do I want this or not? I'll take this medication here, but it won't solve my life problems..." hum no no (/) Time passed (/) I started to cry, cry, cry... _What the hell is this I'm taking that makes me cry even when I see a pretty flower...? Then, I started to notice the colorful flowers (...). So the next time I came, I talked to E1 and she said: _There it is! No distress anymore! I love this! And we started it". (FR1)

While FR1 was in the "try-the-flower-remedies" phase, she did not consider she was already under treatment. Only after noticing the first results with the continuity of the therapy and conversations with the nurse did she actually feel that she had initiated the flower remedies therapy. FR2 also reported she began using the flower remedies by her own choice, though she still doubted the results:

"I used to live like, a puzzle... So I asked: _ Flower remedies? _and EX referred me (...) So I thought: _I'll be here anyway, I'll try it... and then I found flower remedies in my life and I'm enjoying it a lot. E1 is also very nice (...). So she started talking with me and I cried, cried, cried... _Instead of her helping me, she's traumatizing me even more?!" (Laugh) (...) _I thought: _I won't come back because this doctor is making me cry all the time... _And she started showing me..." (FR2)

The active posture in choosing to use the flower remedies or not is present in the testimonies of all this group's participants. It is marked by expressions that indicate power of choice as an act of determination to develop self-expression and transformation: "I decided", "I'll try", "I've asked for a referral", "I think". This decision goes through a careful choice process to know the truth that leads to action¹².

The testimony of the Reiki user is marked by self-cure, self-knowledge, free choice, and awareness. Her speech emphasizes the patient and not the professional:

"it was something I wanted and nothing happens by chance and I got it. (...) The reason I've opted for these practices is because you can find out that you have the power to cure (...) it's part of me, being free (RC1)"

At the very beginning we asked the participants of the group of medicinal-plants users what they thought about ICT and the following emerged:

"I think it's very good. I've used it but not anymore...Because I don't have money for it. I used to get acupuncture, drink teas. I kept the teas, I still drink the teas. This one [showing her calendar] I take everyday".

The approach to the participants revealed that even though they were receiving a therapy provided by the polyclinic and they actually used phytotherapeutic products, which was the reason they were selected to participate in the study, many did not know they were using phytotherapy. See the following excerpt:

"So the use of these lotions, phytotherapy lotions, was it the professionals' idea or yours?" (R).

Everyone replied at the same time positively nodding his/her head: "Yes". MP5 completed: "I didn't even know it existed."

In regard to the right to choose to use phytotherapy or not, almost everyone replied they did not have this option, that is, they were not asked whether they would like to use phytotherapy products, or were not even informed of the product or in which circumstances it is used, though the nurse informed them of some beneficial purposes of its use. They stated they use what is offered to them:

They said it would relieve my foot, because my foot used to get chapped and I used sandpaper and it'd get even more chapped and then they gave me and I started to use it. And that little needle used on the foot, to test the foot's sensitiveness, it improved also. (MP5)

"For me, it was my doctor who referred me to the diabetic foot and I didn't even think of using it (phytotherapy)" (MP2).

MP1, though, reported she had a choice:

It started with my mother, she wanted to use it because her feet were all chapped.

So she asked: _Do you want to use it? _Then she (mother) said: _If you give I'll use it. _ She didn't know. Then I took it and it healed her foot's chapping. Then it was my turn and she asked: "Do you want to use it?" I, want and use it even 'till today and will not stop using it.

It is apparent that the speech of the flower remedies group is marked by words of action that bring the idea of suggestions from the professionals (indication, referral). The dialogue between patient and professional is imposed as essential in the decision for the therapy and its continuity, a conduct that is antagonistic to the prescriptive and conventional care model, which is often adopted in health actions. This conduct is much used in the biomedical model and is not in tune with humanistic thought, or that of a holistic nature. In turn, the discussion with the medicinal plants group showed a different kind of participation of patients, whose position revealed passivity.

Participation in nursing care that provides ICT

Even though there are initiatives of an ethical nature in the health scenario promoting respecting and valuing the participation and autonomy of patients in actions related to their wellbeing, even today we observe that a linear mode of education prevails, a banking model of education^a, anchored on a dominant school model³. The group using flower remedies showed there was a democratic relationship of care, as opposed to an authoritarian relationship.

The conversation, listening, and exchange of knowledge that permeate the relationship between nurses and patients has the meaning of "equal to equal": *"Then the woman talking in her office, then I saw the flowers (...) Because it was... ummm (/) Colleague to colleague, friend to friend, like... before any professional... and today I'm here..." (FR1)*. The users of flower remedies showed that they participate in the care process in a democratic relationship, through conversation, discussion, freedom to say what they considered to be good for themselves or not: *"(...) before she starts working, she talks a lot with you". (FR2)*

We discuss when she will start the flowers... What happens (/) "I don't want" "don't like it". (Laughter) (...) It's what happens here (shows the calendar) I'm climbing", I'm acquiring self-knowledge about things I didn't know, even as a professional and everything, this discovery and everything. This is me here (in the calendar) climbing and she is holding me (Laughter) because we have to have guidance. (FR4)

Participation is opposed to "assistencialism"^b, which is an action in which knowledge is merely transferred without any interest in dialoguing or taking into consideration

what the other person is or knows. Thus, unlike what first appears, assistencialism mutilates, constrains any initiative, leaving the person at the mercy of a situation of eternal dependency. In summary, it is an attitude inappropriate for the entire process of awareness because it is antagonistic and not "liberating".

Assistencialism steals something that is essential, which is responsibility. This lack of responsibility implies a lack of attitude, of decision-making power, which translates as a condition of passiveness, of domestication. This situation is overcome only with the population's effective participation in issues experienced by Brazilian society¹².

In contrast with the group using flower remedies, the discourse of the phytotherapy users was marked by passiveness in relation to the care process, though it does not mean there is no care or zeal on the part of nurses toward the patient, as highlighted by MP3: *"She takes a look and takes care of anything if necessary, takes good care of us, at least of me, she pays great attention to me. An excellent doctor; she is great". (MP3)*

Concerning the nursing consultation that involves the prescription of phytotherapy products, MP5 signaled: *"It's like: "_How are you doing?". Then I say "_I'm doing fine". And: "_How is your foot?". "_My foot is well. _Then she takes..."*

We interrupted her speech and asked whether the nurse explained what she was doing: *"Until recently, she wouldn't explain, but now, she's explaining. She takes a skewer like a little needle, you know, to put on the foot, on the toes, you know, to see whether people have feeling in them, you know".*

The repetition of this expression "you know" implies an underlying insecurity about what the nurse does, and expects from the researcher a positive answer indicating, "it is right". We asked whether she received an explanation concerning the phytotherapy lotions: *"no, my daughter [a phytotherapeutic pharmacist] explained it to me".*

It is important to note, however, that "every care process is constructed by the subjects who participated of it. This process imbricates the social, political, economic and cultural context, both of those involved and of the facility where care is provided. Hence, care is directly influenced by these spheres: the political-institutional project, to which patients and professionals are linked, and the context of life in which both are inserted"^{14:28}. These are relationships that are based on the investment of both, in reciprocity, where one values another's desires, what is of his/her interest.

Therefore, both need to take a position in the relationship as active subjects, questioning, criticizing, and agreeing. The discourse of MP3, participant from the group using medicinal plants, is an example of this imperative and contributes with a reflection that the dialogical experience contributes to the active participation

of the subject recipient of care, while a lack of it makes the individual feel insecure and incapable of making decisions and self-managing.

Today I told her, you know, I always use that ointment... It's ...Sulfa... silver (Silver Sulfadiazine) So I told her [to the nurse]: My injury has been like this for five months. _She took care of me, gave me the ointment and I got well. But this time I got hurt and now the ointment is making it worse (the wound) and I told her and she already gave me another ointment.

Another aspect that marked the speech of this group was the use of plants along the lines of allopathy. The lotions are used for a period, for a specific purpose, focused on a specific part of the body. In the case of diabetic patients, it is focused on their feet, with the claim that its active principle will benefit the treatment or prevent wounds. Following this reasoning, the philosophical essence of ICT and the principles that ground it are lost; that is, approaches are lost that seek to encourage natural disease-preventive mechanisms and health recovery, that emphasize receptive listening, encourage therapeutic bonds, and the integration of the human being with their environment and society².

It is worth taking into account a necessary caution not to divert the focus from the applicability of these practices. It is important to reflect on the fact that with the implementation of ICT within the SUS, the biomedical model may assimilate these practices, adapting them to its mechanistic model, completely deviating therapeutic aspects that are part of a holistic system.

In this sense, both the National Policy of Integrative and Complementary Therapies² and the National Policy of Medicinal Plants and Herbal Medicine¹⁵, which define guidelines, lines of actions and responsibilities to include Medicinal Plants/Herbal Medicine, Homeopathy, Traditional Chinese Medicine/Acupuncture, Social Hydrotherapy/Crenotherapy and Anthroposophy Medicine, are crucial therapeutic options within the SUS. It is, however, important to keep in mind the implications of its applicability by professionals and the degree of interest and participation on the part of users, as well as the employment of these therapies by users in this context.

CONCLUSION

The principle of a human being's integrality refers to the thought that the main interest of health professionals lies in the person affected by a given problem or a set of clinical manifestations and the care necessary to reestablish balance and/or recover physical, mental, social, and spiritual wellbeing and other care actions able to meet

the patient's health expectations. We consider, however, the subjective aspects and the experiences of each patient who participate in the care process. This participation is manifested in many ways, through attitudes and verbal and non-verbal behaviors.

Both the National Policy of Humanization and the National Policy of Integrative and Complementary Therapies refer to principles of the First International Conference on Health Promotion - Ottawa, according to which, health is constructed and experienced by people within what they do in their everyday lives. It is constructed by the care of each individual, both within themselves and with another, through the ability to make decisions and have control over his/her own life and through struggles so that society provides conditions that enable all its members to obtain health, thus "involving collective subjects, who in concrete and routine practices, transform the way health care is produced and transform themselves as well."^{16:402}.

Human care is an ethical attitude in which beings perceive and recognize each other's rights. In this sense, people relate to each other in a way to promote knowledge and the well-being of another. Therefore, we question the ethics that prevail today¹⁷. Taking care of another person, in its larger sense, is to help her/him grow and achieve self-realization. Growth, in this context, is in the sense of becoming more self-determined, of choosing one's own values and ideas according to his/her experiences. Providing care is opposed to the inappropriate use of another person to satisfy our own needs.

The humanization process should be guided by the following values: autonomy, co-responsibility, an active role for the subjects involved, solidarity among those with whom bonds are established, respect of users' rights and collective participation in the management process. For the values that guide humanization to be effective, the users' right to choose and their participation is required. In humanization policy, ethics implies changes of attitude on the part of workers, users, and health managers, in which everyone becomes responsible for the quality of actions and of services provided in this field. Additionally, it aims to encompass the health production system of people who subjectively seem autonomous and are protagonists of this process⁷.

In the context of fragmentation and the need for integration, ICT is seen as one of the means to de-concretize integrality in health care². Nonetheless, parsimony is required to avoid losing these practices' essence of integrality, to avoid merely transforming them into a new "service delivery" as part of the biomedical model. Hence, the need arises for discussions that also concern the ethics related to the respect of philosophical bases that cover these practices. This aspect is one of the concerns of the World Health Organization and for this reason it provides

technical support and information in order to enable its efficient and safe use, preserving and protecting the theoretical framework of the complementary medicine.

Nursing should not be left out of the discussion concerning the regulation of ICT employed within the SUS, reflecting on these practices and demanding that they be legitimate in the sphere of nursing care. The holistic view of nurses associated with complementary therapies plays an essential role in its applicability.

Information concerning the correct use of therapies, adjuvant to treatment and the maintenance of the users' health can and should be shared with them. But for this to happen, knowledge needs to be broadened, discussions on the theme need to take place in the academic sphere and further studies in field are required. It is important for users to be included in this discussion, as well, and a dialogical practice should be adopted to understand what patients think, know, desire and how they participate or expect to participate in this process of choice and care provided through ICT.

REFERENCES

1. Saad M, Medeiros R. Terapias Complementares-Cuidados para Evitar Cuidados Adversos. *Einstein: Educ Contin Saúde*; 2009;7(1 pt 2):42-3.
2. Ministério da Saúde (Brasil). Política nacional de práticas integrativas e complementares no SUS. 2006. Brasília(DF): Ministério da saúde. 92 p.
3. Alvim NAT, Ferreira MA. Perspectiva problematizadora da educação popular em saúde e a enfermagem. *Texto & contexto enferm.*, 2007 Abr-Jun; 16(2):315-9.
4. Alvim NAT, Ferreira MA, Ayres AV, Magalhães MGM Fitoterapia e Enfermagem. In: Silva MJP, Salles LF, Enfermagem e as Práticas Complementares em Saúde. São Caetano do Sul, SP: Editora Yendis; 2011. p. 97-110
5. Alvim NAT, Ferreira MA, Cabral IE, Filho AJA. O uso de plantas medicinais no recurso terapêutico; das influências da formação profissional às implicações éticas e legais da sua aplicabilidade como extensão da prática de cuidar realizado pela enfermeira. *Rev. Latino-am enfermagem*. 2006 [acesso 2010 set. 03]; 14(3):316-23. Disponível em: <www.Eerp.usp.Br/rlae>.
6. Ministério da Saúde (Brasil). HumanizaSUS: a clínica ampliada. Brasília(DF): Ministério da saúde; 2004. p 1-19.
7. Fortes PAC. Ética e saúde. São Paulo: Editora Pedagógica Universitária; 1998. 120 p.
8. Fortes PAC. Ética, direitos dos usuários e políticas de humanização da atenção à saúde. *Saúde soc*. 2004 [acesso 2010 jun. 05]. p 1-6. Disponível em: <www.scielo.br/pdf/sausoc/v13n3/04.pdf>. Acesso em junho 2010.
9. Polit D, Hungler B. Fundamentos de pesquisa em enfermagem: métodos, avaliação e utilização. 5. ed. Porto Alegre(RS): Art-med; 2004.
10. Cabral IE O Método Criativo e Sensível: Alternativa de pesquisa em enfermagem. In: GAUTHIER, Jacques Henri Maureice et al. Pesquisa em Enfermagem: Novas Metodologias Aplicadas. Rio de Janeiro: Guanabara Koogan;1998, 177-203 p.
11. Orlandi EP Análise de discurso: princípios e procedimentos. 6. ed. São Paulo: Pontes; 2005. 100 p.
12. Freire P. Conscientização: teoria e prática da libertação: uma introdução ao pensamento de Paulo Freire. 3. ed. São Paulo: Centauro, 1980. 102 p
13. Freire P. Pedagogia da autonomia: Saberes necessários à prática educativa. 37. ed. São Paulo: Paz e Terra, 2008.
14. Barcelos LMS, Alvim NAT. Atenção e presença física: dimensões expressivas e a prática dialógica do cuidado de enfermagem na perspectiva do cliente hospitalizado. *REBEN*. 2006 jan-fev. 59(1):25-9.
15. Ministério da Saúde (Brasil) Programa Nacional de plantas medicinais e fitoterápicos. Brasília(DF): Ministério da saúde; 2009. 136 p.
16. Deslandes LF. O projeto ético-político da humanização: conceitos, métodos e identidade. *Comunic, Saúde, Educ*. 2005;9(17):389-406.
17. Waldow VR, Cuidar: expressão humanizadora da enfermagem. Petrópolis(RJ): Vozes, 2006. 192 p

^a T.N. The so-called "banking" model of education was criticized by Paulo Freire and refers to education in which the student is viewed as an empty account where the educator deposits knowledge.^b T.N. As used by Paulo Freire in his book *Education for Critical Consciousness*.