Original Article

TEXTO & CONTEXTO ENFERMAGEM
TEXT & CONTEXT NURSING TEXTO & CONTEXTO ENFERMERÍA

IN-HOSPITAL INSTITUTIONAL VIOLENCE IN THE CHILDCARE PRACTICE: DISCOURSE ANALYSIS FROM THE FOUCAULDIAN PERSPECTIVE

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ABSTRACT

Objective: to interpret speeches by health professionals and companions about in-hospital institutional violence in childcare practices, based on the Foucauldian concept of discipline.
Method: a qualitative, descriptive and exploratory research study with a pediatric unit from a university hospital in Salvador/Bahia as study field. The study participants were 10 companions of hospitalized children and 39 health professionals. Data collection took place from November 2018 to October 2019 using semi-structured interviews. Discourse analysis in the light of Foucauldian Thought was employed in data interpretation.
Results: institutional violence in the care practices is understood by the disciplinary device, having the following as elements: time control and spatial separation; control over the bodies; norms and training; and thorough examination. With care being guided by such elements, situations of care omission, disrespect for autonomy and privacy, lack of listening, lack of attention, physical harms, deprivations and multiple manipulations of the children's bodies were identified, resulting in violations of these individuals' human dignity.
Conclusion: it is necessary for professionals, users, managers and the academic community to propose a change in the modes of care for hospitalized children, strengthening dissemination and debate of human rights in the health services that serve children and their families.

DESCRIPTORS: Child maltreatment. Hospitalized child. Universal access to health services. Qualitative research.

HOW CITED: Santos ACPO, Camargo CL, Vargas MAO, Araujo CNV, Conceição MM, Zilli F. In-hospital institutional violence in the childcare practice: discourse analysis from the foucauldian perspective. Texto Contexto Enferm [Internet]. 2022 [cited YEAR MONTH DAY]; 31:e20220002. Available from: https://doi.org/10.1590/1980-265X-TCE-2022-0002en

VIOLÊNCIA INSTITUCIONAL HOSPITALAR NA PRÁTICA DE CUIDADO À CRIANÇA: ANÁLISE DO DISCURSO NA PERSPECTIVA FOUCAULTIANA

RESUMO

Objetivo: interpretar discursos de profissionais de saúde e de acompanhantes acerca da violência institucional hospitalar nas práticas de cuidado à criança, fundamentado na concepção foucaultiana de disciplina.
Método: pesquisa qualitativa descritiva exploratória tendo como campo de estudo uma unidade pediátrica de um hospital universitário em Salvador/Bahia. Participaram do estudo 10 acompanhantes de crianças hospitalizadas e 39 profissionais de saúde. A coleta de dados ocorreu de novembro de 2018 a outubro de 2019 utilizando-se a entrevista semiestruturada. Na interpretação dos dados, foi empregada a análise do discurso à luz do pensamento foucaultiano.
Resultados: a violência institucional nas práticas de cuidado é compreendida pelo dispositivo disciplinar, tendo como elementos: controle do tempo e separação espacial; controle dos corpos; normas e adestramento; e o exame minucioso. Estando o cuidado balizado por tais elementos, foram identificadas situações de omissão de cuidados, desrespeito à autonomia, privacidade, falta de escuta, falta de atenção, danos físicos, privações e múltiplas manipulações do corpo infantil, resultando em violações na dignidade humana destes indivíduos.
Conclusão: é necessário que profissionais, usuários e gestores e a comunidade acadêmica proponham uma mudança nos modos de atenção à criança hospitalizada, fortalecendo a difusão e debate dos direitos humanos nos serviços de saúde que atendem crianças e suas famílias.

DESCRITORES: Maus-tratos infantis. Criança hospitalizada. Acesso universal aos serviços de saúde. Pesquisa qualitativa.

VIOLENCIA INSTITUCIONAL HOSPITALARIA EN LA PRÁCTICA DE LA ATENCIÓN DE LA SALUD INFANTIL: ANÁLISIS DEL DISCURSO DESDE LA PERSPECTIVA DE FOUCAULT

RESUMEN

Objetivo: interpretar discursos de profesionales de la salud y de acompañantes acerca de la violencia institucional hospitalaria en las prácticas de atención de la salud infantil, sobre la base de la concepción de disciplina de Foucault.
Método: investigación cualitativa, descriptiva y exploratoria en la que el campo de estudio fue una unidad pediátrica de un hospital universitario de Salvador/Bahía. Los participantes del estudio fueron 10 acompañantes de niños internados y 39 profesionales de la salud. La recoléccion de datos ocurrió de noviembre de 2018 a octubre de 2019 mediante la entrevistas semiestructuradas. En la interpretación de los datos se recurrió al análisis del discurso a la luz del pensamiento de Foucault.
Resultados: la violencia institucional en las prácticas de atención de la salud se comprende como el dispositivo disciplinario, con los siguientes elementos: control del tiempo y separación espacial; control de los cuerpos; normas y entrenamiento; y examen minucioso. Como la atención de la salud está guiada por dichos elementos, se identificaron situaciones de omisión de atención, falta de respeto por la autonomía y la privacidad, falta de interés por escuchar a los pacientes, falta de atención, perjuicios físicos, privaciones y múltiples manipulaciones del cuerpo infantil, derivando en violaciones a la dignidad humana de estos individuos.
Conclusión: es necesario que profesionales, usuarios, gerentes y la comunidad académica propongan un cambio en las modalidades de atención a niños internados, fortaleciendo la difusión y el debate de los derechos humanos en los servicios de salud que atienden a niños y a sus familias.

DESCRIPTORES: Maltrato infantil. Niños internados. Acceso Universal a los Servicios de Salud. Investigación cualitativa.

INTRODUCTION

Institutional Violence (IV) is defined as the one that takes place through the power relations between users and professionals and which result in harms. This can occur in several ways, namely: trying to adapt the patient to the needs of the service, devaluation of the life experience to the detriment of scientific knowledge, physical violence, lack of attention, omission and pilgrimage. Thus, IV can occur from the search for health care to the moment when health practices are developed, when they are provided inappropriately, compromising care and well-being of the user[1].

The complex panorama involving the construction of IV in health services and the difficulty that professionals and users have making it visible are supported by the way in which these practices have become authoritarian and interventionist over the years. The influence of the biomedical model, present in the history of most health professions, combined with the technological advance of Medicine, makes the incipient concern with respect for human rights in these practices increasingly evident[2].

Oftentimes, development of health practices based on the individuals' needs and on respect for their dignity collides with the paternalistic attitudes of professionals, who generally provide care under the pretext of good intentions; however, they find it difficult to recognize and consider the users' rights, wishes and interests. This condition can be reproduced both in and by the asymmetric power relations between professionals and users, which can culminate in situations of violence in the health services[2].

The presence of violations to human rights in the health practices has a significant historical bias marked by hierarchy, discipline, and control over the bodies. These elements are presented and discussed by contemporary philosopher Michel Foucault, who describes discipline as a specific technique of exercising power through control over a person's body. For this author, control of society by individuals does not take place through an ideology but by and inside the body[3].

Also according to Foucault, Medicine is a biopolitical strategy in which bodies are a biopolitical reality. In this way, the truth speeches conveyed reproduce effects of power, in which individuals are judged, classified, segregated, disciplined and forced to submission according to these discourses[4].

Since their inception, hospitals are considered as institutions that employ discipline to establish medical order[4]. The asymmetrical relationship established between professionals and users consolidates hierarchy, as one person holds a position of superiority over the other and there is no room for negotiation[4–6].

The discipline that occurs within institutions such as hospitals is based on well-defined strategies for controlling bodies: time control, through rigidity of the schedules; spatial separation, through the well-defined distribution of the bodies in space; norms and training, the normalizing sanction; and thorough examination[3].

When the health service users are children, the problem becomes even more challenging, as they are more vulnerable to abusive health practices. In this sense, understanding that a number of research studies evidence the occurrence of harms in hospitalized children as a result of having disregarded abusive care practices[7–10] and that, despite the existence of studies that confirm the presence of physical and emotional abuse in children in general and pediatric hospitals[11], they are still scarce; this demonstrates a large gap in studies involving this theme[12].

Thus, this study sought to interpret the discourses of health professionals and companions about in-hospital institutional violence in childcare practices, based on Foucauldian conceptions of discipline.

METHOD

This is a qualitative, descriptive and exploratory research study. Presentation of this paper followed the Consolidated Criteria for Reporting Qualitative Research (COREQ)[13]. The study resorted to contemporary philosopher Michel Foucault's thought to discuss the theme. Data production took

place from interviews that were interpreted by means of discourse analysis. The Foucauldian discourse analysis devices adopted in treatment of the empirical material were the contents related to discipline as a power technology. In this case, following the Foucauldian reflections, discourse analysis was based on the understanding of disciplinary power as economic, driven by surveillance and by the effects of the sensation that it is capable of producing in the population, being a mechanism that is architecturally and meticulously present in the institutions, converging effectively in the disciplinary examination[3].

The participants were chosen by convenience. The following were considered among the inclusion criteria for the companions to take part in the research: age over 18 years old and being the companions of hospitalized children for more than seven days; and, for the health professionals: having worked in Pediatrics for more than two years to the present day. The exclusion criteria for the professionals and the companions were as follows: being away from work during the data collection period; and not being the people responsible for the children, respectively. During the approach for data collection, two female companions refused to participate in the research due to personal issues.

The research locus was a pediatric inpatient unit of a large-sized university hospital from Salvador/Bahia, Brazil. The care unit has 26 beds and welcomes children aged from 3 months to 14 years old.

Data collection took place from November 2018 to October 2019. The data were collected by means of interviews containing a structured script consisting of closed questions about the individuals' sociodemographic profile and through a semi-structured script with open questions. The guiding questions for the companions were the following: how has your child been treated in this hospital? Have you or your child had any problem during hospitalization? Which ones? Can you identify any situation that can be interpreted as IV during your child's hospitalization? In turn, the questions for the professionals were as follows: In your opinion and according to your professional experience, which problems does a child face during the hospitalization period? Can you identify any type of IV inflicted on the hospitalized child? Which one(s)? The interviews were recorded and transcribed in full. To ensure anonymity, the participants were identified by the word "companion" followed by a number (e.g., Companion 01) and, in the case of health professionals, by the professional category and number (e.g., Nutritionist 01).

The interviews were conducted by the main researcher and a previously trained team. The participants were chosen by convenience. In the case of the companions, the daily Nursing report from the pediatric unit was consulted. Subsequently, the interviewers approached the companions and invited them to participate in the research. With the professionals, the researchers looked for those who were on duty on the data collection day, invited them to participate in the research, and scheduled the interviews. Thus, of the 65 health professionals working in the unit, 39 accepted to take part in the research. The interviews took place in a private place in the pediatric unit itself, being closed after reaching data saturation, totaling 11 hours of interviews, with a mean duration of 15 minutes.

The analytical procedures were carried out after recording, transcribing, and superficially and exhaustively reading the interviews. The technique used was discourse analysis, guided by the reflections and problems of Foucauldian thought as points of analysis, which signals the need to investigate such statements to understand the power games present in the relationships[14]. Directed by the Foucauldian reflections, the empirical material was treated as a set of statements supported by the same discursive formation – about in-hospital IV in child care practices – but without assembling a "rhetorical or formal unit, indefinitely repeatable and whose emergence or use we could mark in history."[15:132]

This research was submitted to the Research Ethics Committee of the Nursing School at *Universidade Federal da Bahia*, being initiated after its approval. The research was conducted within the ethical standards based on the guidelines set forth in Resolution Nº. 466 of the National Health

Council, dated December 2012. After the participants' consent, all signed the Free and Informed Consent Form. To the present day, none of the interviewees has requested to withdraw from the research.

RESULTS

The study participants were 10 companions and 39 health professionals from the aforementioned unit. According to the companions' sociodemographic profile, all were female, aged between 19 and 45 years old, most of them with High School education and incomes of up to one minimum wage. The following health professionals participated in this study: nursing technicians (11), physicians (7), nurses (6), nutritionists (5), physiotherapists (5), pharmacists (2), speech therapist (1), psychologist (1), and social worker (1). In this group, all the participants were female aged from 27 to 62 years old and with family incomes that varied between five and 10 minimum wages. Most of the professionals had worked from 6 to 10 years in Pediatrics.

The way in which discipline, as a power technology, is capillarized within the hospital can be seen in the participants' speeches. It is observed that there are different ways of child subjugation understood in the everyday routine of the hospital norms, which reiterates appreciation of the routines within prescriptive institutional frameworks.

Thus, the data were allocated into four discursive formations, namely: control over time and space; control over the bodies; norms and training; and thorough examination.

Control over time and space

In this discursive formation, it was possible to notice that there was significant concern in the professionals about carrying out the care practices in a given time period and space. With regard to time, in some situations it was controlled by the professionals in such a way that children should wait to receive adequate care, leaving them vulnerable to complications due to lack of attention to their needs: […] *i'm going to have my child operated on! But the surgeon said: "There's no doctor!" Because the doctor who was going to do the monitoring was the Urology chief and he was in the United States. She said she wouldn't mess with his schedule, that she wouldn't take the patients out to put my son in.... Then they said the same every day: "Mother, go away, come back on February 20th, because he might get an infection." But I said: I won't leave, because my child is being treated here and there's no surgeon for him where I live* (Companion 02).

The research participants also mentioned time control in the situations where the professionals denied or delayed care provision. In some cases, this was due to slowness in the administrative processes, to lack of professionals in the sector, or to negligence: […] *the specialists we have are not here every day. Children keep waiting for the specialists. The hospital doesn't have all the exams or procedures. They keep waiting for regulation to take the exams. Waiting for the material to arrive. All this potentiates the risks* (Physician 07).

[…] *I can see that the patient has an infiltrated access and I pretended I didn't see it, then the boy's arm starts to swell until it evolves and I think I shouldn't get the access, because it's the end of the shift. Some people think like that* (Nursing Technician 11).

Spatial separation was understood in the speeches as an important tool to understand the elements of institutional violence against hospitalized children, as spatial control caused care omission, thus determining who would be treated or not. The statements illustrate this situation: […] *there's no reception room at admission. So they're downstairs, in the hallway, in the regulation area, waiting to go up to the ward, so they get hungry, they're waiting in a chair, it's not an ideal condition. Patients are left without comfort and without assistance. If they are in a severe condition, they're even not treated* (Physician 05).

Although the children were undergoing treatment within the hospital space, some situations were verified in which they were received no visits and were not evaluated by the professionals from some pediatric specialties: […] *now her case is surgical, then the doctor said: "Oh, mother, we're going to discharge her from the hospital because she needs an appointment with the neuro and the anesthesiologist, but the neuro won't come to the ward to see her, so we'll have to discharge the patient" . We're going to schedule her return to the clinic, because the neuro won't come* (Companion 10).

Some companions also expressed concern mainly with the risks involved in returning home with the child and with the threat of worsening or complications, as presented in the following statement: […] *then I complained, I said: how come you send a child home knowing that her problem can only be solved with a surgery now? To come back when? In a month's time for an appointment? How am I going to wait for my daughter to be treated and God only knows when to schedule the surgery? What am I going to do if she gets worse at home? What am I going to do if the medication is no good?* (Companion 10).

Control over the bodies

Children's bodies are exposed to multiple manipulations, which occur when they are subjected to an excessive load of examinations and procedures, which can cause physical and psychological harms. Such situation can be verified in the statements, both by the professionals and by the companions: […] *he, my son, has never been hospitalized, a child who is punctured all the time, loses an access, takes a liquid from his tummy, it's all too new for us* (Companion 09).

[…] *the thing of drawing blood all the time, the punctures. This thing of puncturing too much, too much irradiation, when sometimes it's not necessary. They are procedures. We often leave children with an access for a longer time, it favors more infection, more pain, more limitation for them to leave* (Physician 06).

Control over the children's bodies is evidenced in the situations where their autonomy is disrespected, as well as when their body is manipulated without their consent; which generated anxiety, anger and other emotional imbalances: […] *she will be invaded, blood will be drawn, the child is not asked or told what is going to be done. Unfortunately, it is only with time that we gradually realize that this is not an aggressive child, it's a child that is afraid, a child that is being invaded* (Physician 01).

[…] *today you have the blood test, tomorrow you have the echocardiogram, the day after tomorrow you have an X-ray, then you have... Darn, what is all this for? Why so many tests? First comes the psychological wear out, then comes the wear and tear of this invasion, the child's being invaded too much!* (Companion 09).

[…] *we're going to puncture and place the serum anyway. It's not an urgency, an emergency to save the child's life. This is something you can talk, you could show the child and not just restrain him* (Nurse 05).

Despite the disqualification of practical knowledge and of the life experience, in this study it was possible to notice that appropriation of the child's body is such that the mother's opinion is disregarded at the decision-making moment: […] *the pediatrician said: "He's OK, we want to discharge him from the hospital." Then I said: But I won't accept it, I know what happened and he's going to suffer. She said: "No! He's more than OK". A couple of days passed, he started to feel sick, he turned pale, I got nervous. He stayed in the crib for two days without eating, without playing, feeling sick. It was then that they realized I was right* (Companion 02).

Children's bodies were also considered as an control and power object when some members of the health team tried to direct the treatment to what they understood as being "the most appropriate for the patient", without considering the indication of other ways to provide the same care with less

discomfort. The differences are manifested in the discourse, according to each profession: […] *from the point of view of speech therapy, one of our difficulties is that the team doesn't respect children's eating pleasure, the need to feed them orally. They're often children who need and are able to take it orally; however, the team is more aggressive and ends up choosing to pass a tube, which is "easier"* [signaling the quotation marks with her hands]*, as children will gain weight more quickly. But that's very relative, they can often gain weight respecting their normal route, which is the oral route* (Speech Therapist 01).

In addition, situations of control over the bodies were observed when the children were exposed to incorrect behaviors during procedures, either due to malpractice or to recklessness, causing physical harms, as seen in the following reports: […] *this doctor pulled my son's tube too early and ended up hurting his surgery, it gave pus, and filled his tube with pus and inside his bladder and his pee too, he only urinated pus. He got an infection, which was already taking hold of him, he was going to die* (Companion 02).

Norms and training

The hospital rules and norms were described as a behavior guide that assists the professionals in providing care to the patients. However, in several situations it was possible to notice that the imposition of norms and routines in the care provided to the children caused harms in meeting their needs, contributing to the occurrence of IV: […] *sometimes the doctor responsible for the surgery takes a long time to arrive at the pediatric ward to admit the child, so he/she is left without a prescription, that is, he/she doesn't have a diet, he/she gets hungry. Institutionally, we can't release the first meal without having the first prescription. For the nutrition service this patient doesn't yet exist, it has to enter the system* (Nutritionist 05).

Adaptation to a series of pre-established norms and rules can be compared to a training process. The harms resulting from this normalization lead both children and families to be deprived of their basic needs such as sleep, food and care: […] *we have to respect many routines. There are times for administering the medication, for the bath, for waking up, and the child is not used to that. We impose everything on them and sometimes they get more stressed and it's often not just because of the illness, it's because of having to adapt to so much new stuff. The team lacks sensitivity to understand that, sometimes, the bad mood is not because they're spoiled or have a tantrum or are whiny, it's just because they tend to express their stress in that way* (Pharmacist 01).

In addition, the care practice centered on the institutional norms set the necessary pace to ensure agility in care and a false sensation of being caring for the child adequately and competently. However, the professionals acknowledged certain dichotomy between being competent and providing care: […] *and today those things like competence, demand, pressure, "You have to be good! You can't go wrong!", that too, I think it's very disadvantageous, we end up losing a lot of sensitivity, that thing of stopping to talk, getting to know the patient and the family as a whole, right? It's all very mechanized, because it has a lot of protocols* (Physician 06).

[…] *with the routine, it sometimes goes unnoticed, it's automatic. Maybe the routines also harm these children a little, no matter how hard we try to adapt, sometimes we can't do it in a way that is better for them* (Nurse 04).

[…] *the child's complaints are often not heard. They perform the procedure and only explain to the mother/father. There's also the issue of not informing about the diagnosis. There's no clear conversation with the child. Sometimes we think that children don't understand, but they understand everything* (Nurse 05).

Thorough examination

In the hospital space, above all, for being a university hospital, the examination practice related to fragmentation, disarticulation and scanning imposed harms in meeting the children's health needs. In addition, the thorough examination, an action based on the detail of surveillance and body scanning, gave rise to IV situations due to disrespect for children's privacy, causing discomfort and stress: […] *there are often 10, 15 medical students interns here, and then several of these interns will attend to the patient. Sometimes there's exchange of interns and the family members complain about it. There are many professionals in the unit and they* [the family members] *have difficulty seeing the reference professionals. That also hampers the treatment adherence process. It's a university hospital, so we have a lot of changes because of the turnover of medical residents and interns, but this is often not shared with the patient. As professionals, we can notice the psychological impacts of this process* (Psychologist 01).

[…] *first comes the medical student to evaluate the child, then the preceptor, which, in this case, is me, to question something and this even causes crying... Once, when I entered the room to examine the child, she had already been seen by four doctors* (Physician 04).

In the most severe cases, children experience situations of such stress that they can be stigmatized as aggressive and uncooperative children. The professionals describe this situation as pathologization of the child: […] *depending on their age, children can't express what they feel. Those who doesn't have children don't know about it, they don't have this experience and think that it's just the child's behavior and don't like to provide care to that child, then they're left with the stigma of difficult child and difficult mother* (Physiotherapist 04).

[…] *in some situations, the family members are labeled with non-existent psychiatric diseases. There is still this culture of pathologization of the family and childhood. We already had a time when it was very encouraged to medicate the patients with some mood change* (Psychologist 01).

Despite the systematic procedures involved in the thorough examination, a number of situations in which IV was manifested through inaccurate diagnoses were identified: […] *then the Urology doctor arrived, who said that my son wouldn't need surgery until he was about five years old, so he was going to be discharged from the hospital, and he said that I shouldn't worry. I returned on September 26th some time after he was discharged with his exams and showed it to a medical Urology board. Nobody knew what to do, because I said that my son's kidney was already being affected and I had to have this surgery* (Companion 02).

DISCUSSION

According to the speeches by professionals and companions, it is verified that health care practices in children's care are loaded with elements that relate to IV perpetrated in hospital environments. The IV experienced by hospitalized children is manifested through physical abuse, negligence and ethical problems that violate their autonomy and rights.

In the discursive formation called "control over time and space" through the speeches of professionals and companions, it is evidenced in an attempt to adapt children to the time-related norms and standards established by the institution. As a result of the strict control over time during health care provision, an increase in the children's waiting time to be treated was noticed, even when they were in emergency situations, leading to deterioration of their health status.

The search for comprehensive childcare is a difficulty pointed out in another study[16], which emphasizes the relentlessly search for solutions to the problems. Thus, the pilgrimage in different health services and, consequently, the lack of duly trained professionals to serve this clientele are

negative highlights of the functioning of the Unified Health System with regard to the integrality of childcare practices.

A research study carried out with caregivers of children hospitalized in the South of Brazil evidenced that, in most cases, the family is unaware of the hospital norms and routines, initially seeking to adapt to them, as they understand the need to organize work. Therefore, the study highlights the importance of stressing flexibilization of the norms. In addition, the participants reported that, when they identified problems or difficulties in carrying out children's care caused by the norms, they did not accept them and even transgressed them[17].

A research study conducted in a public Brazilian hospital with adult users showed that hospital norms and routines are overvalued. The same study revealed that individuals perceive the hospital as a confinement space, where people who need health care are kept segregated from society for a variable period of time, remaining closed, isolated and formally administered. Thus, norms, rules and routines, which theoretically should facilitate care and ensure comfort, become a domination instrument due to the predominance of the bureaucratic and technical-scientific vision, compromising care resoluteness[6].

Establishing a right time for things is inherent to discipline[3]. In discipline, control over time is established by censorship, so that if something does not happen within the allotted time, it must be censored[3]. In this study, many care omission attitudes were justified by censorship, which created problems for the children.

Discipline can also occur through spatial separation, in which individuals must be isolated and monitored; for that, people are introduced into classifying and combinatorial spaces. In this way, distribution of the institution's internal space must make it conducive to the medicalization practice and not to the needs of the individuals who enter it[3].

The difficulty providing good quality care in all of the hospital's spaces can be justified by the work overload. However, the spatial separation argument should not be supported, as hospitalized children's health needs presuppose that there is prioritization of their care in any environment where health care is offered.

The second discursive formation showed that the care practices have been developed based on control over the bodies, this because the children's bodies have been exposed to multiple manipulations, mostly without their consent. Lack of information and disqualification of practical knowledge to the detriment of scientific knowledge result in loss of autonomy and objectification of child subjects.

A number of research studies prove manipulation of children's bodies without their consent, considering that their fundamental rights are partially applied. This situation was described in studies in which children described the imperative way in which they were approached by some professionals[18–20].

A body is docile insofar as it submits to the imposition of forces that shape and subject it[4]. Control over the bodies through discipline consolidates subjectivation of the child and sick subjects at the same time. In discipline, the body is the target and object of power; therefore, there must be a relationship of docility so that it can be transformed and perfected. However, this relationship of docility often results in aggressions, mutilations and domination nurtured by the abuse of power by the professionals, revealing institutional violence against children in the health service[4].

Subjects are individuals who go through several objectification processes that occur in the truth games and in the power relations[21]. Thus, in subjectivation of the subjects, they are produced by social and institutional truths that induce them to know, think, reflect and understand themselves as those truth games induce them[21].

Based on this premise, children's bodies have historically gone through different objectification modes, being considered an object of pampering, fun and adult distraction, but also of shame and

modesty, which needed to be moralized and controlled in every detail. Therefore, the health practices in which childcare was developed were based on hygienist and eugenicist assumptions that predicted the image of children's bodies as eugenic, white and clean[21–22].

Domination states happen when power relations are crystallized, where there is no change between the partners[3]. In this way, it can be considered that, in some cases, the asymmetrical power relations (which constitute the theoretical frameworks of violence) between professionals and hospitalized children can be replaced by relations of domination, becoming denser, crystallized and difficult to mobilize.

In another situation, the presence of physical violence was observed in the case where a companion reported that the child had his urinary catheter pulled inappropriately and before the time prescribed by a physician, resulting in pain, bleeding, intense crying, anxiety, edema and, later on, local infection. According to Law Nº 13,431/2017, physical violence against children is defined as an action inflicted that offends their bodily integrity or that causes physical suffering; therefore, the situation presented is an example of this type of aggression[23].

A number of research studies confirm the existence of abuse in hospitalized children and evidence the presence of physical abuse characterized by bruises, fractures, rough handling and verbal and sexual abuse. They also reveal that children reported not liking it when the professionals did not talk about the procedures and spoke with them in an imperative way to remain silent[17–18].

A study points out that there is a paradox between provision of care in the medical practice and respect for the principles of human rights, as this category is increasingly equipped with knowledge about the practice and less about bioethics; therefore, countless violations of bodily integrity and human dignity are verified in the name of health and medicine[2]. Consequently, there is still a need to mobilize national and international entities to introduce this topic in the training and qualification of professionals in the health areas[24].

It is important to highlight that the occurrence of stressful situations during the hospitalization period can generate consequences such as emotional trauma, namely: signs of regression (enuresis, reactivity) in childhood and emotional disorders such as anxiety and depression in adulthood[25].

The discursive formation of norms and training shows that the imposition of norms and routines impacts, as is the case with IV, on the care provided to the children due to care omission and to deprivation of basic needs of children and their families, such as rest, sleep and food. This evidence is also observed in studies which show that children experience hospitalization in a negative way because they feel limited by the rules, control, isolation and dependence imposed on them[20,26–27].

Rules allow for the domination game to take place. It is through rules that normalization is practiced, giving rise to violence. In the Foucauldian theoretical perspective, rules are elements that are necessarily allocated in a privileged way, insofar as it is important to know who takes possession of them, who dominates them[3]. According to the National Humanization Policy (*Política Nacional de Humanização*, PNH), humanization presupposes that the rigid knowledge and power structures in health practices are mitigated; therefore, the subject's protagonism must be promoted, highlighting the subjective and social aspects of the health practices[28].

The last discursive formation, thorough examination, allows exploring that the fact that the study field is a university hospital has repercussions on care practices that exacerbate the approach to children by many professionals and groups of students from different health areas. Such condition led to the conception of multiple information; however, communication between these professionals is not established at the same speed, which results in fragmentation of the health practices and, later on, in inaccurate diagnoses.

A study points to the importance of communicating patient information among professionals. In this logic, it is through clear and proper communication that continued and safe care can be offered, thus reinforcing the need for teamwork[29].

Other research studies confirm the increase in the number of procedures performed in individuals seeking health care, showing that, in several situations, people are subjected to obsolete treatments and interventions that exert an impact on hospital costs. To minimize these problems, in 2012, a campaign called “Choosing Wisely” was launched in the United States, with the objective of stimulating conversations between physicians and patients about unnecessary exams, treatments and procedures, reducing the excessive amount of procedures and exams in individuals treated in health services[27,30–31].

Regarding the situations involving multiple manipulations, the participants reported that this event leads children to stressful situations, making them anxious, irritated and very reactive. As a result of this emotional status, children often end up being stigmatized as difficult, nervous, whiny and rebel.

In institutions that govern their practices through discipline, for a thorough examination to take place there must be a scrutiny of the individual’s body, in which it is subjected to a pyramid of gazes and constant surveillance. In addition to that, it is also necessary that continuous recording takes place, as it is through discipline and via the examination that medicalization takes place[4].

Medicalization of children and adolescents is a process that seeks to homogenize or normalize behavioral patterns and deviant behaviors of children[32]. Social and medical practices define the normalization and problematization profile; therefore, it is through the examination, based on the “normality” standards, that a subject is considered crazy, sick or delinquent[20].

It is noted that this study was restricted to investigating IV only in a public hospital from the state of Bahia. Therefore, it is suggested to conduct similar studies in other environments where care is provided to children. It is also suggested to apply other research and analysis methods to carry out other scientific investigations of the phenomenon through different perspectives, even with other age groups.

As for the contribution to the health area, this study brings about important elements for health professionals, especially nurses, who can reflect and redirect the care practices in hospital services in order to reduce all forms of IV inflicted on children while they remain hospitalized. By being able to discern and recognize the main abuses and violations present in the health practices, it will be possible for professionals and managers to practice health advocacy as a way to minimize children’s suffering, promoting their and their families’ well-being.

CONCLUSION

IV in health practices is manifested by control over time, space and bodies, through the norms and training, and by means of a thorough examination. As care was guided by such elements, situations of care omission, disrespect for autonomy, privacy, physical harms, deprivation and multiple manipulations of the children’s bodies were identified, resulting in violations of these individuals’ human dignity.

Here, it is up to professionals, users, managers and the academic community to reflect on the change in the ways of caring for hospitalized children, as hospitals still remain as healing places and that, through discipline, they end up allowing the individuals who resort to them to be exposed to patterns and actions that cause them harms.

In addition, it is necessary to strengthen diffusion and debate of human rights in the health services that serve children and their families. It is possible that, through knowledge and respect for children’s rights, professionals and managers not only abandon abusive and violent health practices, but also become great allies in advocating for the rights of children and their families.

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NOTES

ORIGIN OF THE ARTICLE
Extracted from the thesis - Institutional violence inflicted on hospitalized children from the perspective of companions and health professionals, presented at the Graduate Program in Nursing and Health of the Nursing School at *Universidade Federal da Bahia*, in 2021

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ACKNOWLEDGMENT
We thank *Universidade Federal da Bahia* for granting the Scientific Initiation scholarship through the *Permanecer* Program.

FUNDING INFORMATION
This research enjoyed funding from the Scientific Initiation scholarship by the *Permanecer* Program of *Universidade Federal da Bahia*, through the National Student Aid Plan (*Plano Nacional de Assistência Estudantil*, PNAES), Decree No.7,234 of 07/19/2010.

APPROVAL OF ETHICS COMMITTEE IN RESEARCH
Approved by the Ethics Committee in Research of the Nursing School at *Universidade Federal da Bahia*, Opinion No. 2978609 and Certificate of Presentation for Ethical Appraisal 99681518.0.0000.5531.

CONFLICT OF INTEREST
There is no conflict of interest.

HISTORICAL
Received: February 03, 2022.
Approved: July 04, 2022.

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