Professional autonomy of the nurse: some reflections

Autonomia profissional da enfermeira: algumas reflexões

Autonomía profesional de la enfermera: algunas reflexiones

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Abstract

Objective: To reflect upon the professional autonomy of nurses within the biomedical care model. **Methods:** This study will analyze the issue based on the reflection built from the theoretical reference regarding the work in the area of health and in nursing. **Results:** It was identified that in the biomedical model, the professional autonomy of the nurse is limited and conditioned by the decisions of the physician (in which the work process command the use of roles and health services), due to a fragile construction of a body of understandings linked to the profession, and because of the growing technical division of work in health and in nursing. **Conclusion:** The nurse can widen his/her professional autonomy in other care models that enable the construction of knowledge related to the field of nursing, such as the areas of Mental Health, Obstetrics, and Primary Health Care. These are areas destined to the nurse to develop his/her own autonomous professional practice, consonant to the holistic care in health care.

Keywords: Professional Autonomy; Nurse; Work.

Resumo

Objetivo: Refletir sobre a autonomia profissional da enfermeira no contexto do modelo assistencial biomédico. **Métodos:** Reflexão construída a partir do referencial teórico sobre o processo de trabalho em saúde e em enfermagem. **Resultados:** Identificou-se que no modelo biomédico a autonomia profissional da enfermeira é limitada e condicionada pelas decisões do profissional médico (cujo processo de trabalho ordena o consumo de ações e serviços de saúde), pela frágil construção de um corpo de saberes próprio à profissão e pela crescente divisão técnica do trabalho em saúde e em enfermagem. **Conclusão:** A enfermeira poderá ampliar sua autonomia profissional em outros modelos assistenciais que permitam a construção de saberes próprios ao campo da enfermagem, como os campos da Saúde Mental, da Obstetrícia e da Atenção Primária em Saúde. Esses são espaços propícios para a enfermeira desenvolver uma prática profissional autônoma e consoante com o cuidado integral em saúde.

Palavras-chave: Autonomia Profissional; Enfermeira; Trabalho.

Resumen

Objetivo: Reflexionar sobre la autonomía profesional de la enfermera en el contexto del modelo asistencial biomédico. **Métodos:** Se trata de una reflexión construida a partir del referencial teórico sobre el proceso de trabajo en salud y en enfermería. **Resultados:** Se identificó que en el modelo biomédico la autonomía profesional de la enfermera es limitada y condicionada por las decisiones del profesional médico, cuyo proceso de trabajo ordena el consumo de acciones y servicios de salud; por la frágil construcción de un conjunto de saberes propio de la profesión y por la creciente división técnica del trabajo en salud y en enfermería. **Conclusión:** La enfermera podrá ampliar su autonomía profesional en otros modelos asistenciales que permitan la construcción de saberes propios del campo de la enfermería, como los campos de Salud Mental, Obstetricia y Atención Primaria en Salud. Estos son espacios propicios para que la enfermera desarrolle una práctica profesional autónoma y acorde con el cuidado integral en salud.

Palabras clave: Autonomía Profesional; Enfermera; Trabajo.

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INTRODUCTION

The aim of this article is to reflect upon the professional autonomy of the nurse within the context of the biomedical care model. In this model, today considered hegemonic, provides an impact in the organization of the process of work in health, and consequently, it impedes the technical autonomy of the nurse. In order to provide a starting point in this analysis, the terms "autonomy" and "professional autonomy" needed to be explained.

In its widest concept, the terminology "autonomy" means the capacity of a person or group to determine and follow the rules and laws created by the individuals, in order to "print guidance to the actions, by itself, and independently"[1:467]. In these terms, autonomy is conceived as a capacity to self-determination of a subject or collectivity[1]. It is important to mention that the autonomy of a person or group is exercised within a society, and therefore, it is not possible to exclude the influence of the social context and its particular characteristics for every different time and place[2].

Because of that, autonomy should not be characterized as an absolute, unlimited, and self-sufficient terminology, but as a "condition" that is materialized in the world and not only in the conscience of the subjects. In this perspective, the construction of autonomy "(...) involves two aspects: the power to determine one's own law, and also the power or capacity to perform"[2:12].

In regards to professional autonomy, Eliot Freidson[3] affirms that all professionals seek this autonomy status, which is represented by the liberty one professional have towards the others and by the freedom one has to proceed one's work in the way is more convenient to him/her. In this sense, professional autonomy must be expressed within the technical part of the work, demanding from the professionals the control over technical interventions and proceedings that are part of his/her professional tasks[3]. According to this same author "the technical autonomy is in the essence of what is unique to each profession", as this autonomy "enables [...] a path in which a professional can be considered 'free', even if this person is dependent from the State to establish and sustain his/her own autonomy"[3:65-66].

It is considered that a certain level of autonomy is fundamental to the development of a professional atmosphere, specially in the area of health, in which collective work is widely used and shared/complemented by various other professional categories. Such professionals more than frequently do not share the same background, nor even the same roles and routines. Must of them have their professional etiquette ruled by specific laws, which permits a partial control of the working process and a certain level of professional autonomy[4].

In the field of nursing, there is a discussion which states that the achievement of a higher level of autonomy by the nurse can provide a higher value and social recognition regarding this professional's work and role. However, it is necessary to consider that, in the Brazilian society, the role of the nurse is set and performed based on the historical, social, and sanitary determinants, among which are established by the biomedical care model[5].

The biomedical care model is still hegemonic in Brazil, with a wide and solid political, ideological, and economical support. This model is based on the spontaneous demand, the intervention upon the illness and the ill body, as well as in specialized proceedings and services. Furthermore, the biomedical model has the its privileged *locus* the hospital, and its main agent the physician, above all the specialist, whose work is complemented by the named paramedics[6].

Under the influence of the capitalist organization of workloads in the area of health, the biomedical model reinforces the position of the physician as the organizer of the work process, and it consolidates this professional's hegemony in care practice. Besides that, in this care model the physician is socially and legally recognized as the sole holder of knowledge in the area of health and is placed in the central position of care practices, a situation that places all other health professionals performing their roles as supporting elements to the physician's task[5].

The historical development of the professions related to the area of health, the emergency and consolidation of the biomedical care model, added to the increased level of technical subdivisions of medical labor demanded a large amount and qualified work force to be able to ensure the continuity of care practices, and the implementation of medical orders. In this context, the professional nurse had to resigned in order to suppress this specific demand, and specially, to support the workload from physicians fighting against illnesses and the biological and social control of bodies[7].

In the light of these initial considerations, the constructed analysis of this article originated from the presupposed idea that the biomedical care model and the context of productive restructuring of flexible and precarious labor force, the professional autonomy of the nurse is limited and even sometimes blocked inside the health institutions. This is explained through the facts that, despite this professional's technical practice, it has been determined from the medical practice. Another fact is that the nurse is placed in the social relationships of production a place as a regular daily laborer, a holder of his/her own workforce and lacking any means of production or any other sort of capital, according to Santos[5]. Such scenario imposes to the nurse to sell his/her workforce to the capital, responding positively to the demands of those who employ this professional, as well as to the social determinants of nurse's work, in attention to the productive and precarious labor restructure.

In the context of labor precariousness, the nurse is even more vulnerable and less autonomous as the professional is taken to convey with inadequate working conditions, low wages, extensive and intensive work shifts, besides being responsible to multiple and diverse roles (polivalency at work), as well as having as many different functions in order to increase the nurse's wage[5,8].

It is important to call attention to the fact that in the area of health the autonomy of professionals is not absolute, once the work process is collective and its object of labor (the human necessities socially built) is complex, and demands a collective, shared action based on each professional involved[5,9]. Therefore, the professionals of the area of health must work with a certain level of autonomy, because each care task is singular and requires the decision of adequate proceedings to the health necessities presented by the users.

It is also assumed that there is no possibility of a full autonomy for nurses, once it would set aside the technical and social meaning of their work, which is to provide for the health necessities brought by the users. It would stop their tasks to be subordinated to medical practice, as it is now defined in the work organization of the taylorist-fordist model. On the other side, to perform their roles, in special the managerial one, the nurse has some level of professional autonomy, mainly related to decision-making procedures and to define internal roles and routines, which demonstrates a certain control over the technical component of his/her own work, building a unique understanding to be used to execute the professional's managerial work process.

THE PROFESSIONAL AUTONOMY OF THE NURSE IN THE BIOMEDICAL MODEL

To reflect upon the professional autonomy of the nurse in the biomedical model is necessary to characterize the predominant elements in the work process in the area of health.

The work process in health is composed by the division of services, executed by a wide variety of professionals, each with his own technical function, and in which roles are connected and complement each other. A peculiarity of this process is that this process demands an intense interaction between health professionals and users, as well as among the professionals themselves. This characteristic reveals the collective nature and the necessity to provide room for autonomy, so the professionals can respond adequately to the demands and to face the uncertainties present in the moments of interaction with the users. In this sense, autonomy is necessary in the work process in health, and its coverage is variable depending on the technical and social legitimacy of the knowledge that supports the actions of the professionals involved[10].

In the biomedical care model, the physician is the professional who has the highest level of autonomy in the work process in health, working as the main character, establishing the work process of the other processionals of the area. Peduzzi[10] elucidates that each professional area in health has its own peculiar work process, with their own goals and instruments. However, in the big picture, they are structured according to a medical normative, and as a consequence, they are placed in a secondary level of the health work process, as they are organized and perform their roles according to the decisions and de demands generated by the physicians in their care process[10].

This fact is generated from the capitalist organization of work in health, in which the physician has the task to order the consumption of services and actions, pushing the health industry and generating demands in consumption of medication, feedstock and proceedings[5]. Because of that, physicians have a higher decision power in the work process in health, a fact that provides them with a higher technical autonomy, as it "finds expression in the possibility of the decision-making process, and not in the implementation of the decision"[10:46].

It is important to highlight that the technical division of work in health, in the midst of biomedical model, has reinforced the dominant and determinant role of the physician in the area of health, and it has provided this individual with the title of the "most intellectual" nuclei (the diagnose of illnesses and prescription of medication, besides the use of some privileged techniques) of the work process in health, while the nurse is held to handle "more manual" tasks, which are complementary, aimed to guarantee the continuity of the therapeutic process[9].

Despite the fact that the biomedical model places in evidence the central role of the physician in the work process in health, it does not mean this professional is self-sufficient and has a full professional autonomy, as "the autonomy is not an absolute attribute, once despite the technical imperatives, it also reflects the social dimension of the mode of insertion of agents in the organization of services and work processes"[10:47]. Furthermore, "as both the technical and the social dimensions change, as well the professional autonomy restructures itself"[10:47].

For example: while in health services, specially the hospital ones, there is an increase use of technologies that support the delimitation of diagnoses and treatment of illnesses, there is a relative loss of professional autonomy from the part of the physicians[11], once the control of the medical staff upon their work process is wider than before. Despite that, "both the user and the health professionals, but the physician can have access to information and proceedings that before were appropriated only by the physician himself/herself, and with the intermediation of technology, the information and the proceedings become even more transparent to all subjects involved"[10:47].

Despite that in the execution of the medical work there is an assured level of professional autonomy[10], the procedures are shared with other professional categories and with the user, who "is not limited to a passive entity waiting for the transforming result from work, but the opposite, he is seized in its power, in its dynamics that is capable to influence the whole productive cycle"[11:191].

These perceptions demonstrate that, in the biomedical care model, the professional autonomy of physicians is relative, because the contribution from the user and from the rest of the health professionals involved will always be necessary to achieve the goals of work in health. Besides that, it is necessary to remember that the many specialized positions in health are connected and complementary, and when they are combined, the professionals amplify the possibilities of care and recognition of the health necessities of the users[10].

Therefore, considering the collective nature of the work in health, it is clear that in this work process there are different levels of professional autonomy. These levels are related to the technical and social legitimacy of the knowledge that supports the action and the decision power of the professional who is performing his/her position. The fact that physicians have a higher decision power and wider technical autonomy does not exclude the fact that the other professionals of health, in special the nurses, also participate in the decision and define the conduction to perform their work and to face the uncertainties that belong to health care.

In relation to the nurse, the work under the biomedical model guarantees a continued intervention over the ill bodies, as the bottom structure to the organization of the work care process

are the decisions taken by physicians and expressed from the definition of the diagnosis and medical prescription. On the other side, in the biomedical model the nurse has professional autonomy, even if limited, because, as mentioned by Peduzzi[10], in the work process in health there is no possibility to draw a previous and definite care plan, a fact that provides this professional room to use his/her own judgment, decision, and creativity. These actions will interfere in the decision making process of the physician regarding diagnose and treatment. Moreover, inside the social and technical division of the work in health, each professional area is filled with their own understandings and tasks, and only a fraction of these actions is clearly defined by law as specifically set to one or to another professional[10].

It is worth mentioning that in Brazil the Law of Professional Practice in Nursing[12] delimitates the formal and legal boundaries of the work in the field, and it does not support the expansion or consolidation of the professional autonomy of the nurse based on the following reasons:

- This Law is fragile and its content does not clearly state the attributions of each category of laborers in the field of nursing;
- It does not contemplate the collective nature of the work in health and in nursing;
- Its content is outdated, considering the changes in the production of technical and scientific knowledge and the creation of the Brazilian Unified Health System;
- It does not consider that the autonomy of a profession is related to more or less technical authority, which is not established only technically;
- The Law does not consider that professional autonomy is also connected with the amplitude of the intellectual dimension of labor[10] and with the legitimacy of the understanding that supports the performance of professional work. It is worth to remember that in the biomedical model, the physician is socially recognized as the holder of knowledge in the field of health, and adding to this idea, it is this professional's intellectual dimension that superimpose the same dimension from other health laborers[10]. Hence, both the work of the nurse and the role of the physician are considered most of the times as manual, or even artisanal labor, an affirmative that recalls the origins of both sciences, which had the status of art before they rose as complex wisdom. Despite that, due to the location of the social power physicians have, the knowledge that supports their experience are also socially legitimated and they overcome the understandings from other health professionals;
- The majority of the rules and laws that regulate the nurse as a professional is established under the hegemony of the biomedical model, and therefore, such rules enable the nurse's practice to subsidize this care model;
- In the end, in the biomedical model the knowledge appropriated by the nurse to create a basis that will provide for the performance of his/her work are intimately linked to the ones from medicine, and the construction of a singular body of knowledge in nursing is very weak.

Within this context, it is considered that in the biomedical care model the professional autonomy of the nurse is surrounded by the demands established by the physician, in which the main tasks related to the diagnose and drug prescription make the second professional a mediator between the necessities brought by the user and the health services available[10]. This scenario only contributes to the fact the physician is kept on a hegemonic position and his/her work has higher economic and social value, an element that reduces the possibility to widen the professional autonomy of the nurse.

In a hospital, where the biomedical care model is centered, the set of understandings and roles that could guarantee the nurse an autonomy of his/her own labor are linked to the organization of this space and the management of both the necessary resources to produce the work in health and the work process in nursing. However, the managerial work of the nurse is invisible, once this professional is not paid to perform the managerial roles of his/her own work[5].

It is important to mention that, in Brazil, as well as in other countries in Latin America, there is a progressive increase of the limits of the work of the nurse, mostly related to Primary Health Care (PHC). This fact arises from the quick changes in the socio-demographic and epidemiological profile of the population, as well as the accelerated annexation of understandings and technologies in the process of work in health and in nursing[13,14]. As a result of the increased limits, other performance roles are incorporated to the process of work of the nurse, which were before exclusively given to other professional categories, such as drug prescription.

The drug prescription by Brazilian nurses is permitted according to the Law of Professional Practice in Nursing and other legal documents, from the Brazilian Federal Council of Nursing, being used exclusively in PHC, and according to protocols established by the Brazilian Ministry of Health or other related institutions. Despite the fact drug prescription is legally permitted since 1987, today this task is yet considered not fully legitimated in the area of health, and it is still widely discussed in the field of nursing, as it has a considerably string opposition among physicians[15], commonly translated as a simple "transcript" of medication[16], once the nurse cannot modify the dosage or indicate another drug that is not described in the protocols that sustain the prescribing role[17].

It is important to clarify that the limit imposed to the prescribing role of the nurse does not provide this professional to a larger autonomy, once this practice is based on a process of analysis and decision that must follow parameters established in protocols, which does not guarantee that the nurse will be able to intervene in the problems found if they overcome the limits established in the same protocols. Or in other words: even if the nurse is able to identify the necessity to substitute the dosage

or the need to use another medication that is not described in the protocols, it is necessary a physician to adequate the pharmacological therapy.

Then the issue arises: how much the task of prescribing a drug supported by technical-scientific parameters is conceived to support the autonomy of the nurse, specially when the protocol does not cover the necessities presented by the user? It is necessary to call a physician, or not? This task, among many other similar ones, provides autonomy to the nurse under the perspective of which care model?

An international study regarding the practice of the nurse at a PHC of the English National Health System (NHS)[18] has identified that the prescription of medication by nurses was favorable to the NHS because there was a decrease in the costs of health care to the general population, due to a lower wage paid to the nurse in comparison to the physician. On the other side, for the nurses, there was a higher professional recognition and an increase in their technical force[18].

However, still recognizing the increase in the technical force of the nurse, there were records of unfavorable results, such as work overload. This fact occurred based on the assumption that the nurse was still responsible for the same traditional roles, but now the professional has added new clinical practices; the inclusion of drug prescription in the work process of the nurse was not followed by an equivalent wage increase. Another element is a continued atmosphere filled with conflicts in the workplace, between the nurse and other health professionals, specially the physician, who do not recognize the technical capacity of the nurse. In the end, "if by one side, the NHS motivates this practice (*drug prescription by nurses*), on the other side, in the health services, the necessity for mentoring would keep a certain control of it by the medical category"[18:188].

Such results show that, even with a higher technical capability, the English nurses continue to be limited and have not achieved a higher professional autonomy when they started to prescribe medication inside the biomedical care model, and with power relations that are kept unaltered. Then, under the perspective that "(...) the prescribing role inside the everyday practice of nursing brings autonomy and professional value"[16:747] must be questioned, because the decision power to prescribe drugs based on protocols is limited and does not permit to act autonomously when the demand of the user is beyond the limit established in the protocols. At last, this scenario leads to question the so-called advanced practice of nursing, which is in fashion in many countries, in fact contributes to provide a technical autonomy to the nurse.

Based on the data here provided, it is possible to confirm that the professional autonomy of the nurse can be amplified in other care model, as seen by the limits imposed by the biomedical care model. Hence, it is fundamental to identify, to build, and to intend for the understandings that belong to the field of nursing.

In Brazil, the Primary Health Care, and in special the Family Health Strategy program, the Psychosocial Care Centers, and the work of obstetric nursing are identified as open fields for nurses to build their own understandings and to widen their professional autonomy, once in these spaces is possible to build knowledge and experience based on the promotion of health, of care, in understandings supported by psychology, anthropology, and sociology, in a relationship beyond the illnesses. Such working and understanding fields are not valued in the biomedical care model and are spaces to build practices and to produce singular knowledge by the nurses[19].

When the nurses perform roles directed to the promotion of health in a PHC, they overcome the emphasis on the cure of illnesses as in the biomedical model, and amplify the roles performed in this area of health care, thus projecting the practice of the nurse "with a higher level of autonomy when compared to the medical practice, consonant to a wider definition of health and of holistic care"[19:993].

It is worth to mention that the nursing practices performed under the promotion of health are part of the PHC and contribute to consolidate the promotion of health within this program. In this direction, the nursing care practices performed to promote health develop the capacity of individuals, families, and the community to identify their own health necessities and to co-participate in the search for solutions[19]. In other words: the nurse starts to contribute with the construction of life projects of the users, either individually or collectively.

Ergo, the promotion of health is an important strategy to amplify the professional autonomy of the nurse, once it amplifies his/her labor beyond the limits impodes by the physicians and brings the work process in nursing to the promotion of life. It is not possible to say that the promotion of health is a field that enable nurses to build their own knowledge, in order to reassign their work process and to widen the borders of their professional autonomy.

For beyond the promotion of health, the work of the nurse in the fields of mental care and obstetrics have some potential use of development with a higher level of autonomy. The present context of health policies - influenced by the neoliberal political-economical scenario - lead the State to invest in parturition care done by obstetric nurses, which involve light and low-cost technologies, in confrontation with the hegemonic representations and forces of the medical category in obstetric care[20]. This are became favorable to rescue the place of power the nurse has when working side-by-side with the mother during the process of midwifery, a process that requires to proceed according to the nature of the feminine body and it requires from the nurse the role that is not linked to the knowledge of medicine, which is to support, to alleviate, and to accompany the mother during the moment of care and reproduction of life.

In the field of mental health, the Psychiatric Reform and the Antimanicomial Movement are directed to the fields that new understandings and practices can be developed, which will demand from the nurses the development of researches in order to build singular practices of care to the people and their families in this area.

Despite supporting the autonomy of the nurse, the promotion of health can contribute to construct new therapeutic projects in which the users have a higher level of autonomy over their bodies, in order to choose life habits that they consider healthy and then becoming responsible to their own process of health-illness-care.

FINAL CONSIDERATIONS

The analysis of this study provide ground to affirm that within the biomedical care model, the professional autonomy of the nurse is limited and conditioned to the demands of medical labor. The main reasons for this conclusion are: 1) the capitalist organization of work in the area of health, reinforced by the biomedical care model, which the physician takes the core role as the organizer of the consumption of health roles and services; 2) in the biomedical model, the understandings that support the performance of medical labor are socially legitimated, superposing the knowledge of the other professionals of the area of health, and consolidate the technical authority of the medical practice in health care. It is important to mention that despite the physician has an elevated professional autonomy, it is not absolute once his/her work process is also shared with other professionals of the area of health and with the users.

Therefore, in the biomedical model there is no room for the nurse to amplify his/her professional autonomy, as the work process of this professional will continue to be conditioned by the demands imposed by the medical work. It is necessary to state that even when the nurses incorporate the role of drug prescription and other technical practices to his/her work process - even those that were exclusive to physicians, such as the technical performance of electrocardiogram exams and central catheter of peripheral insertion, in Brazil, and the anesthesy procedure, in some parts of the USA - there are no significant developments for the field of nursing, once the performance of such roles depend on the permission and approval of a physician, going against what Eliot Freidson supports as being one requisite for professional autonomy: the technical component of the work of a profession cannot be evaluated nor controlled by other professions in its own division of labor. Such settings are new ways to amplify the technical division of labor in health.

As a counterbalance, the development of professional autonomy of the nurse can be achieved in another care model that enables this professional to build his/her own field of knowledge, not as a subsidiary to medical practice. In this sense, the fields of Mental Health, Obstetric Nursing, and Primary Care are priviledged spaces for the nurse to construct a body of unique understandings that enable the development of a more autonomous practice, consonant to a holistic care to people, families, and communities.

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