

# Embracement with risk classification: relationship of justice with the user

*Acolhimento com classificação de risco: relação de justiça com o usuário*

*Acogida con clasificación de riesgo: relación de justicia con el usuario*

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## ABSTRACT

**Objective:** to describe the conception of justice of nurses and users regarding the Risk Classification in Emergency Unit; to analyze the conception of justice in the implementation of the Risk Classification in Emergency Unit from the user's recognition; to discuss, from Axel Honneth's Theory of Recognition, justice with the user in the Risk Classification in Emergency Unit. **Method:** qualitative research of descriptive, exploratory typology, which used action research as a method. Bardin's Content Analysis was carried out. **Results:** a category was created: "Justice versus Injustice" and three subcategories: "Autonomy/Freedom versus Heteronomy/Subordination"; "Communication versus Hermeneutic Problems"; "Contributions versus Conflicts". **Final considerations:** Embracement with Risk Classification presents difficulties in its interpretation and effectiveness; there are situations of disrespect that compete against the required ethics. Justice addressed by this study will be achieved by an emergency access system that meets user expectations, recognizing it as a subject of rights.

**Descriptors:** User Embracement; Classification; Emergency Service, Hospital; Emergency Nursing; Ethics.

## RESUMO

**Objetivo:** descrever a concepção de justiça de enfermeiros e usuários na Classificação de Risco em Emergência; analisar a concepção de justiça na implementação da Classificação de Risco na Emergência a partir do reconhecimento do usuário; discutir, a partir da Teoria do Reconhecimento de Axel Honneth, a justiça com o usuário na Classificação de Risco em Unidade de Emergência. **Método:** pesquisa qualitativa de tipologia descritiva, exploratória, que utilizou como método a pesquisa-ação. Análise de Conteúdo de Bardin. **Resultados:** foi organizada uma categoria: "Justiça versus Injustiça" e três subcategorias: "Autonomia/Liberdade versus Heteronomia/Subordinação"; "Comunicação versus Problemas Hermenêuticos"; "Contribuições versus Conflitos". **Considerações finais:** o Acolhimento com Classificação de Risco apresenta dificuldades em sua interpretação e efetividade, com situações de desrespeito que concorrem contra a ética requerida. A justiça de que trata esse estudo será alcançada por um sistema de acesso às emergências que atinja as expectativas do usuário, reconhecendo-o como sujeito de direitos.

**Descritores:** Acolhimento; Classificação; Serviço Hospitalar de Emergência; Enfermagem em Emergência; Ética.

## RESUMEN

**Objetivo:** describir la concepción de justicia de enfermeros y usuarios en la Clasificación de Riesgo en Emergencia; analizar la concepción de justicia en la implementación de la Clasificación de Riesgo en la Emergencia a partir del reconocimiento del usuario; discutir, a partir de la Teoría del Reconocimiento de Axel Honneth, la justicia con el usuario en la Clasificación de Riesgo en Unidad de Emergencia. **Método:** investigación cualitativa de tipologia descriptiva, exploratoria, que utilizó como método la investigación-acción. Análisis de Contenido de Bardin. **Resultados:** se organizó una categoría: "Justicia versus Injusticia" y tres subcategorías: "Autonomía/Libertad versus Heteronomía/Subordinación"; "Comunicación versus Problemas Hermenéuticos"; "Contribuciones versus Conflictos". **Consideraciones finales:** Acogida con Clasificación de Riesgo presenta dificultades en su interpretación y efectividad, con situaciones de incumplimiento que concurren contra la ética requerida. La justicia de que trata este estudio será alcanzada por un sistema de acceso a las emergencias que alcance las expectativas del usuario, reconociéndolo como sujeto de derechos.

**Descriptorios:** Acogimiento; Clasificación; Servicio de Urgencia en Hospital; Enfermería de Urgencia; Ética.

## INTRODUCTION

Embracement with Risk Classification (ACCR) is a device of the *Política Nacional de Humanização da Atenção e Gestão* (National Humanization Policy in Care and Management) of the Brazilian Unified Health System (SUS- *Sistema Único de Saúde*) - *Humaniza-SUS*, initiated in 2004 by the Ministry of Health, which focuses on streamlining care according to “risk potential, health problems or degree of suffering”, prioritizing the most severe cases and proposes a more fair and embracing care for users, breaking the exclusion paradigm and facilitating access<sup>(1-2)</sup>. It is a process that aims to order care according to urgency, breaking with the old model of care in order of arrival<sup>(3-4)</sup>. Risk Classification (RC) has been implemented in Emergency Units to increase and facilitate access. It is divided into at least four colors: red (emergency calls), yellow (urgent calls), green (little urgent calls) and blue (not urgent calls)<sup>(1)</sup>.

In order to have a fair care, nurses are professionals capable of evaluating patients through signs and symptoms, classifying the risk in emergency hospitals<sup>(5-6)</sup>. This dimension of practice requires broad application of nursing knowledge in its various patterns that are part of nursing knowledge: scientific, ethical, aesthetic and personal<sup>(7)</sup>. Thus, nurses' role in ACCR requires, in addition to technical-scientific knowledge, the development of a critical sense for assessing the state of users, which includes access to acquired knowledge, capacity of each professional to establish relationships and a kind of metacognitive capacity as knowledge of its possibilities and limits against the protocol of ACCR<sup>(8)</sup>. It also requires an ethical approach that incorporates central concepts for the development of good nursing practices and, among these concepts, justice.

For Axel Honneth, justice is directly related to recognition. Its conception of justice differs from distributive goods, corresponding to communicative relations of reciprocity<sup>(9)</sup>. And the conception of injustice, as opposed to occurring by inequalities, is due to lack of recognition or disrespect. In this theory, recognition only happens when citizens show self-respect, self-esteem. For social justice, it is necessary to have the autonomy of the subjects. Thus, justice presents itself as an expression of the common will between free subjects in communication. The subject is free to choose between what is the common good and free to choose what can be contributory to social life. In Honneth<sup>(9)</sup>, the proposal of justice is not an object in the subjective liberties of action; the focus of justice is on the spheres of social communication, that is, reciprocal recognition.

Currently, publications on evaluations of nurses' work in the implementation and implantation of ACCR deal with structural and administrative difficulties and also report demands and emergent situations in this activity. Literature review carried out by the authors in the production available in the Virtual Health Library and CINAHL from 2004 to 2017 returned 36 complete articles directly related to the subject in Nursing. Of the articles identified, four addressed the theme that the main focus is on the user, their conceptions about emergency ACCR operation and their satisfaction with this device<sup>(10-13)</sup>. There are few studies that focus on the user, mainly about the theme that brings relationship of justice, even considering the value that the subject has for professional care.

Converging knowledge gap and relevance of the theme, this study seeks to clarify the concept of justice and injustice by users

and nurses of the Emergency Department of a municipal hospital in Rio de Janeiro State about risk classification and reclassification in ACCR proposed by the *Política Nacional de Humanização* (PNH - National Humanization Policy). Justice used as a category of analysis in this production is directly related to communication, autonomy and freedom for recognition from Honneth's perspective.

## OBJECTIVE

To describe the conception of justice of nurses and users regarding the Emergency Risk Classification; to analyze the conception of justice in the implementation of the Emergency Risk Classification from user's recognition; to discuss, from Axel Honneth's Theory of Recognition, justice with users in the Risk Classification in Emergency Units.

## METHOD

### Ethical aspects

This study was approved by the Research Ethics Committees of the proposing institutions (*Escola de Enfermagem Anna Nery/UFRJ*) and coparticipant (Municipal Health Office of Rio de Janeiro State). Steps of the Free and Informed Consent Process were fulfilled, so that, according to Resolution 466/12, the participant could decide autonomously, conscientiously, freely and enlightenedly their participation in the study. Participants signed the Free and Informed Consent Form after receiving guidance on the ethical and legal issues that involved the study. In order to ensure participants anonymity, the “U” code was used for users and “N” for nurses, followed by Arabic numerals, according to the data collection.

### Type of study

The study is descriptive-exploratory, with a qualitative approach, where the action-research method was applied, which aims to produce knowledge, obtain experiences and contribute to the discussion about the topic under debate<sup>(14)</sup>; it has participatory, reflexive and dialogical character. Action research is “associated with various forms of collective action that are geared to problem solving or transformation goals” and runs through three phases: exploratory, which is defined by the observation of the problem; developmental, consisting of seminars; and conclusion, where there is analysis, discussion and dissemination of results<sup>(14)</sup>.

### Methodological procedures

This article comes from the Master Dissertation entitled: “*ACOLHIMENTO COM CLASSIFICAÇÃO DE RISCO EM EMERGÊNCIA: relação de justiça com o usuário*”<sup>(15)</sup> presented to *Escola de Enfermagem Anna Nery/UFRJ*. In this article, there is deepening in issues of justice that are inherent to the ethics in ACCR.

### Hypothesis

The descriptive hypothesis is that there is insufficient information, active listening and linkage in the setting of this research, in order to reach the conception of justice in ACCR that approximates

the recognition of Honneth, resulting in exclusion, communication deficit and heteronomy of users.

### Study setting

This study was conducted in ACCR sector of the Emergency Care Service (ECS) of a Municipal Emergency Hospital of Rio de Janeiro.

### Data source

From the understanding that users are the main core of ACCR and that nurses are professionals that daily are in front of this device, the selected population for this study was of users from the ECS and nurses (from 21 years old) of both genders and literate from the referred sector.

Participants in the study were those classified as "not very urgent", who were waiting for medical service in the waiting room or after medication, excluding those who did not present clinical conditions to respond to the research and/or other type of RC, and nurses from the referred to the day shift, which was composed of 6 nurses, divided into 3 shifts. One nurse who was on leave and the researcher, who is also a member of this team, were excluded. Thus, the sample consisted of 4 nurses and 34 users, totaling 38 participants.

### Collection and organization of data

Data collection was carried out in the first half of 2016, in three concomitant stages: seminars, which are the main technique of data collection in action research because at this stage decisions about the investigation process are examined, discussed and taken. It occurred with the contribution of the theoretical-practical knowledge of the researcher, a nurse working in this setting with groups of 3-4 users at a time, captured in a waiting room and informed about the research topic in a dialogical way, with exchange of know-how, doubts and knowledge. The theme of the seminars was planned according to the main focus of the research, so that the objectives of the study were achieved and brought contributions to the setting. Thus, there was discussion on ACCR device, focusing on issues of justice with the user, due to the dynamics of the sector studied. With nurses, semi-structured individual interviews were conducted and participant observation with field diary, which involved observation of the dynamics of the setting where ACCR occurs.

As it is an environment of continuous rotation, all these steps were accomplished sequentially and on the same day. The data collected during seminars and interviews were recorded in audio and later transcribed in a Word file.

### Data analysis

Content analysis<sup>(16)</sup> was organized around three poles: 1<sup>st</sup> - pre-analysis: objectified the organization of the material of analysis so that the researcher could conduct the subsequent operations; 2<sup>nd</sup> - material exploitation: referring to the application of analysis techniques in the *corpus* such as codification and categorization; and 3<sup>rd</sup> - results treatment: inference and interpretation.

Through content analysis, a category of interpretation of the findings, named *Justice versus Injustice* was organized. From it emerged three subcategories: "*Autonomy/Freedom versus Heteronomy/Subordination*"; "*Communication versus Hermeneutic Problems*"; "*Contributions versus Conflicts*".

## RESULTS

Characterization of the sample of professionals by age, gender, training time, length of service in ECS and post-graduation resulted in four female participants of which two were between 30 and 40 years of age, one between 41 and 50 years old and one older than 50 years. As for training time, two had more than 20 years, one between 1 and 5 years and one between 6 and 10 years. Two had up to 1 year of service in the ECS of the hospital and two with more than 2 years. All of them had a post-graduate level of specialization, forming a more up-to-date professional group prepared for the demands of ACCR.

Users were characterized according to gender, age, schooling, family income and RC. The most frequent age group was between 21 and 30 years, corresponding to fourteen users, followed by the age group from 41 to 50 years, with seven users. Of the thirty-four participants, twenty were female and fourteen were male. As for educational level, eighteen users had completed high school, six users had incomplete elementary and middle school and six users had incomplete elementary and middle school; only four users had incomplete higher education. Twenty-two of the interviewed users had family income between 1 and 2 minimum wages, the most expressive number. All participants were classified as green.

Characterization of nurses and users of the setting studied indicates a picture of experienced reality, which favors the description of phenomena and articulation with the limits and possibilities in ACCR, and influences the understanding of categories and subcategories analysis of this research.

Although subcategories culminate in "*Justice versus Injustice*" in the conception of the Honnethian Theory of Recognition, they were individually analyzed for a better understanding of the principle contained in Honneth's Theory<sup>(9)</sup> that there is only justice when there is an effective communication process to give support for a conscious decision-making that emphasizes autonomy, thus offering freedom and co-responsibility in the care process. Likewise, actions in ACCR that weigh social status, order of arrival, or any type of conflict-generating actions are not acceptable, as all users should be equally recognized as law-abiding, which is considered justice by Honneth.

### *Justice versus Injustice*

In ACCR, there are users who feel contemplated and others who do not, and this conception is more directly related to waiting time for care than quality of care. Users associated the conception of injustice with the delay for medical service and also to be classified by the professional:

*I think they put the risk rating because we come before, but after we get a person with a more severe condition [...] because there are people who arrive early, but then a person arrives in a*

*precarious state, then will get ahead, so we understand that the case of that person is more severe, that is why we are behind. Because, for example, the person arrives with a strong cold, it is possible to wait a little. The person arrives with a stroke, why am I in front of a person with stroke if I can wait a little? I agree with this classification. (U24)*

*I think it should be a little faster service. Because people suffer waiting, because give [explanation about ACCR] a few minutes, but we wait much longer. (U4)*

*We classify, but because of the demand, which is very large, it ends up waiting beyond the time gives proposal of classification. Because every classification has a waiting time and here ends up extrapolating. Sometimes it takes time to be ranked, by the amount of nurse you have in the sorting room and by the amount of doctor as well. It ends up expecting more, it [the service] ends up not being so humanized. (N1)*

Speeches point out that there are users who understand RC and the need to prioritize certain types of care due to severity, but the concept of injustice is pointed out in the long waiting period for medical care and also to be classified (see N1). The complaint about too much waiting time also came from the participant observation data.

Waiting time higher than what is recommended or desired is also pointed out in the speeches, generating a perception of impairment in the process of humanization of care.

### **Autonomy/Freedom versus Heteronomy/Subordination**

During interviews and field notes in participant observation, nurses made reports that referred to the reflection about autonomy and heteronomy. One of the reports accounts is as follows:

*I have reclassified patients who were green, who complained of pain and this pain increased, or [blood] pressure increased because it was too long, and the patient returned and was reclassified. And it happened the other way around, the patient was there and remained the same, but he felt that it had to be reclassified because he realized that yellow classification was getting ahead. But it has remained stable and has not been reclassified, but it has already happened to evolve as well and we have to reclassify. (N1)*

This report shows that RC is not an action imposed by the health professional in the on-screen setting, it occurs in a coparticipative way, where the user is heard and understood in their subjectivities, which converges with the current policy of the ACCR's proposal and the Honnetian perspective, contributing to the desired justice. This fact was also observed in the participant observation, in which a woman complaining of abdominal pain had received green RC, but she questioned why she did not have priority. The nurse reported that, according to the unit protocol, complaints of abdominal pain were classified as green; the user reported that her pain was very strong, that she had already used analgesics and that there was no improvement and that she was not suffering from pain. An user did not present symptoms of pain or change in vital signs, but her RC was changed to yellow by the nurse due to her report of intense pain as pain is an inherent symptom.

*So far I do not even know what green, yellow, red means, once I was sick and they turned green and I was only seen by the doctor because I started to vomit at the door of the room, then she came [and asked]: "What do you have?" Me: this, this, this and that. "Ah, but did they put the green on you?" Yeah, what will I do? I do not even know what that green means. Then she picked it up and put me in there, asked the staff and said, "Oh, he's going to get in here because he's feeling sick." He gave all the exams, took an injection, and I felt better. Okay, that's all. Unfortunately, they pass on something to the patient and do not explain what it is. I think I should put here the classifications, a framework, for the person to feel there, read at least: green is for that. (U11)*

This report refers to the lack of information and guidelines, since users do not understand the color criteria, which means that they do not understand their own RC or why someone is treated with priority, which generates the concept of injustice. In participant observation, this was verified at the moment when the request was verified, mainly by attendants of priority RC. When asked what the reason was, they reported that it was due to the user's age. At that moment, they received information from the nurse that the RC is made according to the health problem.

Autonomy issues in ACCR reach both users and professionals, according to the following reports:

*I find difficulty handling with the doctor who, sometimes, often, does not agree with our classification, goes until we complain that our classification is wrong. (N1)*

*I think the medical team could work very well, but it recriminates our ratings too much. From them come and talk like this: "Look, this is green, did you put it yellow?!"[...] They discriminate, they recriminate our classification, our ability. (N4)*

These reports show that nurses also have their autonomy attained due to their non-recognition by another professional category as being able to cooperate correctly in ACCR. This was ratified in the participant observation, in which, on several occasions, doctors went to the classification room to question the RC, in many cases, with users inside the room and without seeking to understand the reason for the RC, only imposing their conduct in a non-ethic.

### **Communication versus Hermeneutic Problems**

In ACCR, one of the aspects that impact the conception of injustice is the lack of information and understanding about this device, in which is imbricated a bad communication among users, professionals and institution, which generates hermetic problems. In many cases, users are not aware of what ACCR is or how ACCR is performed:

*[...] there is a patient who understands [...]. There is a patient who does not understand. If we pick up and give a green and he wants a yellow because he has yellows getting ahead, he comes with aggression on top of you. "Oh, why are you getting ahead of me?" He does not understand, no matter how much you explain. I at least like to explain: "Red, orange and yellow gets ahead of you, okay? The green you keep waiting for, "but they always come hoping that the doctor has to meet them immediately and fast. (N4)*

[...] we go through type a screening with Nursing, where they gauge our pressure, ask questions, by a nursing technician, to give an opinion, to send directly to the doctor, this is the process there of them. then back to the reception for the girl to get the data from us, address, everything, and from there to wait for the doctor to call us. In this period it takes a long time. (U1)

I think in addition to having a nurse, I mean, a nursing technique, should have a nurse there assisting. (U9)

Previous statements show that there is a misunderstanding about how the ACCR process is, since it is not a prior medical diagnosis, but rather the collection of signs and symptoms for risk assessment. In addition, these users are unaware of who performs the RC, even pointing out the need for the presence of the nurse, who is the professional who acts in front of this process in the setting studied. Therefore, they are outraged that they believe that RC is not carried out by those who are competent because of the lack of information.

### Contributions versus Conflicts

Protocols use in health intuitions based on the PNH's premises are fundamental to a standardized and effective practice in ACCR and contributes to make this device fair, by valuing equity and avoiding that service is performed on a first-come without considering the severity of each case:

We follow quite the same classification. [...] we try to follow the protocol, and the protocol is fair, yes. (N1)

In this category, reports show that nurses are based on their RC, the institutional protocol, which ensures that their classifications are not performed at random. Data from interviews show that one of the conflicts faced by nurses is the responsibility of orienting users who are classified as blue, that is, low risk, about the fact that they should be seen in Basic Health Units:

[...] because when we classify a patient to blue, it's primary care, we have to refer him to another unit. And we send him to another unit without knowing if it will be answered right now. (N4)

This report shows that the precarious functioning of the basic health network overloads the Emergency Units, as well as hinders the continuity of health care, since, when redirecting to a BHU, there is no guarantee of care. This fact could also be verified in participant observation. Users, when advised that their cases were of a blue classification, and that they should be taken care of at the Family Clinic, reported that in those units they could not get care because there was no doctor or for the long time to get a medical or nursing consultation, and who, therefore, sought emergency care.

In the setting studied, there are situations that hurt the ethics of care, so that conflicts of interest arise in which privileges are granted to some to the detriment of others:

[...] Because sometimes you're there feeling bad, it's in the green, then goes a person there less bad and he is in the red. I do not know if it is kinship, then gets ahead. I've seen it happen. The person

is bad, is green, then comes kinship and red boot, there goes in front. That's unfair! (U11)

I only know that once I came, I had already spent with my daughter for nursing care, her classification was no risk. She started to feel sick after she passed by [RC], and she hot ahead of everyone. The lady at the front desk who sent you. I did not do anything, she took her file and said, "Come in". She went and changed the rating. (U24)

[The RC] It has already been disrespected both by the user and by the doctor who serves. With the doctor: sometimes an acquaintance who was gotten ahead of the others, a priority classification. And by the user who is dissatisfied with the rating that was given and wants to get ahead of everyone. (N2)

According to data from interviews, "undue reclassifications" cannot be noted, since there are prioritizations in the service of some users performed by professionals who do not belong to the health area. In addition, there are still cases where this prioritization is the result of knowledge or kinship with professionals working in this unit, which generates unethical and unfair service.

### DISCUSSION

Results expressed in the category "Justice versus Injustice" elucidate that the great waiting time for the care can generate negative consequences, mainly for users of high risk<sup>(17)</sup>. In addition, the fact that individuals "get ahead" in the service can generate doubts in users, which causes feelings of injustice, which leads them to the concept of not being recognized as subjects of law. However, this conception can be minimized with health education performed in the waiting rooms, being explained how the process is in ACCR<sup>(1,18)</sup>, corroborating with the method of data collection used in this research. In this conception, Honneth<sup>(9)</sup> argues that recognition is denoted as a comprehensive part of the constitution of the subject. One approach to justice is the guarantee of individual rights, "in securing rights, a fair legal framework protects individuals from such forms of disrespect"<sup>(19)</sup>. People can, out of solidarity and love, understand rationally the effective needs, leaving aside their will to ensure morally what is correct, which has repercussions in recognizing the other as a subject of rights, i.e., an autonomous being<sup>(9)</sup>. Thus, the understanding that the ordering of care is performed through a risk assessment generates in the subjects a sense of justice.

This fact is confirmed in subcategory I, Autonomy/Freedom versus Heteronomy/Subordination. The data express that the guarantee to the user service is given through the evaluation by a professional nurse on the health status of the user, which, from the dialogue, comprises being the clinical evaluation the only means of ordering care. This process must be dialogical and guarantee an equitable service. By valuing equity, protocols are used as instruments of support for the exercise of ACCR<sup>(17,20-21)</sup>, however, the active participation of the user is indispensable for the valorization of their autonomy. It is an essential criterion for its proper functioning, since care for the human being is something complex and wrapped in subjectivities. From this perspective, a strong educational tendency towards social interaction and social sensitivity in ACCR can be evidenced, which

helps them to perceive the demands of others, gradually ceasing to focus on themselves, becoming less self-centered. Such facts point to the importance of permanent dialogue between users and professionals, as was done in this research, which allowed the clarification of doubts about ACCR, its understanding and strengthening of its autonomy.

Autonomy is a relational dimension, it does not follow an individual logic, it is intersubjective. It is composed through the reciprocity of recognition through living relationships, which are considered fair, so that we learn to value each other's needs, convictions and abilities on the other hand, heteronomy is understood as the opposite of autonomy<sup>(22)</sup>.

This activity should take into account the peculiarities of each user and their biopsychosocial conditions, which requires a holistic view of professionals and permanent dialogue between multidisciplinary team and users, which was constantly worked during the dialogues interviews, by the researcher. In addition, referral and counter-referral networks should be agreed so that continuity of assistance can be ensured<sup>(23)</sup>.

With this, a good communication between users and nurses should be extended to all multiprofessional team and it is necessary for an adequate assistance that meets the rights of users. The lack of information and embracement generates feelings of subordination and exclusion to users<sup>(24)</sup> who are subjected to a system that provides privileges to some to the detriment of others. According to the Honnethian perspective, practices that generate sensations of subordination or exclusion are considered unfair, since they substantially harm the autonomy of the subject<sup>(19)</sup>. ACCR is a multiprofessional device in which the participation of all those involved, including the user, must be respected. Nurses must have their autonomy assured, being recognized as being able to care for the other<sup>(17)</sup>.

A subject can only recognize himself as a being of rights, an autonomous being and identify his goals and aspirations in the moment that adds self-confidence, self-respect and self-esteem, which are the three forms of Recognition, according to Axel Honneth's Theory, being inseparable<sup>(9)</sup>.

In order to solve the hermeneutic problems associated with ACCR, an effective communication process is necessary. This process presents the following elements: emitter-message-receiver-feedback, without them it can be said that there is no communication. However, this information exchange is not always successful. It cannot be guaranteed that this message is properly given as desired, not only by language, but also by the essence of the message emitted and the set of elements that interfere in the understanding of the message, giving rise to the hermeneutic problems.

PNH encourages a factual communication between health professionals and users<sup>(1)</sup>, a fact that contributes to care that values the autonomy of the caregiver and provides co-responsibility. Based on the Honneth's Theory, users and professionals need to be understood in order to be recognized and to establish a relationship of trust, which is at the heart of the therapeutic act, since "[...] only insofar as it is granted in principle to all subjects, with the establishment of civil law, individual freedom of decision, each of them is also in a position to define the goals of his life without external influence"<sup>(9)</sup>.

Subcategory II, Communication *versus* Hermeneutic Problems, maintains that users should understand ACCR, since this understanding is not a scientific knowledge but rather that RC understands that it is performed by a trained professional and is not random<sup>(17)</sup>. In addition, dissemination of information with good communication should be promoted so that the user can understand the purpose of the RC, which aims to streamline and prioritize the most urgent cases.

In this study, it was found, as explained in subcategory III, Contributions *versus* Conflicts, that, sometimes, emergencies become reference units for these users in search of health care, even in cases of low complexity. It should be emphasized that there is no specific "gateway" in health services; users need to have their needs met regardless of the care unit sought<sup>(24)</sup>. In addition, they must be received in a resolute and fair manner, taking into account the ethical principles of care.

One of the factors that affects the ethics of care is related to "undue reclassifications" performed by non-health professionals<sup>(24)</sup>, and prioritization of care based on knowledge or kinship with professionals working in the unit that generate a sense of injustice in the other users, who are disadvantaged, extending to nurses who have their RC disrespected. These attitudes are in line with what is advocated by the ACCR device, which aims to provide care according to the degree of health impairment and not the impersonal. As regards service priority, "the legal system must be understood from now on as an expression of universalizable interests, so that it no longer admits exceptions and privileges according to its pretension"<sup>(9)</sup>. That is, people should be treated as equals, without exception, being their different needs and thus requiring a fair service.

ACCR is contributory in that it brings together the evaluation and constant review of the care and management practices employed in health institutions. Health production factors are linked to collective and cooperative actions among the subjects, built in a relational way, requiring interactivity and permanent dialogue. Through this dialogue, questions arise that contribute to the practices of co-responsibility and autonomy between users and professionals and an ethical and fair service<sup>(5,25)</sup>.

For nurses, justice was directly related to the collective, in which some would have priority to attend to situations of health problems, while to users, justice was perceived as the urgency of their care, waiting time, referring to an individualistic view in its conception of justice.

From the moment of subordination, as we have seen, the relationship of justice is compromised. In this sense, it becomes paramount the understanding of these users about the functioning of this device, since only through knowledge and awareness about their social role the user can feel contemplated, solidarity, within this assistance model.

An active listening makes professionals have another understanding about the user, as well as understanding ACCR makes users feel fairly treated by this device. Not always, clarifying something is embracing. At certain times, attitudes, such as looking into the eyes, calling by name, greeting, recognizing their conceptions, answering their doubts, being resolute, makes the person feel embraced, that is, they lack the subject's human issues and not the issues policies. Along with the technical-scientific competence,

these ethical issues need to be considered, even recognizing that technical competencies are ethical issues, especially when talking about a sense of justice. Nurses must be an ally of the community and users in this process, which is an educational, dialogical and also cultural work.

The research strategy provided an opportunity to listen to these users and clarified their doubts, promoting joint reflection between users and nurse-researchers. It also provided a moment of reflection with nurses about their practice, which converged to transform that reality and helped each of the participants to strengthen their esteem and social participation.

Recognition spheres from the theory that provides the basis for this analysis have emerged as conditions for the user to be heard more and act as a strategy multiplier so that ACCR works better and responds more to the demands of users themselves from firmer relationships of love, solidarity and rights with each other.

### Study limitations

The study limitations are inherent to the non-participation in this research of all professionals involved in the service process in ACCR, since it is a multiprofessional action and that can only result in effective changes in this setting with the strengthening of teamwork. It is suggested, in this sense, research in multidisciplinary scope.

### Contributions to the fields of Nursing, Health or Public Policy

This study contributed because it has brought a user-centered approach, aiming at its comprehensiveness and the recognition of its direct ones, according to the Axel Honneth's Theory of Recognition. By providing critical thinking that promotes the rethinking of nursing practices, identifying values and principles and social responsibility with users, by showing a picture of this reality, can motivate for new strategies to be idealized and implemented by each of our readers.

In addition, the proposal of dialogue strategies corroborated to clarify issues of justice and injustice, minimizing these problems. It was possible to show users the role of the nurse in ACCR and

an opportunity for improvement in the community. However, this isolated act is not enough to extinguish these tensions and conflicts. Health education actions in waiting room with users should be implemented. It also requires the constant training of the multiprofessional team.

### FINAL CONSIDERATIONS

Regarding nurses' and users' conceptions, there is a deficit on both sides. Some professionals partially understand ACCR, not valuing the importance of listening and. As for users, there is a lack of knowledge about what ACCR is and there is no dialogical presentation of it so that one can truly identify doubts of users about ACCR. Therefore, converging with the PNH's proposal, it is recommended that a dialog space be built to expand conceptions and improve communication among users, nurses and multiprofessional team working in ACCR.

According to results, it was verified that users do not understand the criteria of RC and prioritization of care only by checking the different colors and emergency situations, which generates feelings of subordination and exclusion to users. Lack of information and bad communication among users, multiprofessional team and institution are one of the aspects that impact the conception of injustice, thus, there is no knowledge on the part of users about what is or about how ACCR is realized. There were also cases of conflicts of interest, which are in line with the proposal of this device. Thus, the descriptive hypothesis of this study was confirmed, especially when it was offered information with exchange, feedback, active listening and bonding, in the emergency setting studied, in the quest to reach the conception of justice regarding ACCR, approaching the Honneth's recognition, including users through effective communication so that they were recognized and recognized in their autonomy.

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