

NURSING CARE PROVIDED TO BLOOD DONORS - FROM THE PERSPECTIVE OF INTEGRAL HEALTHCARE

O cuidado de enfermagem aos doadores de sangue - a perspectiva da integralidade

Atención de enfermería a los donantes de sangre - perspectiva integral de la salud

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ABSTRACT

Objective: To analyze the operative rationale in the field of nursing care provided to blood donors. **Method:** This is a descriptive, qualitative study, with an ethnomethodological approach. The study was approved by the Institutional Review Board at HUCFF (protocol No. 138/07). A total of 26 blood donors aged between 18 and 65 years old, both genders, were interviewed. **Results:** Present the operative rationale in the field of nursing care provided to blood donors, highlighting the biomedical model existing in the local micro-politics with a tense relationship with the proposition of integrality as a guiding axis of care in health macro-politics. **Conclusion:** This is a possible scenario for transitioning between health technologies, without intending to impose a new way to model the demand for healthcare, but proposing what is possible within the micro-political space, where nurses encompass the SUS assumptions with integrality as the guiding axis of daily relationships and care practices.

Keywords: Nursing; Blood Donors; Comprehensive Health Care; Blood Banks.

RESUMO

O objetivo deste estudo foi analisar a lógica que opera no campo do cuidado de enfermagem aos doadores de sangue. **Métodos:** Estudo descritivo, com abordagem qualitativa, à luz da etnometodologia, aprovado pelo Comitê de Ética em Pesquisa do HUCFF sob o número de protocolo 138/07. Foram entrevistados 26 doadores de sangue entre 18 e 65 anos de ambos os sexos. **Resultados:** Apresenta-se a lógica que opera no campo do cuidado de enfermagem aos doadores de sangue, destacando-se o modelo biomédico vigente na micropolítica local em tensa relação com a proposição da integralidade como eixo norteador do cuidado na macropolítica de saúde. **Conclusão:** Este é um cenário com possibilidades para a transição entre as tecnologias de saúde, sem a proposição de uma nova forma de modelar a demanda, mas com a proposta de que é possível, no espaço micropolítico, que as enfermeiras encampem os pressupostos do SUS tendo a integralidade como eixo norteador nas relações e nas práticas cotidianas do cuidado.

Palavras-chave: Enfermagem; Doadores de Sangue; Assistência Integral à Saúde; Bancos de Sangue.

RESUMEN

Objetivo: Analizar la lógica que opera en el campo de los cuidados de enfermería a los donantes de sangre. **Métodos:** Estudio descriptivo, cualitativo, con un enfoque etno-metodológico, aprobado por el Comité de Ética en Investigación de HUCFF (Protocolo 138/07). Se entrevistó a 26 donantes de sangre entre 18 y 65 años, de ambos sexos. **Resultados:** La lógica en el campo de los cuidados de enfermería a los donantes de sangre es basado en el modelo biomédico de la micropolítica local. Existen tensiones con la proposición de integralidad como guía de la atención en la macropolítica de salud. **Conclusión:** Este es un escenario posible para la transición entre las tecnologías de la salud, con la proposición de un espacio en el micropolítico donde las enfermeras puedan abarcar los presupuestos del Sistema Único de Salud, más allá de las relaciones y las prácticas cotidianas de cuidado.

Palabras-clave: Enfermería; Donantes de Sangre; Atención Integral de Salud; Bancos de Sangre.

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INTRODUCTION

The establishment of the Unified Health System (SUS) was based on the Brazilian Federal Constitution from 1998¹. The SUS's assumptions include equity, universality and integrality of care. Among the reasons for its conception and development were the population's health status and the State's responsibility to efficiently intervene in order to improve Brazilian society's low parameters that express economic and social inequalities, providing actions and services necessary to ensure the citizens' right to health. The prospect of equality in a unequal society, however, is uneven and despite the legal definition found in the SUS of a universal and cost-free unified public system, its implementation was configured as a process of health policy formulation that resulted in the consolidation of a hybrid system - public and private².

Within the SUS sphere, the idea that health problems are linked to social, cultural, economic and political contexts that influence the health-disease continuum and go beyond the field of exclusive health policies is linked to the idea of a broadened health concept. From this perspective, the biomedical theoretical-conceptual model is an epistemological obstacle for the proposal of integrality, which goes beyond the rationale rooted in "physical normality", and which is based on joint actions among the multidisciplinary team, health workers, and patients and then on levels and in spheres of public power related to healthcare³.

Among the three sets of meanings of integrality⁴, we connected with the one that refers to the quality of health practices, not as synonymous with access to all the system's levels; we understand that greater or lesser integrality of care delivery is a consequence, to some extent, of the way workers' practices are connected.

In this sense, we start from empirical observation, based on professional experience in the field of hemotherapy since 1997, in which we perceive that the care and management models are guided by the country's macro-politics, and we argue that the space to accumulate visible success and implement significant changes in the SUS is at the micro-management level, at the level of micro work process and micro-politics, "the space to act in the routine of subjects, in the relationship between these and the scenario in which they are inserted"^{5:459}. Hence, the nursing care setting in hemotherapy is where there is tension in the dialogue between micro- and macro-politics. The rationale of the biomedical and hospital-centered model is structured on the know-how-to-do practice of the first and the principles of universality, equity, integrality and inter-sector cooperation that are related to the second⁶.

Given the previous discussion, this study is justified both due to the limited scientific production in the field

and the need to discuss the current scenario of the hemotherapy specialty considering the possibilities for more efficient practices to be constructed in the healthcare routine. Hence, this study's objective was to analyze the rationale underpinning the nursing care provided to blood donors, based on the constitutional principle of integrality.

The hemotherapy service and clinical screening

The hemotherapy service (HS) has the function of providing hemotherapy and/or hematological care, recruit donors, blood processing, implementing the tests necessary to ensure the safety of the transfusion process, store and prepare transfusions, and may or may not provide outpatient care. It is a typical hospital service, which, given the need for blood donated by a supposedly healthy portion of the population, encounters typical users of the primary health care service during clinical screening (CS)⁶.

Dependence on people who donate blood, the raw material that enables the entire process that comes later and in a scenario in which the central focus is specialized care for transfusions, takes place in a fragile and tense environment that involves care provided to SUS users: those supposedly healthy and those diagnosed as being sick.

Blood donor candidates are men and women aged between 18 and 67 year old, whose current health status and history are individually assessed to determine whether blood can be collected without harming them and to verify whether the transfusion of the blood products prepared with their donation may pose any risk to potential recipients. Donors are not well suited to donate blood whenever there are issues related to physical parameters that are considered inappropriate or there is information that emerges during the individual interview⁷.

The role of nurses working with CS is to implement the proposals of the Ministry of Health in their work process, ensuring that the questionnaire is individually applied. This questionnaire addresses issues concerning the donor's current and past health, life habits and other questions that are necessary to assess a blood donor candidate. Assessment is based on measurable criteria that compose clinical screening and subjective criteria associated with these results, in a space that incorporates the definition of normality and that composes the relationship of the worker and user when the CS is conducted.

Based on the encounters of nurses with donors in the CS, in operational, political, communicational, symbolic, and subjective flows, there is a need and also a possibility of production through live work. This work, with the use of technologies of relationships, communication, embracement, bonding and empowerment, with the use of

"light technologies", consumes and produces tensions with the production of dead work, centered on the procedures of hard and light-hard technology⁸.

We look at this field from the perspective of the integrality of care and perceive it to be fertile for the proposition of care within CS, beyond the SUS's basic guidelines⁹, looking at it as a field that brings the possibility of getting connected to a way that indicates characteristics that are desirable for the health system and the practices performed within it⁴.

This study is aligned with Resolution COFEN 306/2006¹⁰, which encourages scientific production in the nursing field in hemotherapy, and the Priority Health Research Agenda¹¹ - 18.1.1, which proposes understanding integrality as a device to promote health in a given area of nursing practice, impacting the magnitude, dynamics, and understanding of diseases and events, working within a broadened concept of health and contributing to the field of the articulation/tension between micro- and macro-politics.

METHOD

This descriptive study was developed with a qualitative approach under the light of ethnomethodology in a setting in which the nurses' healthcare acts undertaken toward the blood donor candidates are permeated by interactions in a dynamic process of organization and reorganization, in which there are micro-politics, health work processes, and healthcare delivered to blood donor candidates.

The study's subjects were 26 blood donor candidates or their blood products at the Hemotherapy Service at Clementino Fraga Filho Hospital. Both genders were represented among the participants, with ages ranging from 18 to 65 years old and they all voluntarily consented to participate in the study after receiving clarification regarding the objectives and signing free and informed consent forms, from January 2nd to January 7th and from October 16th to October 31st, 2008.

We sought during data analysis to identify and understand how the participants of social interactions used such situations to interpret and act within the social worlds in which they construct their practices. These interactions were treated and categorized according to the interviewees' testimonies¹², which were collected in a dialogical interaction based on semi-structured interviews and also from the records of participant observations recorded in a field diary.

Data related to the construction of the blood donors' profiles originated from the service's database and from questions directly asked to the donors during the interviews. Quantitative information that composes the

donors' profiles was treated in terms of simple frequency, averages and medians. The quantitative analysis was complementary: the quantitative results supported the interviews' qualitative analyses, which had priority.

This study was approved by the Institutional Review Board at the Clementino Fraga Filho University Hospital on November 6th 2007 (Protocol 138/07). Confidentiality of both the participants' and professionals' identities was ensured. Authorization to disseminate the participants' answers and information was given through signed free and informed consent forms.

RESULTS

CS is one of the stages of the blood donation cycle and consists of a private interview held with the donor candidate. Its purpose is to ensure the safety of both the donor, given the potential risks inherent to blood donation, and that of the recipients of blood products. It is a strategy to ensure the quality of the blood to be donated, selecting those who are apt to donate blood and exclude the ill-suited ones. CS must be performed by a qualified and capable health professional with a bachelor degree, under the supervision of a medical team⁷.

The CS usually takes from five to ten minutes and during this period the candidate is asked about his/her clinical conditions and behavior. Inclusion and exclusion criteria are determined by the Technical Regulation of Hemotherapy Procedures⁷ (TRHP) and by protocols in each unit, which may have broader criteria than the current regulation.

The study group

In the group of 26 participants, men (80.0%) are distributed according to the following ages: 23.1% (6) were between 30 and 34 years old; 15.4% (4) were between 18 and 24 years and between 25 and 29 years old; 7.7% (2) were donors between 35 and 39 years old and between 45 and 49 years old; and finally 3.8% of the group were between 40 and 44 years old, 50 and 54 years old, and between 55 and 59 years old; that is, there was one donor in each of these age groups. The age group with the largest number of donors among the five women (19.2%) was 25 to 29 years old (7.7%), followed by the groups 30 to 34 years old, 35 to 39 years old, and 60 to 64 years, each with 3.8% of the female participants.

Of these, 16 (61.53%) were replacement donors and most (12 - 46.1%) were donating for the first time in the institution: one (3.8%) woman and 11 (42.3%) men.

Body data and care provided during CS

The data analyzed by the nurses, herein called the body's data, refer to the verification of vital signs,

anthropometric measures and hemocytometry assessment before CS. In regard to this information we highlight two elements concerning the rationale that operates in this field that are directly related to the prevention of disease and health promotion in the sphere of cardiovascular diseases: hypertension and obesity.

The TRHP indicates the blood pressure level that is compatible with blood donation, maximum limits of systolic pressure (180mmHg) and diastolic pressure (100mmHg). In practice, if this variable is considered in isolation, a person with a blood pressure of 180x100mmHg is considered fit to donate blood, while an individual presenting values above or below 140x90mmHg in a consultation assessment requires other measurement methods and diagnostic definition¹³.

A total of 19.2% of the group presented borderline hypertension; 23% presented stage 1 hypertension; and 3.8% presented stage 2 hypertension. Of the interviewed donors, 46% were noted as needing to receive guidance and be referred to a healthcare unit for monitoring and controlling cardiovascular risk and its consequences for the body. It is common in these cases that ill-suited donors are oriented to seek healthcare, whether from a private facility when they have a private health plan, or from a public healthcare facility close to their homes. Guidance and clarification regarding the reasons individuals are ill-suited and for how long, as well as the measures that need to be taken and the need, when it is the case, of monitoring and/or treatment, are verbally transmitted and reported to some extent, as are the health procedures and technologies available at this service, the CS.

Nonetheless, mechanically providing verbal guidance concerning the risks of hypertension and its required care does not mean care is being delivered to donors. Due to numerous factors in this context, there are healthcare acts that are actually distant from individual, unique therapeutic projects, since such guidance is closer to a mere application of knowledge concerning the disease than it is to a perspective of integrality, of negotiation between health professionals and patients with an understanding of specific contexts of different encounters⁴.

The second element we stress refers to the computation of Body Mass Index (BMI), body weight divided by squared height, commonly considered in health outcomes such as mortality¹⁴. The participants' median BMI was 27.4 Kg/m²; 38.5% of the donors were overweight and 30.7% presented varied degrees of obesity.

Because BMI is not taken into account by the TRHP, which considers a minimum limit of 50Kg as a criterion for being able to donate blood, in the service routine this situation is underestimated, and often, ignored.

I consider my health to be great considering how I take care of myself. I'm a person who, wow, I don't have the habit of going to the doctor for anything. Ah! Like, any little thing [...] Since I know I'm overweight and I'm 30

already and I know it's time for me to take care of myself [...] I'm trying to lose some weight because I know that from now on, it won't be good for me. [...] It doesn't change my life in any way but I know it will. Other than that I have nothing; I never had even a toothache you - know? - never broke an arm. I consider my health, like, to be good. (E1)

Another set of information that nurses consider during the CS, even though answers appear as "yes" or "no", are the responses to questions addressing the donor's life habits, history and lifestyle. Nurses are entitled, due to their professional activity, to ask about the donors' private lives. This is an opportunity for nurses to establish bonds with donors and listen to their health needs. This issue is related to situations such as one's perception of disease. Such a perception is more intense among those who have lower incomes, according to their access to the health technologies available in the system and inadequate distribution of equipment and professionals, as well as due to income disparities and social inequities.

I want to have dental treatment but money is short; I'm unemployed. Unemployed cannot do anything. [...] I have only one disease, which only Jesus can cure: lack of money [...] [the wife works to support the family]. She is holding up... I don't know what I had... a lot of jobs, I was in demand, people would call me, don't know what happened [...] I guess there's a crises really. [...] Well, we're holding up, God willing, we have enough for beans and rice. (E2).

Hence, it is the role of nurses to take hold of the SUS, based on the assumptions of service organization, and establish processes and practices that ensure universality of access and that embrace users, as well as to assume responsibility to establish bonds between professionals and the population with integrality of care, observing the services' strategy of regionalization, decentralization and hierarchy to better manage and adapt to local realities, promote inter-sector cooperation, referral and counter-referral, as the situation in the following excerpt demands:

[...] I'm used to solve problems; this is how I am; I'll never say to you that I have no conditions to do something and if I find there's a minimum possibility. [...] This situation is emotionally draining for me [crying] and physically too. [...] I guess I slept about three hours; my clinical data are normal, only my nervous system is a bit altered. [...] It's because I can't rest at home, I can't sleep, you know? It's difficult

for me even going home because I can't sleep [pause] if someone gave me some medication... and it's not good for me either. [...] I wanted to have some peace of mind now, to get some rest, but the reality is that I won't have peace of mind now. (E17).

Given the individual needs identified in physical measurements or information obtained during the interviews, the HS will depend on each nurse's commitment to provide care to the candidates, including the service in the health network, linking the levels of healthcare to the SUS or not linking them. From this perspective, in part we blame the TRHP for a lack of clarity on how the flow should be organized so that the CS would be an integral part of the healthcare network. We note that the HS that served as the study setting for nursing care is part of a field based on a rationale of functioning, circuits and flow of users, built on protagonism, interests and meanings that cannot be submitted to a single organizing rationale. For this reason, the subject of integrality was chosen as an agent of thinking about this practice within the logic of the healthcare network.

DISCUSSION

Given the previous discussion, it is clear that the physical body and concrete information, measured with the use of hard and soft-hard technologies, have great importance for CS. When nurses analyze this information, they are using an arsenal of theoretical and technical knowledge to ground their decisions concerning a candidate's donation. A course of reasoning is constructed for the decision concerning whether the donor is well suited for donation or not, in order to protect the physical integrity of donors and that of future recipients. Nonetheless, nurses do not advance in the face of a refusal of the reductionism and objectification of subjects, in an attempt to overcome dissociation between the public and welfare healthcare practices, looking at integrality not only as an attitude but as a way to organize the work process⁴.

In this context, where there are minimum criteria to allow candidates to donate blood and protect them physically during the donation process, taking care of donors is an individual action for each professional, who, during the *encounter*⁸, experience the donors' social, behavioral and individual situations. Knowing the donor opens the possibility for health needs to emerge and for nurses to provide care to donors and recipients, establishing bonds and relationships among them, articulating and using different health technologies. Additionally, the need to construct the idea of a network among the professionals

who operate the local micro-politics is apparent, since in order to put integrality into effect, it is necessary for there to be cooperation and connection among the unit's health professionals, users, the health services and institutions. Various technologies are distributed in different services, overcoming the fragmentation of knowledge due to excessive specialization, in order to propose solutions for the integrality of health actions¹⁵.

In this context, nurses with their structured and socially recognized knowledge, in the role of guiding the relational and screening process, have a central role in the achievement of integrality, and in establishing a connections between the system and the users' health needs. Needs are modeled by the supply of services, where many follow the rationale that a disease is a deviant behavior both in its physiological dimension and as a response of the individuals under social pressure¹⁶.

The micro-politics of the work process presents a dynamics based on the model of specialties, on the fragmentation of health services and on limiting care to the specificity of screening donors, overlapping integrality as a possibility of being a structuring axis of the care model that is operated locally. Hence, among the various factors interfering in the achievement of integrality as a conductor of care, there are: those artifacts SUS inherited from the hegemonic model of healthcare focused on a curative approach; the qualification of professionals with curricula based on Flexner's model; the consequent fragmented practice of professionals; and the market interests that are opposed to the SUS¹⁵.

Inversely, in order to put integrality into practice, one is required to make a systematic search, in their routine and processes, for the more silent needs, meaning that services need to create devices and adopt collective work processes able to provide actions that are based on individuals' experiences of suffering⁴. These elements thicken the space where micro-politics is developed and express life experiences, while political actions gain social materiality, which then forms the creation and appropriation of the reproduction of collective life, as a field of observation of institutional practices¹⁷.

In this sense, nurses have to transcend the limitations of issues concerning the physical body and the biomedical model, so that different ways to develop work can articulate a technical composition in order to employ health technologies, also considering, in an articulated manner, the place that the core of light technologies occupy and their way of operating productive processes, as well as disputing models that compete within this spaces⁶.

In certain situations, nurses will have to break from serialized practices that exist in networks and are not individualized and are also practices with a low level of connective flow. At the same time, in this same setting, there is an intermediate: the operation of highly desired subjectivities with the live work that takes place in the act⁵. This configuration generates an expectation that a moment of change is taking form, transitioning from an old to a new work process in the HS's micro-politics of health and its implications for nursing care and blood donors⁶.

We highlight in this process that the perspective of inter-subjectivity goes beyond our knowledge of disease, of what we believe we know about the production of life of those with whom we interact in the health services, and implies the construction of individualized therapeutic projects based on light technologies⁴. For this reason, given what we have discussed so far, we view the relationships between professionals and users as being probable successes, intertwined with the implications and processes of subjectivities, and in the access to care demands, to overcome dead work and the use of hard technologies in order to provide care from the perspective of integrality.

FINAL CONSIDERATIONS

With our persisting quest to establish a patient-centered care process, we glimpse paths that indicate a paradigm shift, from the hospital-centered healthcare model toward integrality as a guiding axis of the work process within the CS, as an integrant part of the official health policy and, at the same time, included in the capitalist model of production, which has its own diversity of knowledge, practices, and culture inherent to a given reality¹⁸.

Hence, in the micro-political space in which CS operates, there is articulation and tension and there are also possibilities to meet the needs of donors, which in part, depend on the nurses' self-government together with the users of the Brazilian Unified Health System. On the other hand, they also depend on institutional change and coordination among the routes of levels of care, so that donors do not need to adapt their needs to normative needs, which is a concern of people in relation to their health problems, or what they expect from services, where the main focus is centered on the professional and on the established norm¹⁶.

The redefinition of the current model can be based on a re-discussion of the health service philosophy and on a necessary methodology of nursing care proposed to the unit, considering the consumption of dead work by live work and where light technologies

gain expressiveness, linking the nurses' healthcare acts to the donors' health needs.

This is a possible scenario of making a transition between health technologies, noting that we do not propose CS as a new way to model the demand but rather as a proposal, in the micro-political space where nurses work, in which the intention to encompass SUS assumptions may exist to make an association of knowledge proposed in the collective health field with those in the field of hemotherapy, constructing the possibility of transcending daily relationships and practices.

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