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Rationalization and sensemaking in care management: an experience of change in a hospital of the SUS (Unified Health System)

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Abstract *This study aimed to analyze organizational processes of change in the hospital care management by using qualitative evaluation developed in the case study. The study was developed at the Hospital Fornecedores de Cana de Piracicaba, in São Paulo State, Brazil, in September and October of 2012. There were 25 interviews with members of the senior board of directors of the hospital, managers and health professionals linked to healthcare of adults, in addition to the analysis of managerial documents and observations of some activities. In this article it is analyzed part of the results, dividing the organizational change in three axes: the planning process developed in the healthcare sectors; The protocol/creation of assisted routines in order to obtain better efficiency and safety for the patient; and the work of hospitalist physicians. The study highlights the complexity of the processes of change in the care management sphere in hospitals and the dynamism between a given management concept and its rational tools and the subjects and groups that seek, in the micropolitic and intersubjective processes, meanings to their practices.*

Key words *Hospital management, Care organization, Health work, Healh care quality, Subjectivity and management*

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Introduction

The debate on health management in the national and international contexts highlights the importance of hospital management in governmental policies, as an almost natural corollary of cost reduction policies and the search for greater efficiency for the sector. The search for a new management model – founded in new structures, rules, incentives, tools and managerial practices that induce more efficient health services, with best results, making available care in a safe and good quality – focus on hospitals as its primary target[1].

The issue of management and especially the one linked to the excellence and quality of care in hospitals has developed an increasingly important role in the daily routine of the managers, health professionals and users. In this context, intense studies and initiatives for adoption of guidelines and clinical protocols of hospital accreditation, standard definition and a search for a high level of security for the patients, among other measures whose purpose is the qualification of hospital health care[2-5]. In the same way, in the last decade, issues such as the comprehensiveness of care, care promotion, teamwork, reception and health services humanization are increasingly occupying a noticeable position in the sectoral discussions of the country[6-9].

The issue of cooperation/agreement between managers and agents or actors in general involved in health sector is an important challenge in a scenario in which the presence of conflicts of interests and the fragmentation of processes of health care has been a trend[1,3].

Involved in this discussion we presented the study developed in the Hospital Fornecedores de Cana de Piracicaba (HFCP), philanthropic hospital of high complexity of the SUS (Unified Health System), which analyzed the care management experience and the possibilities of changes implementation in the work processes and in the improvement of hospital assistance quality, considering the complex and multidimensional nature of health care. This part of the research Evaluation of Innovative Experiences Within the Organization and Attention Management in Hospitals of the SUS[10]. The first stage of the research was based on the active search of experiences in hospitals of the SUS throughout the country, with 100 or more beds, through electronic inquiry, generating a database with 239 hospitals. The central objective of the study was to identify and assess, in hospitals of the SUS, experiences of organization and management of care focused on the improvement of the care quality and for the introduction of management innovations, in this field. Public hospitals and philanthropic organizations stood out in the development of initiatives for care management; associated with better conditions for the management of care, the processes of contractualization, accreditation and certification have been highlighted.

The analysis of the experiences/initiatives of organization/management and care improvement implemented, through the inquiry, tried to identify, among other variables, its scope, methodological approaches or strategies and organization devices of adopted care, besides changes in the structure, processes or the results related to hospital assistance and, also, possible changes, resulting in the mission or hospital profile, in the labor management and management models. Considering their conditioning nature, some elements such as the legal nature of the hospital, characteristics of the hospital management model, selected elements of the health care profile and complexity of the hospital, in addition to the insertion into current policies of certification, accreditation and incentives to improve the quality of care.

The research also resorted to a precise and qualitative evaluation by means of the accomplishment of case studies, focused on analysis of singularity of the organizational processes and the challenges faced in the implementation of changes to the management way and care production. The cases were selected from the experiences/initiatives of management of hospital care gathered through the inquiry. For selection of hospitals the following general criteria were considered: a) initiatives that express or translate an integral understanding of care; (b) submit proposals, devices and processes of intervention which favors the increase of accountability of professionals with care quality, teamwork and the patients autonomy; and c) experiences whose process of organization and care management has been involved or has had an impact on the hospital as a whole (not restricted to one sector or service isolated).

The choice of a general hospital to carry out the case studies was strategic – for the scope of the healthcare profile and greater representation in hospital scenario – so we defined the existence of an emergency room as a second filter. We selected 3 hospitals for case study, trying to contemplate hospitals that stood out in the analysis of the initiatives and also to include different sit-

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uations regarding the legal nature, management model and region of the country. We selected a public hospital, from the SES/SP, administered by an OSS, a philanthropic hospital from the SUS (Unified Health System) in São Paulo State, object of this article, and a public hospital maintained by the Federal University of Bahia.

Methodology

The study is theoretically and methodologically based on the following benchmarks of health management: (i) approaches from the perspective of quality assessment in health and geared toward the improvement of quality, such as accreditation, contractualization and the clinic management/Clinical Governance and patient safety[3,4,11]; (ii) approaches that highlight the micropolitical and intersubjective dimension of the organization and management of the health work process and the care production, being recognized the central role of the subjects in the health care production[9,10,12-16].

The first group of approaches which in another study we analyzed and named "approaches toward the rationalization of medical-hospital practices and continuous quality improvement"[9] and which here, more briefly, we are going to call it "approaches rationalizers" pursuit the quality through rationalization processes of medical-hospital practices, and it is guided by the creation of more powerful mechanisms of control of the work processes in the hospital, particularly those relating to access and use of its assistance strategic resources, the outsourcing of activities and the strong emphasis on protocolization of processes. The redesign of work processes and systematic activities are indispensable to reduce risks to patients. In this perspective the improvement of quality is understood as a process not just individual, but essentially organizational. However, these approaches are based on a strictly rational and functional vision of the organization, reducing the understanding of change processes and organizational culture[9,17,18].

The second group of approaches, that in the work already mentioned[9], we studied and named "approaches focused on the expansion of the clinic and for the centrality of the subject in health practices", look for answers to an assistance and management crisis, which, although focused on global problems, has a specificity in the Brazilian political, social and institutional reality. This second axis assumes the recognition of the systemic and strategic rationality limits and the hegemonic management thought to satisfy the complexity and uncertainty that mark the life of complex organizations, especially the hospitals. In this perspective the most procedural elements of the quotidian and the micropolitical, dialogic and intersubjective processes, as bases for construction of a project of change and qualification of assistance are valued[9,10].

We have included in this second tendency, approaches which recognize the complexity of processes of change in health organizations and consider them as organizational and social processes of difficult control, valuing the relational and intersubjective dimension of healthcare. With this concern, we sought authors who propose the reconstruction of the clinical work trace, the centrality of the subject at health work, and thus the recognition of subjective mobilization of workers, a central issue to the increase of accountability with the work. Such understanding points to the delicate process of care coordination in the hospital and for construction of co-management, being central the autonomy of workers and their irreducible ability to produce senses and creativity[7-10,14,15,18,19].

By establishing a dialog with authors of this second tendency, we employ the framework of French psychosociology[15,20] that relies on a psychoanalytic perspective to understand the organization and its processes of change as a living reality, in which the subjects live your desires of affiliation, refusing to separate the individual from the collective, the affective from the institutional. It stands out in this perspective the position of the subject from the field of the unconscious, the desire and the narcissistic demands of recognition, but also of its investment capacity, psychic work and formation of social ties. This conceptualization, although recognized by Campos[14], was not deepened by him and represents a promising way in the dialog with other readings of subjectivity[12,13]. The French psychosociological approach adopted[15] comprises the psychic dimension in its linkage to organizational process and experience of belonging. With these concerns we emphasize the symbolic and imaginary dimension which subjectively constitutes the linkage with the work and the organization, the intersubjective and group processes and its implications for cooperation and solidarity. We emphasize, in particular, the category of organizational imagination, considered by Enriquez[20,21] as an interpretation system emotionally invested, facing construction of meaning, equivalent to an

imaginary social policy that represents "what we are, what we want to be ...and in what type of organization we wish to intervene or exist"[21].

In this study we examine both the role through the rational perspective translated into the adoption of accreditation as a strategy for change, as well as the ability of subjective mobilization and psychic investment of subjects and groups in the change process in progress.

The research in the HFCP has tried to identify the scope of initiatives of the organization and care management in the hospital and to examine the strategies and devices of care organization adopted. The following innovative initiatives of the hospital were informed during the inquiry: management of critically ill patients; hospitalist physician; care for the patients of high dependence; humanized visit; trimming edges; project to combat venous thromboembolism - TEV. The empirical study was carried out in September and October 2012, contemplating the analysis of institutional documents that provide an understanding of the changes in the processes of management and qualification of assistance in development at the hospital, as the management report; 25 interviews with members of the hospital senior management, managers and professionals linked to the adult patient care and observations of some care activities and innovative education aimed to care qualification, such as the humanized visit at the ICU (Intensive Care Unit) and formative activities of reflections on death and mourning developed with nursing staff. We seek, particularly through the interviews; investigate the meanings of innovative practices for managers and professionals.

The analysis was guided through the understanding of innovative initiatives, devices and incorporated management tools and the challenges faced in the implementation of changes in the hospital management in its linkage with the management of attention. Through the interviewees' narratives, directors, managers and health professionals, we tried to characterize the initiatives and management tools and explore their meanings for these institutional actors. For this purpose, we used interview scripts with the same orientation, but with a general or specific focus to capture the vision of the different levels of management and professionals who are in care practice, but trying to prioritize the free narrative of interviewees[22]. The analysis is guided by the examination of the role of rational trends and its linkage to the intersubjective issues in practices of change in HFCP.

In this article, we analyzed part of the results considered from three axes: the planning process carried out in the care sectors; the protocolization/ creation of routines seeking greater efficiency and safety for the patient; and the work of hospitalist physicians. The last two fall into a broader project of mortality reduction in hospitals. We chose the area of adult care for analysis of devices care management[22]. The research was approved by the Research Ethics Committee of the ENSP/Fiocruz.

Results and discussion

The analyzed hospital

The HFCP, located in Piracicaba, is a reference for the 26 municipalities belonging to the Regional Health Department of Piracicaba, São Paulo State.

The HFCP, at the time of the study, counted 268 beds besides 26 adult ICU, 9 neonatal ICU/ pediatrics and 10 surgical centers, 270 physicians and 1,367 "collaborators" (other health professionals). These are hired under CLL laws (CLL-Consolidated Labor Laws), while the physicians of various specialties are hired as a legal person and, thus, as services providers. The SUS patients accounted for 60 to 70% of the total and had access to all the specialties of admission. The HFCP showed good physical structure, having a master plan of works and participated with 34% of the total number of beds and 32% of intensive beds of the region. The hospital was a reference for transplants - kidney failure, heart and Bone marrow. The entrance door was formally regulated, with referrals from central regulation of the SUS[22].

The hospital began an accreditation process in 2006 through the program of evaluation and continuous quality improvement of the CQH (Program of Hospital Quality Control), achieving the full certification in 2010. There was an important change in the management model and in the devices for care management, generating an impact on the hospital as a whole. The organization chart was reviewed, dividing the hospital in three broad areas: Strategic, Operational and Technical. The core activities comprise the technical direction and are divided into critical and emergency management, surgical clinics and maternal and child care. Four management boards were created as new devices for communication and decision, involving managers and health professionals.

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The change of organizational structure in the HFCP has a new management model, providing the central place for the collegiate spaces. It was hoped that through a model of co-management a participation increase in the assistance management and less fragmentation of work.

Considering the organizational context, it is important to highlight the deep involvement of the management group in the process of change and improvement of quality, as a daily effort. The leadership development was an important aspect of the experience.

Action plans for the sector

The process of annual strategic planning is focused on the structure of management boards and has been based on criteria of CQH. There was an important training component for its development, once all the management team has been trained to work with indicators, protocols and plans of action. It is based on SWOT tool, which has a methodological simplified structure.

In the context of assistance services, the planning focused on the elaboration of action plans. The construction of these plans proved to be an institutionalized process favorable to discussion of problems in staff, always guided by the search monitoring, targets and indicators. Reports of Monthly Activity and indicators were displayed in tables in the respective sectors.

From strategic guidelines, the action plans were prepared by teams of employees from each sector, coordinated by the nurse administrator, being subsequently reviewed by the technical manager of the care sector and forwarded to the 2nd collegiate staff, proceeding with the hospital planning.

The interviewed managers pointed to the improvement in the result of the indicators and greater knowledge of the sectors, especially by nurses. However, there were still little involvement of physicians in cases of collective discussion process and resolution of problems at the nursing teams and supporting teams. These professionals only focused on meeting of their own professional category. Such behavior of physicians has been repeated in other studies[14,23,24]. At the general ICU, however, a greater coordination between physicians and nurses was observed.

The "viability actions" also caught our eyes for its heterogeneous nature. If some involved regulation and formalization, others indicated actions in the interactive sphere, with greater involvement of the psychology sector, use of group work with leaders, among other features.

However, if the construction of the plans for the assistance sectors represented a commitment to the care improving, it also showed its limits. The "viability actions" indicated in the plans of action, in many cases, were limited to compress complex problems and revealed the weight that the sectors management attributed to the formal dimension. As an example, the problem of commitment to work, identified in the emergency sector, was faced with actions which could be called norms: "monthly meeting with the teams supervisors using the tool SWOT of quality (strength and weakness) as an indicator for control "Adoption of the protocols and filling of forms" without considering its insufficiency to change the professional practices.

Considering the complexity of the work in health[18,19,25] we inferred that it demands, for its coordination, a set of interactive actions and collective bets that go beyond the objective solution and pragmatic approach that the group can point. It is comprehensible that the meeting is organized around the plan, which may represent a dialogical effort and build a sense group, favoring, therefore, the linkage with the work and working as a space of psychosocial articulation[26].

Protocolization

From guidelines of the accreditation process and the commitment to conquer the seal of quality, but also as a demand of strategic planning, a set of protocols has been developed for the care to patients. A new advisor board instance was created in the HCP to build routines and protocols considered fundamental for *...all services speak the same language.* [Identify] *the own routines still failed e not existent... Is it written? No… so let's create it* (manager). So, to coordinate the work and develop the quality, we sought the formalization, based on technical standards and regulation, expressing the ideal work into processes of accreditation/certification[3].

In the context of clinical surgical care procedure the following protocols are highlighted: (1) systematization of nursing care (SAE), (2) Sorting/meeting of the multidisciplinary team, (3) Report of occurrences of sentinel event, (4) Protocol for assessing the risk of thromboembolism (TEV) and prescription of prophylaxis, (5) Braden scale (control of the risk of pressure ulcers), as well as the protocols identified as (6) "Yellow Code" for complications and (7)"Blue Code" for cardiopulmonary arrest, accompanied by a large number of them, by routines to be followed.

Professionals have been recognizing the use of such instruments as support and technical support:

It is the first hospital in which I work at, where there are all these protocols. In many hospitals where I have worked at, nursing is adrift. There is not a pattern to follow and no correct technique to be applied to the patient care (Nurse)

What is important is to make the hospital work in a regular way, independent of the morning, afternoon or evening period. I speak from the point of view of processes, for example, of a catheter. The majority of cases involve altogether the nursing area (physician)

The sense of overload of work also was relevant:

We work with the SAE. Each nurse has to make 22 SAE, it is impossible. It gives a direction to the technician. There is also no waste of material. They follow what it is written. But it is a lot of paper (nurse).

Although the adoption of protocols represents the improvement of care through technique standardization, you must be aware to clinically considerate aspects which differentiate each case. Thus,

It is a guide, and the professional may not be a robot [...] *For example, the protocol of TEV has to be analyzed with discretion because not every patient will be in this protocol, but not always the patient is met by the nursing staff. If there are more than 4 hours since the beginning of the event, it is not possible to use thrombolytic. Sometimes the nursing staff wants to trigger off the protocol* (doctor)

Protocols also tried to streamline the assistance work and fulfill the function of generating autonomy and power to nursing. It is like this here in the protocol "team multi. " The HCP has developed a form that enables the nursing staff to directly ask the assessment/referral of professionals of nutrition, psychology, social service, without relying on a medical request.

We understand that the set of forms/protocols represents a rational initiative to qualify the care, seeks to induce the appropriate follow-up to the patient and encouraging precocious diagnosis. Through a psychosociological approach, we emphasize that such management tools also play a subjective role of safety, psychic protection and mediation of professionals in contrast with the patients and their suffering. Thus, we can assume that the standardization processes meet a structuring proposal and of safety of the patients through control of care processes, but at the same time, by the subjective processes which favors. In the subjective plan it is also necessary to recognize that the care practices will be impacted by the singular form by which the professionals subjectively interpret the needs of each patient and build their therapeutic plans.

Hospitalist physicians

The inclusion of the hospitalist physician, a new function for the general physicians who care of hospitalized patients[25-27] represented an innovation in the management with the expansion of the clinical support to critically ill patients and improvement of flows. This initiative in the HFCP occurred in the context of creation of the care line to critically ill patients, seeking to integrate emergency, clinical care, and ICUs, representing a greater support for care transitions.

The proposition of hospitalist physician encompasses the organizational functions of coordination of care to the hospitalized patient, being recognized its importance for faster responses in the changes of clinical status, improvement of the quality of the hospitalized patient, reducing the fragmentation of medical care, as well as a greater efficiency[25-29].

By means of the hospitalist physician aspects of management and patient safety were valued in the HFCP, but particularly the artisanal characteristics of labor care, specific to clinical judgment.

Hospitalist physician plays the role of guardian of the ward, he can directly face the problems, manage the use of beds, streamline a discharge [...] *so the patient can has the best in post-surgery care, an early discharge with quality of treatment* (doctor).

We identify the potentially critical patient, the patient who had neurological abnormality, dyspnea, high fever, lowering of consciousness level, chest pain. We identify and communicate the nurse. [...] *This patient will receive a package of measures of 6 hours and we must continue the treatment, once that is the moment which saves* (doctor).

At the HFCP, hospitalist physicians were also responsible for promoting palliative care, being among its activities, the reception and communication with family members and patients.

Managers and professionals met each other at the beginning of a process that requires many adjustments. At the time of the survey there were a coordinator and a hospitalist physician every 24 hours covering approximately 150 beds.

Once it is possible to anticipate problems, and quickly respond to changes in the patient

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conditions, we assume, from a psychological understanding, that the hospitalist figure in an imaginary way as the "guardian of the ward" or as the one who is present "on the moment which saves" and also with the task of accepting the anguish of the patient and family. He condenses and represents the investment of the management of the hospital in clinical care, in its technical and managerial aspects, but also intersubjective.

Relations between physician and nursing staffs: work discontents

The relation doctor-nurse, its tension and conflicts have emerged in the interviews. There was a clear understanding that nursing has grown in prominence in the management and that there were difficulties to the doctor adopt the desired model, in which the leadership of the nursing staff became paramount. These issues manifested as work discontents:

I think that the soul of a hospital is the nursing team. It is a relationship historically difficult. The nurses are increasingly assuming a function more pro-active than reactive in the hospital. The doctor is more concerned about the disease (physician - manager).

The nurses began to grow wings. But we are trying to adjust (doctor- manager).

Some protocols and sectoral plans included as instruments for strengthening the power of the nursing staff in relation to physicians. But these seemed to resist.

Almost all the administrative role is in the hand of the nurse. The doctor opened the gap and the nurses took over. Some functions have to be exercised by the doctor. It is difficult to get a doctor who does this without gaining anything (doctor).

Conflicts expressed a confrontation between corporations and difficulties of interaction. However, they indicated also the complexity and the paradoxical role of power of the nurses in contrast with the usual power of doctors:

"*With the nursing staff we observe that there are very harshly relations. Here and in various hospitals, nurses are acting in an imperative and aggressive way when in contact with physicians. For example, yesterday, there was a patient in a ward, who was dyspneic; an assistant spoke with a physician who was checking the procedures and he replied that he was not a hospitalist. In this moment, the hospitalist arrived at the room. She (the nurse) left the place reporting that the doctor refused to examine the patient when asked for. I heard that. A distrust, as if they were enemies.* [...] *the doctor who refused to examine the patient said he intended to quit* (doctor).

Sometimes the nurses set the bar very high for doctors. Nurses has a direct link with the management, causing discomfort to the doctor…but many doctors with low sense of responsibility were properly taken out of the hospital because of the assessment of nursing staff (doctor).

The nursing staff showed its version of the facts: *The doctors do not hear the nursing staff. We all spoon-feed the doctors but they do not gather the information. Previously, they used to humiliate the nursing staff. The novice physicians have an open mind. They approach the nursing and ask about the patient. The hospitalists come and ask - we have a better communication. In the past the assistant doctors sometimes hung up on us* [...] *the improvement of nursing care favored the improvement of the relationship with physicians, it has improved the link with the doctor*.

Although sometimes the malaise is assigned to "communication problems", it is clear that there are more complex issues concerning the power[13] construction bases and the intersubjective aspects, even the symbolic place of each corporation and professional, as also the demands for recognition of each group and subjects, as well as the possibilities of establishing trust relations and cooperation[15] between physicians and nurses.

Among the initiatives analyzed, the protocolization, while routinization and standardization of assistance work processes is a dimension quite consistent with the perspective of accreditation, trying to ensure, from a rational logic[9,10] the adoption of standards of quality and safety in the production of care, adding to the streamlining of care process. If it is important to recognize that the strategy of protocolization and creation of routines tries to face relevant problems and already well identified in Brazilian hospitals[11], as the non-application of recommended procedures, the non-use of prophylactic treatments and delays in treatment, on the other hand, it is also necessary to consider the meaning of overload work and especially of control of work process[18], working, in the case of doctors, as interference in the autonomy, making difficult the acceptance and implementation. It is clear that the search for definition of prescribed work[29] comes from the attempt to improve coordination and accountability of professionals concerning the quality of work, but this does not eliminate the contradictions between the prescribed work and real work[11].

The professional autonomy, on the one hand and accountability, on the other hand, represent points of tension in the work coordination efforts of the multi-professional teamworking, combined with the peculiar hospital problems which has proven extremely fragmented and specialized[9,18]. In the case studied, the rational strategy, on behalf of the quality and safety of processes, perform an inducing function and support that is more effective for nursing. For the doctors there are many doubts about the efficiency of the standardization of forms as a strategy to increase the commitment with the quality of assistance. It is important to emphasize that we are here talking about forms/protocols and routines which try to standardize processes and it is important to differentiate them from clinical guidelines, that are systematically designed to guide physicians and patients about health care in specific clinical circumstances[4].

Supported by the French psychosociological approach of organizations[20], we infer from the study, the constitution of what we call an imaginary[30] dominant in which the organizational development, the quality and excellence are associated to images of the hospital as a gear, in which prescribed work would have a value above any other.

The strategic planning seemed to represent a dividing line between two images related to change: on the one hand, the rational planning, the design of actions to face problems; on the other hand, the debate with state-of-the-art professionals to monitor and solve. Although the formalization of planning actions is a reflection of the "imaginary of gear", it represents, at the same time, a dialogical way[31] and mediation[26] between these universes - the one of the actions which engender requirements and the processes which are from a more interactive sphere, group, representing the agreements between the professionals and the transit between each subject and the group, with their intersubjective bets for care improvement.

We can see then, beside the imaginary of gear, other imaginary significations for organizational change. In this sense, the subjective aspects, interactive and supportive group emerged as elements to be considered in the management of care.

The hospitalist physician represented another strategy of change in the care management, in which the clinical attention and the care coordination are strengthened, representing a way for coordinating the work of nurses, physicians, assistants and specialists. Perhaps this new character in the hospital routine, with well-defined activities, represents the hope of a certain appeasement of conflicts and psychic support to workers who face, when taking care of a patient, a routine of pressures and risks. The work of hospitalists showed then, simultaneously, strong technical, clinical, managerial and, also, interactive dimension.

It should be also emphasized the function of the hospitalist physician as a support for the family, aiming at "reduction of anguish", being then considered the psychic suffering as an important factor in care. We could assume that the hospitalist would be adopting, from the point of view of the work organization, the role of protagonist of the quality improvement of possible reassure for specialists in hospital care, expressing other imaginary of gear. We would be in the field of judgment and clinical action, work in health in its artisanal axis which requires autonomy[18], being valued interactive aspects and that also express concern about the humanization of care. However, all of this mixed with the pursuit of mortality reduction, greater efficiency in the use of resources, better flows, with protocols, showing the simultaneity of rational and normative dimension and intersubjective and interactive dimension, even with professionals or patients.

Altogether analyzing the initiatives, it should be further emphasized the pursuit of collective devices, whether for planning, monitoring and decision-making process. This seems to be a promising way, recognizing that the incorporation of new practices is a long process and necessarily collective. So, regular meetings, collegiate and case discussions, showed how fundamental strategies in the process studied.

In the analysis of organizations and work in health, the collective devices to for agreeing intervention lines and establish common assistance projects[14,26] have been valued. These regular meetings are organizational arrangements that assume that the actions of health are not articulated by themselves, spontaneously, simply because the workers share the same work situation. It is crucial to emphasize connections and relations that exist between the interventions; the recognition and respect for differences and specificities of knowledges and practices of each professional[32]; the consideration of the intersubjective dimension present in health organizations[15,26], and their effects on recognition of the other as member and negotiator on the teamwork. In any case, there is always a risk: the risk of transform these spaces in ritualistic spaces and with no elements of professional daily life.

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Although there are various instances and mechanisms for actualizing the participatory process, there are difficulties in the HFCP to the collective devices involve both doctors and other professionals. It is important to recognize that the greater involvement of physicians has been a great challenge on experiences in hospitals of the SUS[8,19,24]. At the HFCP, this process has as important protagonists, the clinical director and technical director trying to promote accession of physicians to proposals of reorganization of work and at the same time pursuing an intersubjective and political institutional mediation between demands of clinical staff and administrative possibilities.

It is important to note that the engagement in the dynamics of work organization presupposes efforts to debate of opinions, decisions, joint engagement and involvement of workers, always supposing the existence of risks and efforts[33]. So, it is important to emphasize that the job of the collectives and the cooperation "... passes through a specific mobilization and irreplaceable role of workers in the design, setting and in managing the organization of work"[33]. Following this understanding, the processes of standardization and control, among other rational mechanisms, show their limits. It is necessary to consider with Dejours[33] that the subjective mobilization for work is fragile and that the worker "...should not be seen as 'narrowly performer', confined to 'the obedience and passivity".

Although, as the team of direction had evidenced itself as a great integration between the various levels of coordination and technical direction, it became evident that the segmentation between physicians and nurses who expressed himself on separated management devices, as well as in conflict. We understand that the ideal of cooperation implies the recognition of the contribution of each one and assumes agreements which are possible only in conditions in which it is established the trust[29]. The cleavage and affronts within the team represent, in our understanding, mistrust and lack of cooperation.

Concerning the hospitals, corporate conflicts between physicians and nurses have a role which cannot be denied. The malaise present in HFCP can be an expression of the strategy of managerial change which emphasized the operational management, whose highest expression is the increased power of nursing management. If this was the way of the HFCP, at the same time it represents a strategy present in reforms promoted in health systems in other countries:

> *That direct itself, mostly, to the levels of institutional and operational management, so that its effects will be felt, in a more extreme and immediate way, by nurses who exercise functions, once it is up to them, although sometimes informally, the management of the healthcare units, which they are responsible for*[35].

We understand that the increase of relative importance of nursing in the management at the HFCP represents a policy that has been established in the management of health services in Brazil, in pursuit of a greater monitoring and control of work processes.

Conclusions

Through the study, we examine limits and possibilities of the strategic planning initiatives in healthcare services, of the mechanisms of protocolization of care and of the incorporation of the hospitalist physician in the experience of HFCP, considering that they represent clues to reflect on strategies for improving the quality that has been adopted in Brazilian hospitals. The study of the process of change in this hospital shows the great challenge of coordination of care practices, revealing a dynamism between the design of management guided by rational tools, by formalized rules and well-defined instruments, as seen, for example in the spreadsheet of action plan, in the protocols and forms to systematize the activities of attention, in which they originate pressures on pursuit of a systemic and functional working of the hospital; and the groups, corporations, and individuals who seek meaning in their experiences, demand recognition and reflect what is 'at boiling point' and conflict, thus increasing the meanings of organizational processes we then assume that the professionals accede to processes and improve the quality in the hospital, invest and rely on the subjective process of change, but also face internal conflicts when opposing the face of reproduction and control present in the managerial tools adopted.

We tried to demonstrate, through this study, the complexity of processes of change in hospitals, especially in the care management sphere, analyzing its rational aspect - while processes of standardization and control and the entanglement with the individuals and groups that pursuit in the dialogic and intersubjective meanings, to construct senses for their practices. Certainly such questions express not only the local conditions of HFCP, but indicate the challenges and

the complexity of the processes of qualification of hospital care which always requires a lot of coordination and inclusion of workers in their conception and adjustments.

Collaborations

CS Azevedo and MC Sá were responsible for the conception of the study and information analysis. CS Azevedo was responsible for writing. MC Sá held the final review. M Cunha, GC Matta, L Miranda, V Grabois participated in the collection, analysis and final revision of the article.

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References

1. Braga Neto FC, Barbosa PR, Santos IS. Atenção Hospitalar: evolução histórica e tendências. In: Giovanella L, Escorel S, Lobato LVC, Noronha JC, Carvalho AI, organizadores. *Políticas e Sistema de Saúde no Brasil.* Rio de Janeiro: Editora Fiocruz; 2008. p. 577-608.
2. Portela MC, Martins M, Lopes CMB. Caderno de Estudo: Gestão da Qualidade em saúde. In: Barbosa PR, Costa e Silva V, organizadores. *Programa de Gestão em Saúde.* Rio de Janeiro: EAD/ENSP; 2010. p. 11-14.
3. Vecina Neto G, Malik AM. Tendências da assistência hospitalar. *Cien Saude Colet* 2007; 12(4):825-839.
4. Portela MC, Brito C, Vasconcellos MM, Ferreira VMB, Escosteguy CC, Vasconcellos MTL, Lima SML. Fatores associados ao uso de diretrizes clínicas em operadoras de planos de saúde e prestadores de serviços hospitalares no campo da Saúde Suplementar no Brasil. *Cien Saude Colet* 2008; 13(5):1553-1565.
5. Agência Nacional de Vigilância Sanitária. Acreditação: a busca pela qualidade nos serviços de saúde. Informes Técnicos Institucionais. *Rev Saude Publica* 2004; 38(2):335-336.
6. Brasil. Ministério da Saúde (MS). *Humaniza SUS: Política Nacional de Humanização: documento base para gestores e trabalhadores do SUS*. Brasília: MS; 2004.
7. Merhy EE. *Saúde: a cartografia do trabalho vivo*. São Paulo: Ed. Hucitec; 2002.
8. Cecílio LCO, Mendes TC. Propostas alternativas de gestão hospitalar e o protagonismo dos trabalhadores: por que as coisas nem sempre acontecem como os dirigentes desejam? *Saúde e Soc.* 2004; 13(2):39-55.
9. Azevedo CS, Sá MC, Miranda L, Grabois V. Caminhos da Organização e Gestão do Cuidado em Saúde no Âmbito Hospitalar Brasileiro. *Política, Planejamento e Gestão* 2010; 1(1):1-34.
10. Sá MC, Azevedo C, Miranda L, Grabois V, Oliveira SP, Matta G, Cunha MS, Silva AM, Celiliano G.S, Silva HC, Viola ACS. *Avaliação de Experiências Inovadoras no âmbito da Organização e Gestão da Atenção em Hospitais do SUS*. Relatório de Pesquisa. Rio de Janeiro: Escola Nacional de Saúde Pública Sergio Arouca/Fiocruz; 2012. Mimeo.
11. La Forgia GM, Couttolenc BF. *Desempenho Hospitalar no Brasil: em busca da Excelência*. São Paulo: Editora Singular; 2009.
12. Merhy EE, Cecílio LCO. A integralidade do cuidado como eixo da gestão hospitalar. In: Pinheiro R, Mattos RA, organizadores. *Construção da integralidade: cotidiano, saberes e práticas em saúde*. Rio de Janeiro: UERJ, Abrasco; 2003. p. 197-210.
13. Cecilio LCO, Merhy EE. O singular processo de coordenação dos hospitais. *Saúde em Debate* 2003; 27(64):110-122.
14. Campos GWS. *Saúde Paidéia.* São Paulo: Editora Hucitec; 2003.
15. Azevedo CS, Sá MC, organizadores. *Subjetividade, Gestão e Cuidado em Saúde: abordagens da psicossociologia*. Rio de Janeiro: Editora Fiocruz; 2013.
16. Bernardes A, Cecílio LCO, Nakao JRS, Evora YDM. Os ruídos encontrados na construção de um modelo democrático e participativo de gestão hospitalar. *Cien Saude Colet* 2007; 12(4):861-870.
17. Chanlat JF. O Gerencialismo e a ética do bem comum: a questão da motivação para o trabalho nos serviços públicos. In: Anais do VII Congresso Internacional Del CLAD sobre reforma del Estado Y de La Administracion Pública, 2002. Lisboa.
18. Campos GW. Co-Gestão e neoartesanato: elementos conceituais para repensar o trabalho em saúde combinando responsabilidade e autonomia. *Cien Saude Colet* 2010; 15(5):2337-2344.
19. Campos GWS, Amaral MA. A clínica ampliada e compartilhada, a gestão democrática e redes de atenção como referenciais teórico-operacionais para a reforma de hospitais. *Cien Saude Colet* 2007; 12(4):449-459.
20. Enriquez E. *Organização em análise*. Petrópolis: Vozes; 1997.
21. Enriquez E. O vínculo Grupal. In: Matta Machado MN, Castro EM, Araújo JNG, Roedel S, organizadores. *Psicossociologia: análise social e intervenção*. Petrópolis: Vozes; 1994.
22. Azevedo CS, Cunha M. Relatório do Estudo de caso do Hospital Fornecedores de Cana de Piracicaba. Projeto de Pesquisa Avaliação de experiências inovadoras no âmbito da organização e gestão da atenção em hospitais do SUS. Rio de Janeiro: Fiocruz; 2013.
23. Cecilio LCO, organizador. *Inventando a mudança na saúde*. São Paulo: Hucitec; 1994.
24. Cecílio LCO. O 'trabalhador moral' na saúde: reflexões sobre um conceito. *Interface (Botucatu)* 2007; 11(22):345-363.
25. Sá MC. A fraternidade em questão: um olhar psicossociológico sobre o cuidado e a "humanização" das práticas de saúde. *Interface (Botucatu)* 2009; 13(1):651-664.
26. Sá MC, Azevedo CS. Subjetividade e Gestão: articulações psicossociais no trabalho gerencial e no trabalho em saúde. *Cien Saude Colet* 2010, 15(5):2345-2354.
27. Barcelos G. O médico hospitalista. Entrevista presidente da Sociedade Panamericana de médicos hospitalistas. [acessado 2015 jan 5]. Disponível em: http://proqualis.net/video/entrevista-dr-guilherme-barcellos
28. Ribas EO. *Avaliação do processo de implantação de um novo modelo de abordagem assistencial nas unidades de internação do hospital Mãe de Deus* [dissertação]. Porto Alegre: UFRGS; 2006.
29. Freese RB. The Park Nicollet experience in establishing a Hospitalist Systems. *Ann Intern Med* 1999; 130(4):350-354.
30. Dejours C. O trabalho como enigma. In: Lancam S, Sznelvar LI, organizadores. Dejours C. *Da psicopatologia à psicodinâmica do trabalho.* Rio de Janeiro, Brasília: Editora Fiocruz, Paralelo 15; 2004.
31. Azevedo CS. A dimensão imaginária e intersubjetiva das organizações de saúde: implicações para o trabalho gerencial e para a mudança organizacional. *Cien Saude Colet* 2010; (Supl. 1):977-986.

32. Uribe J. *Análise Estratégica e Gestão pela Escuta*. Rio de Janeiro: Editora Fiocruz; 2003.
33. Peduzzi M. Equipe multiprofissional de saúde: conceito e tipologia. *Rev Saude Publica* 2001; 35(1):103-109.
34. Dejours C. *Trabalho e emancipação*. Brasília: Paralelo 15; 2012.
35. Carvalho MTG. *A Nova Gestão Pública, as reformas no sector da saúde e os profissionais de enfermagem com funções de gestão em Portugal* [tese]. Aveiro: Universidade de Aveiro; 2006.

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