DOI: 10.1590/S0080-623420130000400020

Original Article

Nursing duties in the basic health unit: perceptions and expectations of nursing assistants

ATRIBUIÇÕES DO ENFERMEIRO NA UNIDADE BÁSICA DE SAÚDE: PERCEPÇÕES E EXPECTATIVAS DOS AUXILIARES DE ENFERMAGEM

FUNCIONES DEL ENFERMERO EN UNIDAD BÁSICA DE SALUD: PERCEPCIONES Y EXPECTATIVAS DE LOS AUXILIARES DE ENFERMERÍA

Cândida Elizabete dos Santos Soares[1], Rosângela Elaine Minéo Biagolini[2], Maria Rita Bertolozzi[3]

ABSTRACT
The present study aimed to analyze the perceptions and expectations regarding nursing duties of nursing assistants (NA) working in basic health units (BHUs) in a region of the municipality of São Paulo. This qualitative study used the collective subject discourse (CSD) technique. It took place in three BHUs with 20 NAs. Data were collected from interviews conducted in 2007. The NAs interviewed associated nursing duties with personal attitudes in daily work, seeing the nurse as a direct care provider who has the role of advisor and coordinator and who performs an excessive number of duties. The expectations of the interviewees were the participation of nurses in providing direct care to the user and the power to coordinate the team and assess the users' needs. Understanding nursing duties is important to respond appropriately to the needs of the community.

DESCRIPTORS
Primary Health Care
Nursing team
Nurse's role

RESUMO
O presente estudo teve por objetivo verificar as percepções e expectativas dos Auxiliares de Enfermagem (AE) que trabalham em Unidades Básicas de Saúde (UBS) de uma região do Município de São Paulo, sobre as atribuições do enfermeiro. Estudo qualitativo que utilizou a metodologia do Discurso do Sujeito Coletivo. Foi realizado em três UBS, com 20 AE. Os dados foram coletados por meio de entrevistas, realizadas em 2007. Constatou-se que para os AE entrevistados as atribuições do enfermeiro estavam associadas às atitudes pessoais no cotidiano do trabalho, que o enfermeiro era prestador da assistência direta, que tinha o papel de orientador e coordenador, bem como excesso de atribuições. As expectativas dos entrevistados foram: participação do enfermeiro no atendimento direto ao usuário, competência para coordenar a equipe e avaliar as necessidades dos usuários. Conhecer as atribuições do enfermeiro é importante para responder apropriadamente às necessidades da coletividade.

DESCRITORES
Atenção Primária à Saúde
Equipe de enfermagem
Papel do profissional de enfermagem

RESUMEN
Este estudio tuvo como objetivo verificar las percepciones y expectativas de los auxiliares de enfermería (AE), que trabajan en Unidades Básicas de Salud (UBS) de una región del Municipio de Sao Paulo, a partir de las funciones de los enfermeros. Estudio cualitativo, que utilizó la metodología del Discurso del Sujeto Colectivo. Fue desarrollado en tres UBS con 20 AE. Los datos fueron recolectados en el año de 2007 a través de entrevistas. Se identificó que, para los AE, las funciones del enfermero se asociaban con las actitudes personales en el trabajo diario; así como percibían que el enfermero brindaba atención directa a la clientela y que tenía el rol de asesor y coordinador; pero al mismo tiempo, contaba con excesivas funciones. Las expectativas de los entrevistados fueron: participación del enfermero en la atención directa al usuario, competencia para coordinar el equipo y evaluar las necesidades de los usuarios. Es importante, conocer las funciones del enfermero para responder adecuadamente a las necesidades de la comunidad.

DESCRIPTORES
Atención Primaria de Salud
Grupo de enfermería
Rol de la enfermera

[1] Nurse. Professor, Department of Health Sciences, Nove de Julho University (Universidade Nove de Julho), São Paulo, SP, Brazil, candida.elisabete@uninove.br [2] Doctoral Candidate, Graduate Program of the School of Nursing, University of São Paulo (Universidade de São Paulo - USP). Professor, Department of Health Sciences, Nove de Julho University, São Paulo, SP, Brazil, romineo@usp.br [3] Nurse. PhD in Public Health. Full Professor, Department of Nursing and Community Health, School of Nursing, USP, São Paulo, SP, Brazil. mrbertol@usp.br

Received: 06/06/2012
Approved: 02/11/2013

OnLine Português / Inglês www.scielo.br/reeusp

INTRODUCTION

The main *loci* of action of primary health care (PHC) are the basic health units (BHUs) and family health units (FHUs), and these services represent the decentralization and dissemination of services in the Brazilian territory. Both provide the ability to establish links and provide accountability and collective action for health promotion and disease prevention in the community, in family and in individual care, offering a comprehensive and complete service[1].

The traditional BHU is predominantly characterized by a service flow driven by spontaneous demand, which is generally a function of medical specialties. FHUs are units deployed within the family health strategy (FHS) and, therefore, provide another form of organization and service to the population. Each FHS team generally consists of a doctor, nurse, dentist, nursing technicians or assistants and community health agents and is responsible for monitoring a defined number of families[2]. The specific duties of nurses in FHS teams are explained in generic terms in ordinance No. 1625 of 2007[3].

To understand how the nursing team is organized, it is necessary to revisit the origins of the profession. Between the sixteenth and seventeenth centuries, especially in England, nursing began to experience a social division of labor. Hospitals were run by the *matron*, and care was performed by *sisters.* In the nineteenth century, *Nightingale* schools created two distinct categories of nurses: *ladies-nurses*, who came from social groups with greater resources and played different roles including the supervision and control of nursing services, and *nurses*, who belonged to a lower social strata and who performed the manual work of nursing under the supervision of the *ladies*[4].

In the early twentieth century in the United States, where the English nursing model was adopted, Virginia Henderson, a nurse, drew attention to the fact that the nurse performed tasks that were not part of her role, emphasizing the need to prioritize her unique tasks in the care process[5].

In the 1920s in Rio de Janeiro, the Brazilian School of Nursing, the Anna Nery School (Escola Anna Nery), was founded and linked to the National Department of Public Health (Departamento Nacional de Saúde Pública)[6]. The process of nursing professionalization was performed in association with women from diverse parts of the population and coming from different social strata. Candidates from the proletariat attended nursing assistant courses and were trained to complete predominantly manual activities, while candidates coming from the bourgeoisie were trained in supervisory tasks, teaching and administration[6].

The division of labor in nursing is not something new that requires learning by the team. Additionally, it is not just a technical division but also a fundamentally social one[7].

In Brazil, the practice of nursing is regulated, and its professionals have their duties specified in decree No. 94,406 from June 8, 1987, which regulates law No. 7,498 from June 25, 1986. This decree describes who nursing professionals are and what their duties are[8], but it makes no distinction between the work of the nurse within PHC and other levels of health care.

PHC requires health professionals and, therefore, nurses to possess a wide range of skills. There is a lack of specificity in nursing duties that may originate in the activities of the professionals themselves, whose main purpose in the daily life of the BHU is yet to be formally identified and who also perform functions and *activities* other than their own[9].

A study on the impact of the organization of the work of nurses, technicians and nursing assistants concluded that it is necessary to look specifically at the organization of work in PHC because this environment, unlike the hospital, calls for more diversity in the activities of nursing staff and nurses in particular[10].

The division of labor in nursing is not something new that requires learning by the team. Additionally, it is not just a technical division but also a fundamentally social one.

Because the work within PHC is operationalized in a team, it is essential that the various individuals who work in this sphere of care know the work of their peers. Therefore, this article presents the results of a study aiming to explore the perception of NAs working in traditional BHUs regarding the nurse's duties in this environment and to identify their expectations about the activities of NAs. FHU staff were not addressed in this study as their nursing duties are somewhat better defined.

METHOD

Exploratory field research of a qualitative nature was performed with all 20 NAs acting in three traditional BHUs in the eastern zone of the City of São Paulo during November and December of 2007. The inclusion criteria were people performing the function of an NA in a BHU, regardless of the length of service, gender, age or current professional training. Two NAs were excluded because they were off work at the time of the data collection.

A semi-structured interview was conducted in which the NAs answered open questions, which were recorded and transcribed verbatim. This was the empirical material from which a discourse synthesis known as collective subject discourse (CSD) was constructed and numbered in increasing order of presentation. A pretest was conducted with two NAs, whose data were not included in the results.

Before starting the data collection, the managers of the BHUs were asked for their authorization to conduct the field research. Prior to the completion of each interview, subjects

received information about the theme and objectives of the study and signed an informed consent form. The interviews were conducted based on the following questions: *What do you know about the work/duties of nurses in the basic health unit? What do you expect nurses to do in the BHU?* and *Do you think it is important to know the nurse's duties?*

The research project was approved by the research ethics committee of the City Hall of the São Paulo Municipality and given Protocol No. 304/07 CEP/SMS, in accordance with Resolution 196/96 of the National Health Authority (Conselho Nacional de Saúde).

The data analysis was performed by constructing the CSD, a technique that was developed based on the need to organize and tabulate qualitative data of a verbal nature. Certain steps must be followed in the construction of the CSD, namely the following: 1) identification of key expressions (KE), which are continuous sections or parts of the discourse that indicate the content of a response, thus revealing the essence of the interviewee's discourse; 2) identification of central ideas (CI), i.e., a summary description that is as accurate a reflection as possible of the sense of the KEs; and 3) a compilation of a single discourse (DC) of key expressions that have the same CI and that provide a way of expressing the collective representation of an idea. This is a methodological strategy that aims to clarify a particular social representation. It is a technique that allows a community to talk directly[11-12].

RESULTS

Of the 20 interviewees, 90% were female, and the mean age was 52.7 years for the women and 44 years for the men. Regarding training, 75% were nursing assistants, 15% had completed a nursing technician course, and 10% performed a nursing assistant role despite having graduated in nursing.

The collective discourse analysis led to the emergence of three themes that guided the participants' representations of the work of nurses in the BHUs. The first one expressed how they perceived the work of the nurse in the BHU. The second revealed the expectations that they had in relation to the nurse's role in the BHU. The third theme expressed the importance that they attributed to knowing the nurses' duties.

Representations of the type of work performed by nurses in the BHU

Within this theme, five concepts emerged, with the first being that nurses' duties are associated with personal attitudes in daily work:

> It depends on each nurse because there are active nurses and non-active ones. Active nurses are together with the assistants at all times, in good times and bad; they are nurses who get their hands dirty and work together side by side DSC1.

DSC1 understands that nursing duties are linked to the person rather than to the professional; therefore, nurses are described as active or not active, with the former being those who *get their hands dirty*, i.e., provide care to patients.

The second concept is that the nurse is the supervisor and coordinator of the nursing team.

> First and foremost, she is responsible for the nursing staff; she is a support for the assistant. The nurse's job is to guide and coordinate the nursing staff. She has to manage. I think she should be present at all stages of the service. The nurse distributes the work; it's very important to delegate tasks. She has to check what's happening in the area, sort out complications, follow procedures, always be willing to guide us and help us and give answers to almost every question we have. She has to take a stand, for us and for the user. They think you are nothing, but when the nurse says no, then they sit up and listen. She is essential DSC2.

The nurse is the team's support, and she solves the most complex problems and says what is right, therefore exercising a leadership role. This authority is also expressed in relation to the user as follows: *They think you are nothing, but when the nurse says no, then they sit up and listen.*

The third concept is that of the bureaucratic and administrative nurse:

> I know what I see in practice; the nurse does the administrative part, such as the duty roster and the timetable. She takes care of the diabetic kit, works a lot with tuberculosis, filling in tuberculosis forms, dengue forms... She works more with paper because there's a lot of paperwork these days DSC3.

Here the nurse is assumed to be responsible for administrative work and dealing with bureaucracy. She is a *paper pusher*, which has a pejorative sense and speaks to the association between an abundance of paperwork and the rigor of bureaucratic standards.

The fourth concept is that the nurse has too many duties:

> In reality, she does everything here in the BHU. She does a lot!! She has a lot of responsibility. She is responsible for vaccines, KB, medication, stocking materials, and epidemiological monitoring of reportable diseases. She also helps with vaccines, though she doesn't administer them. It's a lot for just one nurse to do DSC4.

In this discourse, there is a clear perception that the nurse has many duties that go beyond the direct care of the user. The excerpt *She also helps with vaccines, though she doesn't administer them* indicates that nurses are concerned with the preparation of health care activities in the vaccination room, which in practice proves to be unfeasible.

The fifth concept is that the nurse is the direct provider of assistance to users:

> The nurse carries out activities with the users and takes care of diabetic and hypertension patients, developing groups. She does nursing consultations and administers medications. She makes home visits, visiting people who have hepatitis and

> tuberculosis, to assess whether the patient is being monitored right, and she gives guidance on medication, treatment and diet. She gives talks, performs preventive work with the population and epidemiological surveillance and monitors dressing of wounds; she's very good! DSC5.

This passage refers to the duty of nurses to provide care to the population in a more immediate way, which is seen as *very good*, perhaps because it leads to a better understanding of the users' difficulties, intervening more quickly and effectively in solving problems and possibly making the process of medical care work, as a whole, more immediate.

Representations of the assistant's expectations regarding the role of the nurse in the BHU

Four concepts emerged within this theme, with the first being that of screening.

> A nurse needs to evaluate the patients in the unit, especially the poorest, to see who is in need and to assess whether they really need to see the doctor or not, as there are only a few vacancies. This is not something we can do; the nurse has to do it DSC6.

This discourse refers directly to the nurse's role of performing patient evaluations, and it indicates that she is the professional who is able to judge who needs medical care and, therefore, is the person who performs the screening.

The second concept is that the nurse has to perform her own tasks:

> I expect her to carry out her duties. She has to do what she's responsible for. She has to be competent in her service, and she has to manage, but she also has to do things DCS7.

This excerpt refers to the NAs' expectation that the nurse is a competent professional who knows her role. In addition to stating that the nurse must exercise the *power of command*, it states that she must also know how to do things. The power to *do* is prominent and is cited by the study subjects as a necessary premise for the supervisor position. This idea is reiterated in the third concept, which is that the nurse should participate in the direct care of the user:

> She has to be participatory and not just delegate tasks. I think she could create more hypertension groups and increase nursing consultations. I expect the nurse to leave some of these notifications and share the work a bit with the employee. I expect her to cooperate and come to our rescue when we need her help and guidance, even in the vaccination room; if I ask her, she can cooperate with me in the room. Sometimes, we feel alone in the room; an emergency happens, and you're kind of helpless, even. I don't think they collaborate as they should. We say something, but the user doesn't agree; the nurse has to provide guidance and talk to the patient. She has to go there and explain, talk about what is happening and what our work is about. It's not just the assistant's job to be with the people, the nurse must be present at all times DSC8.

This section explains the need for the team to have the permanent presence of the nurse, as a holder of knowledge and not just as a service supervisor.

Nursing assistants expressed a lack of recognition of their knowledge by users, as exemplified by the statement, *We say something but the user doesn't agree...* In this regard, they also expect nurses to have authority in direct contact with the user, offering explanations and guidelines and reducing tension resulting from the interaction with users.

The fourth concept is that the nurse is responsible for coordinating the nursing staff:

> She has to know how to coordinate. I expect her to have a good view of the team and to see the team as professionals, without favoring anyone or being biased regarding color, gender or anything; she has to be impartial, always seeking the patient's wellbeing. For me, the nurse is a leader who improves the team and who creates ways for the team to work well. She has to work with loyalty and humanity, without favoring anyone. She has to be competent. She takes a stand in all situations that emerge to try to solve the problem, both with staff and with patients. When a problem comes up that we don't know how to deal with, the nurse has to be there. I expect her to be more participatory within her guiding role as this supports the nursing assistant. The nurse must be aware of everything in the unit. I think that the nurse has to spend all day in the different sectors to check what is happening, to oversee the professional's work, to set standards so that I know standards exist and to develop standards for each room so everyone can work together equally DSC9.

Expectations regarding the nurses' duties include leadership, which is expressed as the ability to work with the nursing staff and demonstrate impartiality in dealing with nursing assistants and technicians. The nurse is seen as the professional who should standardize, supervise and organize, as required, to improve the service.

Representations of the importance of knowing the nurses' duties in the BHU

Three concepts emerged around this issue, the first of which was the importance of knowing the duties to have a *fair expectation*:

> If I didn't know what the nurse's duties are, how could I expect anything from her? We have the right to expect things from her. I wonder to what extent I have a right to complain to the nurse; it may be that sometimes I expect something of her that is not her duty. I just need to know what I should reasonably expect DSC10.

At first sight, the extract *I just need to know what I should reasonably expect* appears pejorative, but it indicates the need to define the nurse's role and what she will contribute in her professional capacity as leader of the team. The term *reasonably* suggests that assistants are concerned about a fair expectation of the nurse based on her duties.

Likewise, the ...*right to complain*, quoted above, should not be seen in a negative sense; however, the assistants and technicians expect the nurse to take part in the everyday running of the BHU, demonstrating that she is present and willing to learn and to contribute to the work.

The second concept relates to the division of tasks among team members:

> I think it's important because we get to know her duties and what she has to do or doesn't have to do, because then I would do what isn't her job, and I wouldn't do the part that's hers; instead, I would call her to monitor me. This even makes her job easier, because if I know that she needs to do something, then I pass it on to her. It is also easier for the patient. Sometimes, we get a little lost, we do not know if this is part of the nurse's duties or not, we don't know what to do, what to ask, when we can or when we can't. It is important not to get ahead of the nurse. Sometimes, we do something or take some action that isn't ours, it's the nurse's; we do so because we don't know. Sometimes, you resolve something, but it isn't your responsibility. It is very important to make the service in the unit work and that everyone knows their place and everyone performs their role DSC11.

The need to identify the competence of each team member is evident in this discourse to avoid the risk of inferring limitations. This reiterates the need to define roles, as previously discussed.

The third concept relates to the importance of knowing the duties of the nurse to facilitate teamwork:

> It is important to know because if you are working in a team, you have to work together for the patient's sake. You have to know how to work. It's like in my house: if I don't know how it works, how can I do my job properly? DSC12.

It is argued here that the assistant needs to know the nurse's work to better perform her own work in the sense of *team spirit*, in which everyone involved can discern what is or is not their responsibility through knowledge of their duties and professional limitations.

DISCUSSION

The interviewees separated the nurses into active and inactive, seeing as *active* those who provide patient care. This relates to the origin of the profession and is characterized by the distinction between *doing* and *managing*. This distinction is reaffirmed when interviewees refer to the nurse as a supervisor and coordinator of the nursing team and someone who exerts authority over the population, which is endorsed by the statement that users *listen* when the nurse *talks*.

A study of the perceptions of PHC nurses about their professional identity revealed an ambiguity in relation to attitudes towards others because although nurses were the point of reference in the services in which they worked, they felt little recognized by other professionals. They also believed that users were not clear about the nurses' duties[13].

The NAs interviewed referred to the nurses' bureaucratic and administrative role in a pejorative manner. However, the administration and management process is aimed at care representatives and resources. In other words, without coordination of the work of providing a service to users, care could not be given, which is the very purpose of the nursing process[14].

Care and management are indivisible characteristics inherent in the nurse's work. According to the interviewees, this notion is not reproduced in daily practice, as some professionals are more oriented towards the administrative side and others towards the care side. In many institutions, the administrative role is the most emphasized and demanded, which may lead the nurse to attribute more significance to her administrative work than to her care work. However, it can also be a way for the nurse to develop a relationship of domination over the other nursing staff, strengthening the technical and social division of labor by using powers that differentiate her nursing work from that of her subordinates[15]. It is important that the nurse discusses the profile needed to work in the BHU with her peers.

The reference to bureaucracy may not be related to slowness or excessive formality in the nurse's routine work. However, it was not possible to understand whether the interviewees recognized the importance of fulfilling these roles in the context of PHC. It is necessary to discuss the importance of administrative and/or bureaucratic work with the nursing team.

The NAs' perception of the nurse's excess workload is that of a permanently occupied professional. This might indicate that she is unavailable for dialogue, causing detachment from both the staff and the community.

A case study conducted with nurses in an FHU in the city of Londrina, Paraná state (PR) revealed that nurses' duties are broad, requiring teamwork and operating according to priorities, and that it is impossible for one nurse to perform all tasks[16]. Another study conducted in an FHU noted that the nurse performs activities on her own that could be shared with other professionals, particularly in relation to the support activities[17]. The results of these studies can be extrapolated to the role of the nurse in a traditional BHU, which corroborates the perception of the participants of this study regarding the extent of the nurses' work.

A study conducted in all BHUs and FHUs in the city of Curitiba, PR identified the following difficulties for nurses: performing nursing consultations and responding to the pressure of demands for medical consultations and a lack of understanding on the part of the health team. The latter affects the care provided by the nurse, demonstrating a lack of awareness as to what is part of her job and not knowing who to ask to resolve problems[18], which confirms the results of the present investigation.

In terms of expectations regarding the nurse's duties in performing screening, it is necessary to differentiate this

from reception. Reception is assuming the stance of listening, guiding and, if appropriate, referring to other health services. Screening is a step in the care process that includes selection and exclusion. Reception can take place in all places and at all points in the service regardless of professional training; therefore, it can also be performed by nursing assistants and technicians[19]. Screening is generally designed to contain the excess demand and/or shortage of the doctors on staff of the BHUs and to settle daily work conflicts arising from the organization of services in the traditional BHUs.

A study on the working conditions in a traditional BHU revealed that a lack of supply of medical services generated conflicts between users and professionals, including reports of violence suffered especially by nursing assistants and technicians. This demonstrates the breakdown of the care model centered on the doctor, who has an eminently caring and curative character[10].

The interviewees' expectation that nurses fulfill their duties appears incoherent because the discourses reveal ignorance of what those tasks are. The expectation of the nurse to be both a leader, with the power to *command*, and also to know how to *do* speaks again to the preoccupation with the direct care of the user and needing to dialogue with the staff about their professional duties[13].

The interviewees also stated that they expected nurses to participate in the direct care of the user, as a strategy to promote the reduction of tension arising in the service. This need for the nurse's involvement in direct care should be noted. However, the way that PHC is currently organized determines that BHU nurses have various responsibilities and areas of activity, which usually leads to an overload and limits her activities regarding direct care of the user or the community. This is reinforced by the fact that nurses organize their work process to control the team through the technical division of labor, which sometimes leads to their detachment from direct care, prioritizing administrative actions and delegating direct care[20].

Assistants and nursing technicians expect the nurse to be responsible for coordinating the team, to be a leader and to be constantly available. The fact that they have such wide-ranging expectations may hinder routine service actions and even lead to frustration when those expectations are not met.

The importance of knowing the nurse's responsibilities in the BHU is recognized by the interviewees as something that permits them to have a *fair expectation* and that increases the need to assign tasks among team members to facilitate teamwork and the division of responsibilities. The fact that the interviewees refer to the need to distinguish their role from that of the nurse and at the same time seem to not know the nurse's duties implies that they do not appear to have a clear vision of their own duties.

CONCLUSION

This study allowed certain contradictions to be identified, in part due to the form in which the service in the traditional UBS is organized, wherein the nurse assumes a multiplicity of duties, and in part due to the lack of a clear definition of the role of this professional within the ambit of PHC and at the other levels of healthcare.

The results reveal the perception of the interviewees that the work of the nurses in PHC is predominantly administrative and bureaucratic. This idea may be due to the demands generated by the institutions and to the social division of labor that attributes direct care to nursing assistants and technicians. This belief generates an expectation that the nurse participates in direct care, which is contradictory to the view that the nurse is a busy professional. There is an expectation that nurses fulfill their tasks; however, their duties are not clear to the team, and there are even those who declare that it would be important to know their duties to be able to have *expectations*.

Undoubtedly, the nurses' duties in PHC are different, requiring different and complex skills because, in addition to acting from the individual perspective, a collective approach is also necessary. Therefore, it is important that several nurses share duties and collaborate with other professionals.

Rather than providing answers, this study seeks to provoke discussion, promoting dialogue among the nursing staff to contribute to the understanding of the daily practice of the profession in health care conducted within PHC.

REFERENCES

1. Brasil. Ministério da Saúde; Secretaria de Atenção à Saúde, Departamento de Atenção Básica. Acolhimento à demanda espontânea [Internet]. Brasília; 2011 [citado 2012 maio 22]. Disponível em: http://189.28.128.100/dab/docs/publicacoes/geral/miolo_CAP_28.pdf

2. Brasil. Ministério da Saúde; Secretaria de Atenção à Saúde, Departamento de Atenção Básica. Atenção Básica e a Saúde da Família [Internet]. Brasília; 2012 [citado 2012 maio 22]. Disponível em: http://dab.saude.gov.br/atencaobasica.php

3. Brasil. Ministério da Saúde. Portaria n. 1.625 de 10 de julho de 2007. Altera as atribuições das Equipes de Saúde da Família – ESF dispostas na Política Nacional de Atenção Básica [Internet]. Brasília; 2007 [citado 2012 maio 22]. Disponível em: http://www.aids.gov.br/sites/default/files/anexos/page/2011/48800/portaria_1625_2007_pdf_14117.pdf

4. Geovanini T, Moreira A, Machado WCA, Dornelles S. História da enfermagem: versões e interpretações. 3ª ed. Rio de Janeiro: Revinter; 2010.

5. George JB. Teorias de enfermagem: dos fundamentos à prática profissional. 4ª ed. Porto Alegre: Artmed; 2000.

6. Silva GB. A enfermagem profissional: análise crítica. São Paulo: Cortez; 1986.

7. Mello C. Divisão social do trabalho e a enfermagem. São Paulo: Cortez; 1986.

8. Brasil. Decreto n. 94.406/87. Regulamenta a Lei n. 7498, de 25 de junho de 1986. Que dispõe sobre o exercício da Enfermagem e dá outras providências. In: Conselho Federal de Enfermagem (COFEn) [Internet]. Brasília; 1987 [citado 2012 maio 28]. Disponível em: http://novo.portalcofen.gov.br/decreto-n-9440687_4173.html

9. Santos RM, Ribeiro LCC. Percepção do usuário da Estratégia Saúde da Família sobre a função do enfermeiro. Cogitare Enferm. 2010;15(4):709-15.

10. David HMS, Mauro MYC, Silva VG, Pinheiro MAS, Silva FH. Organização do trabalho de enfermagem na atenção básica: uma questão para a saúde do trabalhador. Texto Contexto Enferm. 2009;18(2):206-14.

11. Lefèvre F, Lefèvre AMC, Teixeira JJV, organizadores. O discurso do sujeito coletivo: uma nova abordagem metodológica em pesquisa qualitativa. Caxias do Sul: EDUCS; 2000.

12. Lefèvre F, Lefèvre AMC. Discurso do sujeito coletivo. Caxias do Sul: EDUCS; 2003.

13. Beck CLC, Prestes FC, Tavares JP, Silva RM, Prochonow AG, Nonnenmacher CQ. Identidade profissional dos enfermeiros de Serviços de Saúde Municipal. Cogitare Enferm. 2009;14(1):114-9.

14. Sanna MC. Os processos de trabalho em Enfermagem Brasília. Rev Bras Enferm [Internet]. 2007 [citado 2012 jun. 3];60(2):221-4. Disponível em: http://www.scielo.br/pdf/reben/v60n2/a17v60n2.pdf

15. Lima MAD, Almeida MCP. O trabalho de enfermagem na produção de cuidados de saúde no modelo clínico. Rev Gaúcha Enferm. 1999;20(n.esp):86-101.

16. Giroti SKO, Nunes EFPA, Ramos MLR. As práticas das enfermeiras de uma Unidade de Saúde da Família de Londrina, e a relação com as atribuições do exercício profissional. Semina Ciênc Biol Saúde. 2008;29(1):9-26.

17. Pavoni DS, Medeiros CRG Processos de trabalho na equipe Estratégia de Saúde da Família. Rev Bras Enferm [Internet]. 2009 [citado 2012 maio 28];62(2):265-71. Disponível em: http://www.scielo.br/pdf/reben/v62n2/a15v62n2.pdf

18. Silva SH, Cubas MR, Fedalto MA, Silva SR, Lima TCCL. Evaluative study of nursing consultation in the basic networks of Curitiba, Brazil. Rev Esc Enferm USP [Internet]. 2010 [cited 2012 June 3];44(1):68-75. Available from: http://www.scielo.br/pdf/reeusp/v44n1/a10v44n1.pdf

19. Brasil. Ministério da Saúde; Secretaria Executiva, Núcleo Técnico da Política Nacional de Humanização. Humaniza SUS: acolhimento com avaliação e classificação de risco [Internet]. Brasília; 2004 [citado 2012 fev. 4]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/acolhimento.pdf

20. Lucena AF, Paskulin LMG, Souza MF, Gutiérrez MGR. Construção do conhecimento e do fazer enfermagem e os modelos assistenciais. Rev Esc Enferm USP. 2006;40(2):292-8.

Correspondence addressed to: Maria Rita Bertolozzi
Escola de Enfermagem da USP
Av. Dr. Enéas Carvalho de Aguiar, 419 – Cerqueira Cesar
CEP 05403-000 - São Paulo, SP, Brazil