CSP CADERNOS DE SAÚDE PÚBLICA
REPORTS IN PUBLIC HEALTH

REVISÃO
REVIEW

Emergency care under the magnifying glass: a review of ethnographic studies in the scientific literature on hospital emergency services

La urgencia bajo la lupa: una revisión de la producción científica sobre servicios de emergencia en hospitales desde la etnografía

A urgência sob a lupa: uma revisão da produção científica sobre serviços de emergência em hospitais do ponto de vista da etnografia

Anahi Sy [1,2]
Brenda Moglia [1,2]
Gisele Aragunde [1]
Paula Derossi [1]

doi: 10.1590/0102-311X00026120

Abstract

The article presents a review of ethnographic studies in the scientific literature on hospital emergency services, with the objective of systematizing the studies and their principal findings, referring to the health-disease-healthcare process in hospital emergency services from an ethnographic perspective. An integrative literature review was performed of studies published in Argentine and international indexed journals and in the following electronic databases: PubMed, VHL, Scopus, Redalyc, and SciELO. The corpus of the analysis consisted of a total of 69 articles, which were submitted to content analysis, having identified the following analytical dimensions: quality of care, communication and bonds, subjectivity, application of information technologies, methodological reflection, patients' experiences and practices, decision-making, and violence. The results allowed identifying a process that differs from guidelines and protocols, in which healthcare workers' subjective aspects, communication and interpersonal relations, and working conditions shape, orient, and condition the treatment and care provided in the hospital. The article thus highlights the approach to subjective aspects in health studies, to understand not only health workers' perspectives and experiences but also the persistent barriers to providing better quality of care, complexifying a problem ignored by a large share of the analyses.

Emergency Medical Services; Ethnography; Qualitative Research

Correspondence
A. Sy
Instituto de Salud Colectiva, Universidad Nacional de Lanús.
General Villegas 774, Buenos Aires 1826, Argentina.
anahisy@gmail.com

[1] *Instituto de Salud Colectiva, Universidad Nacional de Lanús, Buenos Aires, Argentina.*
[2] *Consejo Nacional de Investigaciones Científicas y Técnicas, Buenos Aires, Argentina.*

This article is published in Open Access under the Creative Commons Attribution license, which allows use, distribution, and reproduction in any medium, without restrictions, as long as the original work is correctly cited.

Introduction

A first approach to the available literature with qualitative studies on hospitals shows that the point of departure for most of the studies is the perspective of the services' users, with their perceptions, expectations, and degree of satisfaction with the care received [1,2], as well as physician-patient relations and communication [3,4,5]. An aspect frequently associated with the above is institutional violence [6,7,8,9,10,11]. Another important line of work has been medical residency training in public hospitals: ethnographic studies include those of Byron Good [12] in the United States and Bonet [13] and Ferrer [14] in Argentina (although all three take an ethnographic perspective in the hospital, the main focus is on medical residency).

Ethnographies in hospital institutions date to the Chicago school, with the study by Goffman, "Asylums" [15], and much of the revealing work has been performed in psychiatric institutions [16,17,18,19]. In general hospitals, we can cite numerous studies around the globe [20,21,22,23,24,25,26,27,28,29,30,31,32,33]. In Latin America [34,35,36,37,38,39,40,41,42,43], although there have been studies in Argentina and México, most of the research has been done in Brazil. Of the total body of work analyzed, only a few studies focus specifically on the healthcare workers' perspective. We agree with Graça Carapinheiro [44], who states that most of the studies on the topic are based on fundamental principles, the first of which refers to the hospital as a structure of care to serve the ill, and the second that assumes good human relations as the key to improvement and efficacy of the institution's mechanisms. Underlying these postulates is a certain organizational and social instrumentality.

This article's particular interest stems from the preliminary results of our ethnographic research in the emergency ward of a public hospital in the province of Buenos Aires, Argentina, focusing on the healthcare workers' perspective. The research revealed the emergency ward as a space with the convergence of emerging and/or conjunctural and problems and demands from the lower-income population, requiring a response to medical urgencies and emergencies (defined and/or regulated as such) in this hospital service. Notably, the demand does not always coincide with what the institution defines and regulates as medical emergencies and/or urgencies or with the medical staff's expectations and daily work process. The current study thus aims to analyze the tensions and contradictions condensed in the space of medical emergency services, which will be the determinants of the perception of those working in hospitals concerning their work process.

A relevant task is a systematic search that we present as an integrative review [45] of the literature published in scientific journals indexed in international databases in order to produce a description of the work published on this theme.

Methodology

The elaboration of this article included a literature review aimed at identifying studies by Argentine and international authors that mention the health-disease-care process in hospital emergency services, from an ethnographic perspective.

For the purposes of this study, the health-disease-care process is defined as a social process operating in all societies and involving large amounts of collective symbolizations and representations related to the knowledge and ways of preventing, treating, controlling, relieving, and/or curing certain illnesses [45,46,47]. We incorporate into the health-disease-care process the category of care, defined as a continuous and open process, without predefined limits and that involves a team (healthcare workers, machines, medicines, bodies, patients, and other relevant persons), with a series of daily tasks to achieve improvement in the illness [48]. In the field of collective health, Ayres [49] develops the notion of care linked to its humanization, in which the intervention points beyond the technical and normative realm.

Among the various types of reviews, we opted to work with the methodological proposal of an integrative literature review. This approach allows retrieving, identifying, analyzing, and summarizing the publications referring to a given theme [50,51]. The approach is characterized by the breadth of data sources, favoring a comprehensive understanding of the target problem, contributing to the development of new conjectures, hypotheses, and theories [51,52].

In this particular review, we proceeded according to the five stages proposed by Whittemore46 for conducting an integrative review. The first stage consisted of demarcating the research problem, where it is essential to clearly orient the review (as presented in the article's introduction). The second stage involves the search strategies, determining the databases and search terms. The third is the evaluation of the collected data, i.e., the theoretical and methodological rigor, in our case studies actually based on ethnographic methods, and the data's relevance (the results of the second and third stage are presented in this methods section). The fourth stage is the analysis, comparing the extracted data to classify and group and code them in categories, according to content analysis, using the method of constant comparison to relate, elaborate hypotheses, and achieve a higher level of abstraction with the coded categories. The fifth and final stage consists of the elaboration of a presentation of the review's results (the information resulting from the fourth and fifth stages was developed in the results section), presenting the analytical categories that result from the coding and a synthesis of the main arguments until the final remarks on the topic.

As part of the second stage, searches were conducted in May and June 2019 in the following electronic libraries: Virtual Health Library (VHL), PubMed, Network of Scientific Journals of Latin America and the Caribbean, Spain, and Portugal (Redalyc), Scientific Electronic Library Online (SciELO), and Scopus. Box 1 provides a description of each database's scope.

Some initial exploratory searches were conducted with various keywords/descriptors/MeSH, followed by a preliminary evaluation of the results in order to determine the most adequate keywords/MeSH and/or descriptors to obtain the closest results for our purposes. The searches were performed with free terms, except in PubMed, where they included both MeSH and free terms (for technical reasons and due to the availability of this resource). The searches were performed in all the databases with the terms in English, since the exploratory stage had shown that more results are obtained this way. The search field included the title, abstract, and keywords, with variants and/or limitations proper to each database, as described in Box 2. No particular time period was determined for the article searches, since our thematic interest (ethnographic methodologies developed in hospital emergency services) was the prime criterion for building the study's corpus.

This procedure yielded a total of 156 articles, 48 of which were discarded as duplicates. The inclusion criterion was scientific articles that address the hospital space from an ethnographic or anthropological perspective, or a social sciences perspective (using a methodology and techniques proper to ethnography).

After reading each article's title and abstract, some exclusion criteria were determined: (1) articles not situated in medical emergency departments in hospitals; (2) articles situated in the hospital emergency department but that address adverse health events and/or some specific health problem (e.g., suicide, alcoholism, and/or accidents, among others). Importantly, no criterion was specified as to the healthcare workers' professional class.

Using these criteria, 25 articles were initially excluded, and 13 more were excluded after reading the full text. The total corpus was thus 69 articles (Figure 1). All of these articles adopted qualitative methodological approaches, including the following techniques: participant observation, interviews, case studies, and informal conversations.

The timeline of the analysis began with a first reading of the title and abstract to produce a preliminary classification of the articles in different categories, which was modified after reading the full text and reworked until reaching the definitive categories: "quality of care"; "communication and bonds", either among the staff or between the staff and patients; "workers' subjectivity"; "information technologies"; "qualitative methodologies", "decision-making", "patients' experiences and practices", and "violence" (as proposed for the third stage of the integrative review).

When we speak of "subjectivity", we refer to Sherry Ortner [53], who proposes that there is a cultural configuration of subjectivities in the social world traversed by unequal power relations; and it involves modes of perception, affect, thinking, desire, and fear, which mobilize acting subjects and that are linked to cultural and social formations that shape, organize, and generate certain "*structures of feeling*" [53] (p. 25). When we speak of culture, we are referring to the construction of meaning that occurs through symbolic processes in a worldview shared by the members of a given social group [53].

Box 1

Coverage and thematic specificity of selected electronic databases.

Electronic database	Coverage	Thematic specificity
VHL	Latin America and the Caribbean	Health sciences
PubMed	Global	Health sciences
Redalyc	Latin America and the Caribbean, Spain, and Portugal	Multidisciplinary
SciELO	Latin America and the Caribbean, Spain, Portugal, and South Africa	Multidisciplinary
Scopus	Global	Multidisciplinary

Source: prepared by the authors.

Box 2

Type of search terms, search field, and number of articles found in the selected electronic databases.

<table>
<tr><th>Electronic database</th><th>Type of search terms</th><th>Terms used</th><th>Search field</th><th>Articles found (n)</th></tr>
<tr><td>VHL</td><td>Free terms</td><td>Health Care; Ethnography; Emergency; Hospital</td><td>Title, abstract, and subject</td><td>50</td></tr>
<tr><td rowspan="2">PubMed</td><td rowspan="2">MeSH terms/Free terms</td><td>Health Care Category; Emergency Health Services; Administration, hospital</td><td>MeSH</td><td rowspan="2">24</td></tr>
<tr><td>Ethnography</td><td>Title and abstract</td></tr>
<tr><td>Redalyc</td><td>Free terms</td><td>Ethnography; Hospital</td><td>Keywords</td><td>5</td></tr>
<tr><td>SciELO</td><td>Free terms</td><td>Hospital Emergency; Ethnography</td><td>Abstract</td><td>6</td></tr>
<tr><td>Scopus</td><td>Free terms</td><td>“Health Care”; Emergency; Hospital; Ethnography</td><td>Title, abstract, and keywords</td><td>71</td></tr>
</table>

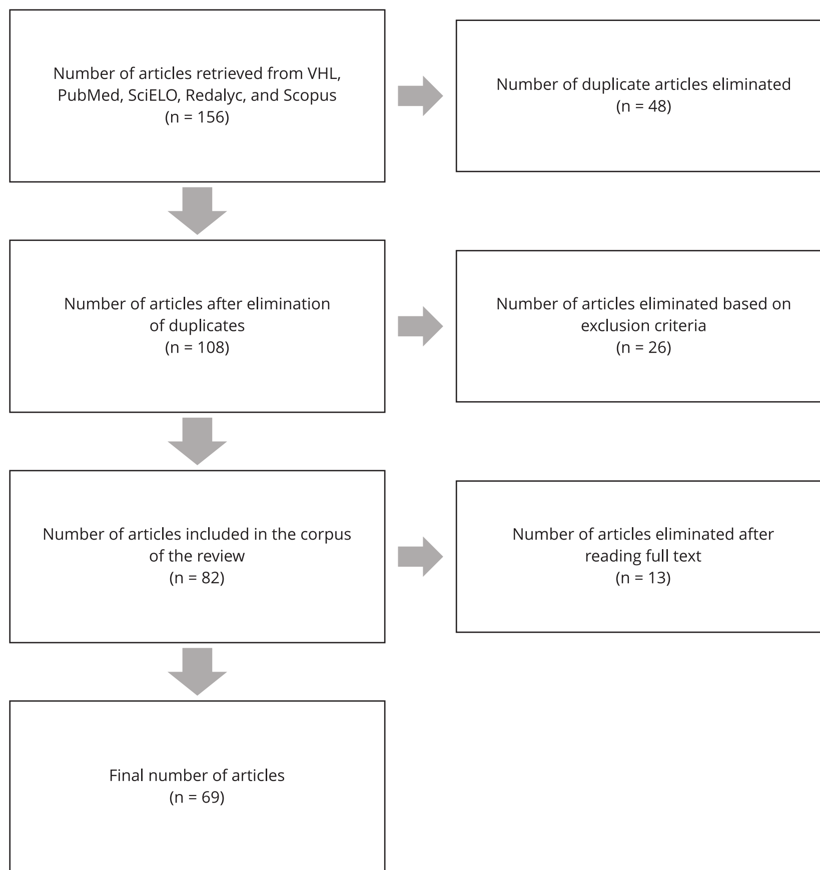
Source: prepared by the authors based on the procedure followed in each search.

With regard to the process of categorization and analysis, in addition to the definition of each of the categories, cross-controls were performed with the classification and analysis of each of the established levels, having elaborated and agreed on the mechanisms of analysis among the current article’s four authors.

Finally, the integrative review has limitations related to the search strategies, which limits the findings to indexed scientific journals (leaving out books and other formats, where a large share of the ethnographic production is published). Thus, the review does not cover the entire production on the topic, but a cross-section that allows building a corpus with a certain homogeneity for the analysis. In this sense, it establishes a good point of departure for elaborating a synthesis of part of the scientific knowledge produced on this research topic, including an overview that allows glimpsing opportunities for future studies [45]. We now present the results of the classification and analysis of the articles (according to the fourth stage of the analysis, as described).

Figure 1

Diagram of the selection process for the literature references comprising the study's corpus.



Source: prepared by the authors.

Results

A first reading and analysis of the studies identified some overall characteristics common to all of them, which to some extent are consistent with the established search criteria.

First, all the studies approach the emergency service as a place and in one way or another base their investigation on ethnography as a methodological strategy or recourse, although we did not retrieve any "ethnographies" in the strict sense of the term. When one refers to the ethnographic methodology, it includes fieldwork, observations and interviews, in some cases also additional techniques such as focus groups and space for discussion and communication of results, among other possible variations.

Most of the studies we analyzed also present commentary on the value and contributions of the ethnographic approach and methodology to produce data that contribute to healthcare, besides emphasizing this methodology's possibility for revealing data that could not be obtained through quantitative analyses.

The apparent methodological and technical homogeneity that unfolds in a unique setting like the hospital emergency department contrasts with the thematic diversity and variety of countries we found in the studies comprising the corpus.

Most of the studies are from English-speaking countries, namely the United States, Australia, and United Kingdom, with much smaller proportions from Brazil and Canada (Table 1). Other countries have no more than one article each. Concerning the Australian studies, the country has one of the highest per capita GDP investments in science and technology, the equivalent of the United States and exceeding that of the United Kingdom [54]. As for the research topic, most of the articles address communication and the relations between healthcare personnel and quality of care. Australia is the country with the highest proportion of articles on these categories, followed by studies that deal with subjective aspects of health work (Table 2).

Table 1

Number of articles and percentage according to country of publication.

Country	Articles	
	n	%
Australia	16	23.19
United States	14	20.29
United Kingdom	13	18.84
Brazil	6	8.70
Canada	5	7.25
Various countries	5	7.25
Netherlands	2	2.90
South Africa	2	2.90
Norway	1	1.45
Italy	1	1.45
Sweden	1	1.45
Finland	1	1.45
Argentina	1	1.45
Not accessible	1	1.45
Total general	69	100.00

Source: prepared by the authors.

Table 2

Number of articles and percentage according to categories of analysis.

Central theme	Articles	
	n	%
Quality of care	13	18.90
Communication and bonds	13	18.90
Subjectivity	12	17.40
Information technologies	7	10.14
Qualitative methodology in health	7	10.14
Patients' experiences and practices	6	8.70
Decision-making	6	8.70
Violence	5	7.25
Total	69	100.00

Source: prepared by the authors based on the results.

Interestingly, the United States is the only country with studies on all the categories described and the one with the most studies on information technologies applied to health. Meanwhile, the United Kingdom features studies on quality of care and decision-making and is the country with the largest proportion of articles on these topics.

In the other countries, the studies are fewer in number and the themes vary, with no possibility of identifying regular patterns.

We now present a description of the articles, analyzed according to each of the respective dimensions.

Quality of care

This includes articles whose central theme is the study of work processes that contribute to and/or hinder care in the emergency departments.

Concerning factors that can affect work processes, a recurrent theme is "interruptions", referring to discontinuity in the work process due to interference by patients, the healthcare staff, and/or lack of inputs or resources [55].

Another factor that affects care is the so-called "weekend effect", indicating greater risk of dying on weekend shifts compared to weekdays [56].

The approach to issues that can improve quality of care refers to variations or improvement in the circuits of care in the emergency department, oriented towards increasing efficiency [57,58] or supervision of tasks on the ward that would have an impact on both patient and staff safety [59]. Concerning specific emergency services such as the obstetrics department [60], additional proposals include the use of patient identification bracelets [61] and person-centered care [62]. Studies also approach the ward classification system as a decision-making tool in emergency services [63].

Other authors focus on the way waiting time operates in quality of care [64,65,66] or the space, time, and power dimensions in hospital care [67]. Other studies discuss the ethics of daily care in the hospital emergency department, analyzed in terms of an "ethics of care" [68].

Communication and bonds

This category includes articles centered on the relations established among workers in the emergency services, highlighting the relational dimension as central to work processes in hospitals, which significantly affects the processes of care and treatment. Importantly, medical emergency work has its own beliefs, logic, and underlying values that extend beyond what is drafted explicitly in the organizational values.

The articles grouped in this category can be distributed in three groups. The first group includes studies centered on relations between health teams, analyzing the way they can favor or hinder interprofessional practices oriented to greater patient safety [69,70]. They also discuss the strengths and limitations of interprofessional teamwork [71,72] and the team's influence on handover and continuity of treatment in other services [73,74].

The second group of articles explores the roles played by certain workers and how they shape certain relations, responsibilities, and practices of care, focusing on the work by nurses [75] and physicians in the emergency department [76,77].

The third group discusses the communication processes between healthcare workers from different professions, centered on management of medications [78,79] and the approach to patient referrals from the emergency department to other services [80]. These studies reveal how the ways of communicating the interpretative frameworks used by healthcare workers have consequences for patient safety and quality and efficiency of care.

Subjectivity

This category includes the articles focusing on healthcare workers' experiences, perceptions, and emotions towards the processes of care and treatment. All of them highlight the importance of healthcare workers' subjectivity when analyzing their practices and improving the quality of care.

We can thus divide the articles into two groups. One discusses the effects of working conditions on healthcare workers: feelings of anguish, fear, stress, or gratification, among others. The other group includes articles that describe the influence of feelings, beliefs, values, and customs on processes of care as facilitators or obstacles to such processes.

Some studies in the first group explore the feelings associated with working in situations of death on a daily basis [81,82] or with patients suffering chronic sequelae [83]. The other group of articles refers to the feelings associated with working conditions, exploring how the characteristics of hospital emergency services such as overload, urgency, constantly changing priorities, pressure, and the mismatch between the care they would like to provide and what they actually achieve generates anxiety and distress among the workers [84,85,86], and many of them reflect on the need to analyze different emotions from the work in order to improve the management and quality of care [27,85].

The second group of articles shows how these feelings, beliefs, values, and cultures affect the care the services provide to patients. The studies on the concept of culture analyze the emergency department as a different culture from that of other hospital departments, which particularly affects the work processes, decision-making, and quality of care [87,88,89]. We also found articles that analyze how patients' or certain social groups' stigmas [90] and physicians' interpretative frameworks [91] influence their professional work.

Information technologies

This category includes articles that present the results of studies on acceptance, application, or revision of virtual technological resources in health institutions. These studies emphasize the integration of various disciplines like information technology, administration, statistics, and the social, cognitive, and biomedical sciences.

The aim of these studies is to improve the quality of patient care [92], in some cases through the incorporation of electronic patient files with clinical histories as a way of ensuring the information and guaranteeing patient safety [93,94] or as a way to expand the usefulness of electronic records of complementary tests [94], and with the potential of reusing secondary data on clinical history from a system for control of care [95]. These studies feature the discussion on access to the available information (i.e., for whom and how it is accessed).

Another group of studies focus on the use of information for decision-making, patients' referral between departments [92,94], and the prehospital communication interface and patient transport [96].

Finally, some studies analyze the installed technologies to implement improvements and adapt the system, through follow-up of the healthcare workers and teams [96,97]. Unlike the previous studies, Tang et al. [97] conduct a comparative study of an information system no longer used by the health staff and the strategies to achieve acceptance and continuity with the incorporation of a new system. Most of these studies emphasize the place occupied by health workers' subjectivity, initiative, and culture in using and making decisions on this type of technologies.

Qualitative methodology in health

This category covers articles on the application of ethnographic methods and/or fieldwork techniques, specifically in hospitals and/or emergency departments.

Some of these studies focus on discussion and development of the specificity of the qualitative methodology and/or ethnographic techniques for understanding patient care practices, decision-making, and health interventions [98,99,100,101]. Others analyze ethical issues, in some cases associated with difficulties in obtaining ethical permission for conducting such studies [102], and in others on the reflexivity of aspects affecting those performing the studies, who in many cases play the dual role of investigator and hospital worker [103,104].

Patients' experiences and practices

The studies in this category mostly explore the behavior patterns and/or perceptions of patients, family members, or accompanying persons in hospital emergency services. Some focus on critically ill patients [105,106,107], others on bonds with the hospital staff [108] and the use of the emergency department for reasons other than urgency in various population groups such as children [109] and/or indigenous peoples [110]. The number of articles in this category was quite small, since many were excluded because they dealt with specific health problems (as explained in the exclusion criteria).

Decision-making

The articles included in this category analyze the way healthcare workers use the institution's guidelines or protocols and how they practice agency and act according to their experience, judgment, and tacit knowledge in their choices and actions in the process of care.

The articles reflect on how medical practice is part of a structure consisting of policies, protocols, standards, norms, hierarchies, knowledge, and forms of institutional organization that shape such practice but do not determine it entirely. Agency exists in healthcare workers, leading them to make decisions based on their experience and tacit knowledge, when their judgment does not coincide with the established standard, when the protocol (generated from the assumed reality, i.e., the "must be") fails to coincide with the concrete reality of the emergency service. Examples are studies on the decision-making process related to patients' referral to different departments and services [111] with the prioritization of cases for treatment [112,113] and the organization and procedures to be used [114,115,116]. On this point, both physicians and nurses have wide room to act in this process, which underscores the impossibility of predicting all the practices, besides healthcare workers' power to transform the practices of treatment and care and to institute new forms of action and the need to investigate how this decision-making process is performed and the implicit knowledge and experiences at play.

Violence

This category includes articles that discus situations of physical or verbal aggression in hospital emergency departments. Most of them analyze violence by patients and/or family members or accompanying persons towards healthcare staff [117,118,119,120]. Only one article describes violence by medical staff against patients, expressed as "inhuman care" [121]. Many of these studies use the "risk" category, seeking to identify possible causes that can give rise to these situations [119,121], such as waiting time for treatment and the impact of empathy on the process of care. Some of these studies also report the healthcare staff's perceptions and the fact that they take such violence for granted [118,120], plus the reporting (or rather the underreporting) of such events in the institutions [117].

Summary

A literature review's challenge is to transcend the analysis and description of each article or set of articles comprising the corpus, to reach beyond the descriptive level in order to generate inferences and hypotheses with a broader scope. The body of articles analyzed in our study allows mapping the themes that have become an object of knowledge from an ethnographic perspective in hospitals, thereby inferring, as the point of departure, a problem or problematization in the sphere of health institutions.

Most of the studies reflect the potential of qualitative approaches, particularly those focusing on ethnographic methods, commenting on the theoretical and methodological contributions of the various qualitative techniques and methodologies applied to the field of health, particularly in institutional healthcare settings. On the one hand, they highlight access to practices by ethnographic approaches when such practices are difficult to capture with other nonintrusive techniques, even qualitative ones. On the other hand, they illustrate how the contribution is not only technical, but also opens an essential discussion on ethical aspects of work in healthcare institutions and particularly those based on

cases in which the healthcare workers themselves conduct the research in their own workspace, with all the subjective and ethical implications for the production of knowledge.

As for the mapping of themes and problems approached in the literature, we identified a central category in the analysis that appears in different ways in all the articles: "quality of care", where we placed in quotation marks the general analytical categories and in italics the analytical dimensions identified within them. In fact, when grouping the articles by each study's central theme, only a few studies were included in the "quality of care" category, but the vast majority worked with some particular topic or problem with the ultimate objective of contributing to quality of care in hospitals.

Among the articles that included "quality of care", waiting, circuits of care, person-centered care, and interruptions appeared as central dimensions, although waiting is also a category associated with the studies on the theme of "violence", which mostly focus on situations of aggression between patients or from patients towards healthcare staff. Another issue related to "quality of care" is patients' experiences and practices, where the central problem is the use of the medical emergency department for problems that do not involve an urgency or emergency. Related with this, we identified questions addressed in health workers' "subjectivity", since patients' stigmas and healthcare workers' interpretative frameworks, beliefs, values, and culture act to condition the care they provide. "Quality of care" appears again, in this case associated with healthcare workers' "subjectivity". On this point, the workers' perceptions of their working conditions, overload, urgency, and pressure create a gap between the desired care and the care actually provided, expressed as anxiety and suffering that necessarily impact patient care. Another issue related to subjectivity and quality of care is "interpersonal communication and relations", and the related roles, organization, and the responsibilities, which become central.

Meanwhile, many articles reveal the gap between the real working conditions and the assumed reality on which institutions' policies, protocols, and standards are based. This observation leads to an interesting hypothesis, namely the gap between what the institution assumes (as established, standardized, or protocoled) and the reality (working conditions and possibilities that do not "fit" the norm), enabling a certain creativity and agency by healthcare workers. In the face of what is supposed to be, the emergency department encounters what is actually possible, which assumes decision-making based on experience, clinical criteria, and tacit knowledge. This process is interesting because it is not about something inherently negative or positive, but something that can contribute differently to the quality of care, according to each healthcare worker's particularities. It thus becomes essential to inquire into these decision-making processes, motivations, and circumstances in various situations that lead to acting and deciding autonomously and creatively, outside the box or the institution's standards.

Thus, the way decisions are made, the communications processes and bonds, time and circuits of care, the way technologies are implemented, and even the ways patients move through the healthcare system are traversed by this gap between what is supposed to be and what actually is. In this sense, the processes can improve the quality of healthcare provision; hence the importance of studying these aspects, using qualitative methodologies that allow an in-depth approach centered on the hospital emergency department's concrete reality.

Final remarks

The analysis allowed identifying a trend in which healthcare workers' subjectivity, creativity, and agency shape the processes of care and treatment and interpersonal communication and relations. The latter shape and traverse workers' subjectivity, and in this sense, together with working conditions, they orient and condition their creativity and action.

Based on this, we can also signal that the gaps between institutional standards and daily reality, day and night shifts, weekdays and weeks, treatment aspirations and actual reality, create a suffering capable of producing, reproducing, and even transforming subjectivities, so the approach to subjective aspects is indispensable in health studies, not only to understand healthcare workers' perspectives and experiences, but also to understand the persistent obstacles to better quality of care, thereby complexifying the problem and the most frequent analyses.

A future task lies in the challenge of tackling work that has still not been addressed in Argentina, while contemplating and bringing into play the study of possible similarities and differences between countries. By way of hypothesis, we dare to say that there are more similarities than differences, more common gaps, and shared suffering. Apparently, in the face of suffering, urgency, and the imminence of death, regardless of nationality, health policy, and institutions, the suffering and problems found here were inherently human and therefore universal.

Contributors

A. Sy participated in the idea, literature search, analysis, writing, and revision of the text. B. Moglia y G. Aragunde contributed in the article searches, analysis, and writing. P. Derossi contritutted in the analysis and writing.

Additional informations

ORCID: Anahi Sy (0000-0002-1281-5333); Brenda Moglia (0000-0002-3640-5232); Gisele Aragunde (0000-0002-3340-0540); Paula Derossi (0000-0001-6770-8220).

Acknowledgments

The authors wish to thank Universidad Nacional de Lanús (UNLa) for funding and supporting the research project of which this review is a part, the Institute of Collective Health (ISCo-UNLa) for supplying the space for academic discussion and research, and National Scientific and Technical Research Council (CONICET) for financially supporting the work of de A. Sy and B. Moglia.

References

1. Gill L, White L. A critical review of patient satisfaction. Leadersh Health Serv (Bradf Engl) 2009; 22:8-19.
2. Sutton LH, García RF, Hernández RA, Roche OFR. Expectativas y experiencias de los usuarios del Sistema de Salud en México: un estudio de satisfacción con la atención médica. México DF: Universidad Nacional Autónoma de México; 2013.
3. Borrott N, Kinney S, Newall F, Williams A, Cranswick N, Wong I, et al. Medication communication between nurses and doctors for paediatric acute care: an ethnographic study. J Clin Nurs 2017; 26:1978-92.
4. Aelbrecht K, Rimondini M, Bensing J, Moretti F, Willems S, Mazzi M, et al. Quality of doctor-patient communication through the eyes of the patient: variation according to the patient's educational level. Adv Health Sci Educ 2015; 20:873-84.
5. Colmenares-Roa T, Huerta-Sil G, Infante-Castañeda C, Lino-Pérez L, Alvarez-Hernández E, Peláez-Ballestas I. Doctor-patient relationship between individuals with fibromyalgia and rheumatologists in public and private health care in Mexico. Qual Health Res 2016; 26:1674-88.
6. Castro R, Erviti J. Sociología de la práctica médica autoritaria: violencia obstetricia, anticoncepción inducia y derechos reproductivos. Cuernavaca: Centro Regional de Investigaciones Multidisciplinarias, Universidad Nacional Autónoma de México; 2016. (Violencia(s), Derechos y Salud).
7. Marton B. La violencia simbólica en la consulta médica: la naturalización de la díada madre-hijo y la promoción compulsiva de la lactancia materna. Sex Salud Soc 2010; (5):119-43.

8. Rueda EA. Salud, violencia estructural y ley estatutaria: un vistazo rápido a nueve patologías estructurales. Anamnenis – Revista de Bioética 2013; 8:91-5.
9. Bodelón E. Violencia institucional y violencia de género. Anales de la Cátedra Francisco Suárez 2014; 48:131-55.
10. Lopera Betancur MA. Atención de la urgencia en casa: una reacción automática. Invest Educ Enferm 2009; 27:54-9.
11. Fleury S. Salud y democracia en Brasil: valor público y capital institucional en el Sistema Único de Salud. Salud Colect 2007; 3:147-57.
12. Good B. Medicine, rationality, and experience: an anthropological perspective. New York: Cambridge University Press; 1994.
13. Bonet O. Saber e sentir: uma etnografia da aprendizagem da biomedicina. Rio de Janeiro: Editora Fiocruz; 2004. (Coleção Antropologia e Saúde).
14. Ferrer M. La maquila de médicos: una etnografía en la guardia del Hospital Nacional de Clínicas. Córdoba: Facultad de Filosofía y Humanidades, Universidad Nacional de Córdoba; 2015.
15. Goffman E. Internados: ensayos sobre la situación social de los enfermos mentales. Buenos Aires: Amorrortu; 2012.
16. Rosenhan DL. On being sane in insane places. Science 1973; 179:250-8.
17. Álvarez Pedrosian E, Vidart D. Los estrategas del Maciel: etnografía de un hospital público. Montevideo: Universidad de la República; 2009.
18. Creswell LM. A critical black feminist ethnography of treatment for women with co-occurring disorders in the psychiatric hospital. J Behav Health Serv Res 2014; 41:167-84.
19. Rhodes LA. Emptying beds: the work of an emergency psychiatric unit. Berkeley: University of California Press; 1995.
20. Abadía BC, Pinilla MYA, Ariza KR, Ruiz HCS. Neoliberalism in health: the torture of the health care workers of the Bogota s Instituto Materno Infantil (child and maternity hospital). Rev Salud Pública 2012; 14:18-31.
21. Day S, Coombes RC, McGrath-Lone L, Schoenborn C, Ward H. Stratified, precision or personalised medicine? Cancer services in the 'real world' of a London hospital. Sociol Health Illn 2017; 39:143-58.
22. Duke M, Street A. Tensions and constraints for nurses in hospital-in-the-home programmes. Int J Nurs Pract 2005; 11:221-7.
23. Farre A, Cummins C. Understanding and evaluating the effects of implementing an electronic paediatric prescribing system on care provision and hospital work in paediatric hospital ward settings: a qualitatively driven mixed-method study protocol. BMJ Open 2016; 6:e010444.
24. Fassin D. The elementary forms of care: an empirical approach to ethics in a South African Hospital. Soc Sci Med 2008; 67:262-70.
25. Gaede BM. Doctors as street-level bureaucrats in a rural hospital in South Africa. Rural Remote Health 2016; 16:3461.
26. Harte JD, Sheehan A, Stewart SC, Foureur M. Childbirth supporters' experiences in a built hospital birth environment: exploring inhibiting and facilitating factors in negotiating the supporter role. HERD 2016; 9:135-61.
27. Henckes N, Nurok M. "The first pulse you take is your own" – but don't forget your colleagues. Emotion teamwork in pre-hospital emergency medical services. Sociol Health Illn 2015; 37:1023-38.
28. Horsley PA. Death dwells in spaces: bodies in the hospital mortuary. Anthropol Med 2008; 15:133-46.
29. Hughes C, van Heugten K, Keeling S, Szekely F. Being-in-the-chemotherapy-suite versus being-in-the-oncology-ward: an analytical view of two hospital sites occupied by people experiencing cancer. Cancers (Basel) 2017; 9:64.
30. Inhorn MC. Privacy, privatization, and the politics of patronage: ethnographic challenges to penetrating the secret world of Middle Eastern, hospital-based in vitro fertilization. Soc Sci Med 2004; 59:2095-108.
31. Larsen LS, Larsen BH, Birkelund R. A companionship between strangers – the hospital environment as a challenge in patient-patient interaction in oncology wards. J Adv Nurs 2014; 70:395-404.
32. Romaní O. Etnografía, técnicas cualitativas e investigación en salud: un debate abierto. Tarragona: Publicacions URV; 2013.
33. van der Geest S, Finkler K. Hospital ethnography: introduction. Soc Sci Med 2004; 59:1995-2001.
34. Castro EAB, Camargo Jr. KR. Por uma etnografia dos cuidados de saúde após a alta hospitalar. Ciênc Saúde Colet 2008; 13 Suppl 2:2075-88.
35. Cecchetto F. Dilemas de uma etnografia da classificação racial em espaços institucionais. Hist Ciênc Saúde-Manguinhos 2011; 18:253-8.
36. Cefaï D. Provações corporais: uma etnografia fenomenológica entre moradores de rua de Paris. Lua Nova 2010; (79):71-110.
37. Dalmolin BM, Vasconcellos M P. Etnografia de sujeitos em sofrimento psíquico. Rev Saúde Pública 2008; 42:49-54.
38. Grupo Transfuncional en Ética Clínica. Valores en medicina: etnografía de sus representaciones en un hospital de cardiología en México. Cuicuilco 2011; 18:115-32.
39. Elsen I, Monticelli M. Nas trilhas da etnografia: reflexões em relação ao saber em enfermagem. Rev Bras Enferm 2003; 56:193-7.
40. Feltrin RB, Velho L. Representações do corpo feminino na menopausa: estudo etnográfico em um hospital-escola brasileiro. Sex Salud Soc 2016; (22):148-74.

41. García MG, Recoder ML, Margulies S. Space, time and power in hospital health care: contributions based on the ethnography of an obstetric center. Salud Colect 2017; 13:391-409.
42. Morais AC, Camargo CL, Quirino MD. A etnografia nas pesquisas de enfermagem com ênfase no cuidado. Cogitare Enferm 2011; 16:549-55.
43. Oliveira M J. Uma etnografia sobre o atendimento psicoterapêutico a transexuais. Revista Estudos Feministas 2014; 22:839-62.
44. Carapinheiro G. Saberes e poderes no hospital: uma sociologia dos serviços hospitalares. Porto: Edições Afrontamento; 1993. (Colecção Saber Imaginar o Social).
45. Menéndez EL. La enfermedad y la curación ¿Qué es medicina tradicional? Alteridades 1994; 4:71-83.
46. Menéndez EL. Modelos de atención de los padecimientos: de exclusiones teóricas y articulaciones prácticas. Ciênc Saúde Colet 2003; 8:185-207.
47. Menéndez EL. Las enfermedades ¿ son solo padecimientos?: biomedicina, formas de atención "paralelas" y proyectos de poder. Salud Colect 2015; 11:301-30.
48. Mol A. The logic of care: health and problem of patient choice. London: Routledge; 2008.
49. Ayres JRCM. El cuidado: los modos de ser (del) humano y las prácticas de salud. In: Paiva V, Ayres JRCM, Capriati A, Amuchástegui A, Pecheny M, organizadores. Prevención, promoción y cuidado: enfoques de vulnerabilidad y derechos humanos. Temperley: TesseoPress; 2018. p. 1110-40.
50. Botelho LLR, Cunha CC A, Macedo M. O método da revisão integrativa nos estudos organizacionais. Gestão & Sociedade 2011; 5:121-36.
51. Whittemore R, Knafl K. The integrative review: updated methodology. J Adv Nurs 2005; 52:546-53.
52. Deslandes SF, Flach RMD. Abuso digital nos relacionamentos afetivo-sexuais: uma análise bibliográfica. Cad Saúde Pública 2017; 33:e0013851.
53. Ortner S. Geertz, subjetividad y conciencia posmoderna. Etnografías Contemporáneas 2005; 1:25-54.
54. Kreiner A. ¿Por qué invertir en ciencia y tecnología? Agencia TSS 2020; 31 jan. http://www.unsam.edu.ar/tss/por-que-invertir-en-ciencia-y-tecnologia/.
55. Brixey JJ, Tang Z, Robinson DJ, Johnson CW, Johnson TR, Turley JP, et al. Interruptions in a level one trauma center: a case study. Int J Med Inform 2008; 77:235-41.
56. Tarrant C, Sutton E, Angell E, Aldridge CP, Boyal A, Bion J. The "weekend effect" in acute medicine: a protocol for a team-based ethnography of weekend care for medical patients in acute hospital settings. BMJ Open 2017; 7:e016755.
57. O'Cathain A, Knowles E, Turner J, Hirst E, Goodacre S, Nicholl J. Variation in avoidable emergency admissions: multiple case studies of emergency and urgent care systems. J Health Serv Res Policy 2016; 21:5-14.
58. Nugus P, Forero R, McCarthy S, Mcdonnell G, Travaglia J, Hilman K, et al. The emergency department "carousel": an ethnographically-derived model of the dynamics of patient flow. Int Emerg Nurs 2014; 22:3-9.
59. Weaver SH, Lindgren TG. Getting safely through the shift: a qualitative exploration of the administrative supervisor role. J Nurs Manag 2017; 25:430-7.
60. Montigny F, Verdon C, Dubeau D, Devault A, St-André M, Tchouaket Nguemeleu E, et al. Protocol for evaluation of the continuum of primary care in the case of a miscarriage in the emergency room: a mixed-method study. BMC Pregnancy Childbirth 2017; 17:124.
61. Smith AF, Casey K, Wilson J, Fischbacher-Smith D. Wristbands as aids to reduce misidentification: an ethnographically guided task analysis. Int J Qual Health Care 2011; 23:590-9.
62. Dellenborg L, Wikström E, Andersson Erichsen A. Factors that may promote the learning of person-centred care: an ethnographic study of an implementation programme for healthcare professionals in a medical emergency ward in Sweden. Adv Health Sci Educ 2019; 24:353-81.
63. Fry M, Stainton C. An educational framework for triage nursing based on gatekeeping, timekeeping and decision-making processes. Accid Emerg Nurs 2005; 13:214-9.
64. Melon KA, White D, Rankin J. Beat the clock! Wait times and the production of «quality» in emergency departments. Nurs Philos 2013; 14:223-37.
65. Nugus P, Braithwaite J. The dynamic interaction of quality and efficiency in the emergency department: squaring the circle? Soc Sci Med 2010; 70:511-7.
66. O'Neill E, Woodgate D, Kostakos V. Easing the wait in the emergency room: building a theory of public information systems. In: Proceedings of the 2004 Conference on Designing Interactive Systems Processes, Practices, Methods, and Techniques. http://portal.acm.org/citation.cfm?doid=1013115.1013120 (accessed on 05/Nov/2019).
67. García MG, Recoder ML, Margulies S. Espacio, tiempo y poder en la atención hospitalaria de la salud y la enfermedad: aportes de una etnografía de un centro obstétrico. Salud Colect 2017; 13:391-409.
68. Fassin D. The elementary forms of care. Soc Sci Med 2008; 67:262-70.
69. Collin KM, Valleala UM, Herranen S, Paloniemi S. Ways of interprofessional collaboration and learning in emergency work. Studies in Continuing Education 2012; 34:281-300.

70. Nugus P. Re-structuring the negotiated order of the hospital. Sociol Health Illn 2019; 41:378-94.
71. Webster F, Rice K, Dainty KN, Zwarenstein M, Durant S, Kuper A. Failure to cope: the hidden curriculum of emergency department wait times and the implications for clinical training. Acad Med 2015; 90:56-62.
72. Petit dit Dariel O, Cristofalo P. A meta-ethnographic review of interprofessional teamwork in hospitals: what it is and why it doesn't happen more often. J Health Serv Res Policy 2018; 23:272-9.
73. Iedema R, Ball C, Daly B, Young J, Green T, Middleton PM, et al. Design and trial of a new ambulance-to-emergency department handover protocol: 'IMIST-AMBO'. BMJ Qual Saf 2012; 21:627-33.
74. Iedema R, Merrick E. Analysing teamwork in health care: what matters when clinicians negotiate the continuity of clinical tasks and care responsibilities? Commun Med 2016; 13:85-97.
75. Nugus P, Forero R. Understanding interdepartmental and organizational work in the emergency department: an ethnographic approach. Int Emerg Nurs 2011; 19:69-74.
76. Gilardi S, Guglielmetti C, Pravettoni G. Interprofessional team dynamics and information flow management in emergency departments. J Adv Nurs 2014; 70:1299-309.
77. van Schothorst J, van den Brand CL, Gaakeer MI, Wallenburg I. The role of emergency physicians in the institutionalization of emergency medicine. Eur J Emerg Med 2017; 24:301-7.
78. Huby G, Brook JH, Thompson A, Tierney A. Capturing the concealed: Interprofessional practice and older patients' participation in decision-making about discharge after acute hospitalization. J Interprof Care 2007; 21:55-67.
79. Liu W, Gerdtz M, Manias E. Creating opportunities for interdisciplinary collaboration and patient-centred care: how nurses, doctors, pharmacists and patients use communication strategies when managing medications in an acute hospital setting. J Clin Nurs 2016; 25:2943-57.
80. Nugus P, McCarthy S, Holdgate A, Braithwaite J, Schoenmakers A, Wagner C. Packaging patients and handing them over: communication context and persuasion in the emergency department. Ann Emerg Med 2017; 69:210-7.e2.
81. Aredes J S, Giacomin KC, Firmo JOA. A práxis médica no pronto atendimento diante do paciente com sequelas crônicas: culpa, temor e compaixão. Trab Educ Saúde 2018; 16:1177-99.
82. Aredes JDS, Giacomin KC, Firmo JOA. O médico diante da morte no pronto socorro. Rev Saúde Pública 2018; 52:42.
83. Aredes JS, Firmo JOA, Giacomin KC. A morte que salva vidas: complexidades do cuidado médico ao paciente com suspeita de morte encefálica. Cad Saúde Pública 2018; 34:e00061718.
84. Kelley ML, Parke B, Jokinen N, Stones M, Renaud D. Senior-friendly emergency department care: an environmental assessment. J Health Serv Res Policy 2011; 16:6-12.
85. Parsons K, Gaudine A, Swab M. Older nurses' experiences of providing direct care in hospital nursing units: a qualitative systematic review. JBI Database System Rev Implement Rep 2018; 16:669-700.
86. Taylor BJ, Rush KL, Robinson CA. Nurses' experiences of caring for the older adult in the emergency department: a focused ethnography. Int Emerg Nurs 2015; 23:185-9.
87. Cole E, Crichton N. The culture of a trauma team in relation to human factors. J Clin Nurs 2006; 15:1257-66.
88. Mackintosh N, Humphrey C, Sandall J. The habitus of "rescue" and its significance for implementation of rapid response systems in acute health care. Soc Sci Med 2014; 120:233-42.
89. Person J, Spiva L, Hart P. The culture of an emergency department: an ethnographic study. Int Emerg Nurs 2013; 21:222-7.
90. Henderson S, Clare L, Stacey DD. Social Stigma and the dilemmas of providing care to substance users in a safety-net emergency department. J Health Care Poor Underserved 2008; 19:1336-49.
91. Hilligoss B. Selling patients and other metaphors: a discourse analysis of the interpretive frames that shape emergency department admission handoffs. Soc Sci Med 2014; 102:119-28.
92. Hilligoss B, Zheng K. Chart biopsy: an emerging medical practice enabled by electronic health records and its impacts on emergency department-inpatient admission handoffs. J Am Med Inform Assoc 2013; 20:260-7.
93. Nelson P, Bell AJ, Nathanson L, Sanchez LD, Fisher J, Anderson PD. Ethnographic analysis on the use of the electronic medical record for clinical handoff. Intern Emerg Med 2017; 12:1265-72.
94. Dahm MR, Georgiou A, Westbrook JI, Greenfield D, Horvath AR, Wakefield D, et al. Delivering safe and effective test-result communication, management and follow-up: a mixed-methods study protocol. BMJ Open 2018; 8:e020235.
95. Dixon-Woods M, Redwood S, Leslie M, Minion J, Martin GP, Coleman JJ. Improving quality and safety of care using "technovigilance": an ethnographic case study of secondary use of data from an electronic prescribing and decision support system. Milbank Q 2013; 91:424-54.
96. Pope C, Halford S, Turnbull J, Prichard J, Calestani M, May C. Using computer decision support systems in NHS emergency and urgent care: ethnographic study using normalisation process theory. BMC Health Serv Res 2013; 13:111.

97. Tang Z, Johnson TR, Tindall RD, Zhang J. Applying heuristic evaluation to improve the usability of a telemedicine system. Telemed J E Health 2006; 12:24-34.
98. Grigg M, Endacott R, Herrman H, Harvey C. An ethnographic study of three mental health triage programs. Int J Ment Health Nurs 2004; 13:145-51.
99. Heasman B, Reader TW. What can acute medicine learn from qualitative methods? Curr Opin Crit Care 2015; 21:460-6.
100. Aredes JS, Firmo JOA, Leibing A, Giacomin KC. Reflexões sobre um fazer etnográfico no pronto-socorro. Cad Saúde Pública 2017; 33:e00118016.
101. Santiano N, Baramy L-S, Young L, Saggu G, Cabrera R, Parr M. Problems and solutions arising during a study in visual semantics of the medical emergency team system. Qual Health Res 2008; 18:1336-44.
102. Roberts L, Henderson J, Willis E, Muir-Cochrane E. The challenges of gaining ethics approval for ethnographic research in the prehospital setting. J Psychiatr Ment Health Nurs 2013; 20:374-8.
103. Bailey CJ. Practitioner to researcher: reflections on the journey. Nurse Res 2007; 14:18-26.
104. Jacoby SF. The insight and challenge of reflexive practice in an ethnographic study of black traumatically injured patients in Philadelphia. Nurs Inq 2017; 24:e12172.
105. Brito MEM, Damasceno AK C, Pinheiro PNC, Vieira LJE S. A cultura no cuidado familiar à criança vítima de queimaduras. Rev Eletrônica Enferm 2010; 12:321-5.
106. Hudgins A, Rising KL. Fear, vulnerability and sacrifice: Drivers of emergency department use and implications for policy. Soc Sci Med 2016; 169:50-7.
107. Barreto MS, Marcon SS, Garcia-Vivar C. Patterns of behaviour in families of critically ill patients in the emergency room: a focused ethnography. J Adv Nurs 2017; 73:633-42.
108. Olthuis G, Prins C, Smits M-J, van de Pas H, Bierens J, Baart A. Matters of concern: a qualitative study of emergency care from the perspective of patients. Ann Emerg Med 2014; 63:311-9.e2.
109. Berry A, Brousseau D, Brotanek JM, Tomany-Korman S, Flores G. Why do parents bring children to the emergency department for nonurgent conditions? A qualitative study. Ambul Pediatr 2008; 8:360-7.
110. Browne AJ, Smye VL, Rodney P, Tang SY, Mussell B, O'Neil J. Access to primary care from the perspective of aboriginal patients at an urban emergency department. Qual Health Res 2011; 21:333-48.
111. Newgard CD, Nelson MJ, Kampp M, Saha S, Zive D, Schmidt T, et al. Out-of-hospital decision making and factors influencing the regional distribution of injured patients in a trauma system. J Trauma 2011; 70:1345-53.
112. Back J, Ross AJ, Duncan MD, Jaye P, Henderson K, Anderson JE. Emergency department escalation in theory and practice: a mixed-methods study using a model of organizational resilience. Ann Emerg Med 2017; 70:659-71.
113. Johannessen LEF. Beyond guidelines: discretionary practice in face-to-face triage nursing. Sociol Health Illn 2017; 39:1180-94.
114. Allard J, Bleakley A. What would you ideally do if there were no targets? An ethnographic study of the unintended consequences of top-down governance in two clinical settings. Adv Health Sci Educ Theory Pract 2016; 21:803-17.
115. Brummell SP, Seymour J, Higginbottom G. Cardiopulmonary resuscitation decisions in the emergency department: an ethnography of tacit knowledge in practice. Soc Sci Med 2016; 156:47-54.
116. Franklin A, Liu Y, Li Z, Nguyen V, Johnson TR, Robinson D, et al. Opportunistic decision making and complexity in emergency care. J Biomed Inform 2011; 44:469-76.
117. Knowles E, Mason SM, Moriarty F. "I'm going to learn how to run quick": exploring violence directed towards staff in the emergency department. Emerg Med J 2013; 30:926-31.
118. Renker P, Scribner SA, Huff P. Staff perspectives of violence in the emergency department: appeals for consequences, collaboration, and consistency. Work 2015; 51:5-18.
119. Lau JBC, Magarey J, Wiechula R. Violence in the emergency department: an ethnographic study (Part I). Int Emerg Nurs 2012; 20:69-75.
120. Lau JBC, Magarey J, Wiechula R. Violence in the emergency department: an ethnographic study (Part II). Int Emerg Nurs 2012; 20:126-32.
121. Shelmerdine S. Pathways to inhumane care: masculinity and violence in a South African emergency unit. SAGE Open 2017; 7:1-12.

Resumen

En este trabajo se presenta una revisión de la literatura científica de estudios etnográficos sobre los servicios de emergencias en hospitales, con el objetivo de sistematizar las investigaciones y los principales hallazgos de los trabajos, que se refieren al proceso de salud-enfermedad-atención-cuidado en servicios de emergencia o guardia hospitalaria, desde una perspectiva etnográfica. En este sentido, se realizó una revisión bibliográfica integradora de textos publicados en revistas indexadas nacionales e internacionales y en las siguientes bases electrónicas: PubMed, BVS, Scopus, Redalyc y SciELO. El corpus de análisis quedó conformado por un total de 69 artículos, a los cuales se aplicó análisis de contenido, habiendo identificado las siguientes dimensiones de análisis: calidad de atención, comunicación y vínculos, subjetividad, aplicación de tecnologías informáticas, reflexión metodológica, experiencias y prácticas de los usuarios, toma de decisiones y violencias. Los resultados permitieron identificar un proceso que se aleja de lo normativo y protocolizado, donde aspectos subjetivos del trabajador, la comunicación y las relacionales interpersonales, así como las condiciones de trabajo, modelan, orientan y condicionan la atención y cuidado que se provee en el espacio del hospital. De este modo, se destaca el abordaje de los aspectos subjetivos en las investigaciones en salud, no sólo para comprender las perspectivas y experiencias de los trabajadores, sino para entender los obstáculos que persisten en el momento de proveer una mejor calidad de atención, complejizando un problema ignorado en la mayor parte de los análisis.

Servicios Médicos de Urgencia; Etnografía; Investigación Cualitativa

Resumo

Este trabalho apresenta uma revisão da literatura científica de estudos etnográficos sobre os serviços de emergência hospitalares, com o intuito de sistematizar as pesquisas e os seus principais achados, que tratam ao processo de saúde-doença-atenção-cuidado nos serviços de emergência ou de plantão hospitalar, desde uma perspectiva etnográfica. Neste sentido, foi realizada uma revisão bibliográfica integradora de textos publicados em revistas indexadas nacionais e internacionais e nas seguintes bases de dados: PubMed, BVS, Scopus, Redalyc e SciELO. O corpus analítico foi composto por um total de 69 artigos, aos que foi aplicada uma análise de conteúdo, após a identificação das seguintes dimensões de análise: qualidade da atenção, comunicação e vínculos, subjetividade, uso de tecnologias informáticas, reflexão metodológica, experiências e práticas dos usuários, tomada de decisões e violências. Os resultados permitiram identificar um processo que se afasta das normas e dos protocolos, onde aspectos subjetivos do trabalhador, a comunicação e as relações interpessoais, bem como as condições de trabalho, moldam, orientam e condicionam a atenção e os cuidados proporcionados no ambiente hospitalar. Assim, destaca-se a abordagem dos aspectos subjetivos nas pesquisas em saúde, não apenas para entender as perspectivas e experiências dos trabalhadores, como também para entender os obstáculos que persistem na hora oferecer uma atenção de melhor qualidade, problematizando um problema ignorado na maior parte das análises.

Serviços Médicos de Emergência; Etnografia; Pesquisa Qualitativa

Submitted on 12/Feb/2020
Final version resubmitted on 20/Aug/2020
Approved on 23/Sep/2020