ORIGINAL ARTICLE

Responsibility in health care: regarding the time we live as intensive care nurses*

RESPONSABILIDADE NO CUIDAR: DO TEMPO QUE NOS TOCA VIVER COMO ENFERMEIROS/AS INTENSIVISTAS

RESPONSABILIDAD EN EL CUIDAR: DEL TIEMPO QUE NOS TOCA VIVIR COMO ENFERMEROS/AS INTENSIVISTAS

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ABSTRACT

This qualitative investigation was supported by Foucault's analysis with emphasis on the notion of governability, and had the following objectives: to analyze the relationship between techno-biomedicine and bioethics as discourses of the contemporaneousness implied in the production of nurses' subjectivity within the context of the Intensive Care Unit (ICU); and approach the responsibility implied in health care as one of the unfolding strategies of technology of speech of bioethics and biotechnology, creating certain forms of the nurse understanding and intervening in the Intensive Care Unit (ICU). From the perspective of the multiple ways that can emerge when analyzing a critical reading of analyzed texts and interviews with nurses, responsibility in health care was unfolded into categories that expressed the responsibility in front of new languages and of nursing as a guardian of certain attributes in the Intensive Care Unit (ICU).

DESCRIPTORS

Intensive Care Units
Bioethics
Nursing
Nursing care

RESUMO

Investigação qualitativa, balizada na analítica foucaultiana, com ênfase na noção de governabilidade, constituiu como objetivos: analisar a articulação da tecnobiomedicina e bioética, como discursos da contemporaneidade implicados na produção da subjetividade do/a enfermeiro/a no contexto da Unidade de Terapia Intensiva (UTI); e abordar a responsabilidade no cuidar como um dos desdobramentos estratégicos e tecnológicos de diferentes discursos, gerando determinados modos de conceber e intervir do sujeito enfermeiro/a na UTI. Nessa perspectiva, dos múltiplos vieses que poderiam emergir ao se fazer uma leitura crítica dos textos analisados e das entrevistas com os/as enfermeiros/as, a temática da responsabilidade do cuidar foi desdobrada em categorias que expressaram a responsabilidade diante das novas linguagens e da enfermagem como guardiã de certos atributos da UTI.

DESCRITORES

Unidades de Terapia Intensiva
Bioética
Enfermagem
Cuidados de enfermagem

RESUMEN

Investigación cualitativa, basada en la analítica foucaultiana, con énfasis en la noción de gobernabilidad, que objetivó: analizar la articulación de la tecnobiomedicina y bioética como discursos de la contemporaneidad implicados en la producción de subjetividades del enfermero/a en contexto de Unidad de Terapia Intensiva (UTI) y abordar la responsabilidad del cuidar como uno de los desdoblamientos estratégicos y tecnológicos de diferentes discursos, generando determinados modos de concebir e intervenir en el sujeto enfermero/a en UTI. En tal perspectiva, de los múltiples puntos de vista que podrían emerger al efectuarse una lectura crítica de los textos analizados y las entrevistas con enfermeros/as, la temática de la responsabilidad en el cuidar fue desdoblada en categorías que expresan la responsabilidad ante los nuevos lenguajes y de la enfermería como guardia de ciertos atributos de la UTI.

DESCRIPTORES

Unidad de Terapia Intensiva
Bioética
Enfermería
Atención de enfermería

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INTRODUCTION

An editorial issued in 1938[1], entitled *Obrigações legais da enfermeira em relação ao médico e ao doente* [Legal obligations of the nurse towards the physician and the patient], written 17 years before the first Law on Professional Nursing Practice No 2.604, issued on September 17th 1955, expressed that nurses, if employed by an institution, was not the main responsible for her actions and conduct. Thus, physicians and employing institutions were Always held accountable in case nurses performed some inadequate practice that entailed possible patient damage. In 1985, a paper recommended that nurses should study and follow the evolution of scientific knowledge, so as to effectively assume the responsibility inherent in their function as nurses[2]. In 2008, i.e. nowadays, we are confronted with a Bio/ethics discourse articulated with nursing. A time, an articulation that states, in different tones and forms, what our responsibility is as nurses, that details measures they should use to guarantee their responsibility in care.

Responsibility, then, which entails a meaning of obligation, task, commitment or duty to comply with or perform something about whose compliance or performance an agreement was reached. Legal accountability refers to compliance with the clauses of the Law of Professional Nursing Practice; ethical responsibility is mistakenly understood as compliance with Nursing Professionals' Ethics Code (CEPE), in view of the understanding that no ethics code manages to fully cover all ethical dilemmas experienced in view of enhanced scientific and technological development[2]. Besides, the change in the title, from Nursing Deontological Code to CEPE marks an attempt to broaden its range towards current times, as concern with nurses' accountability and duties, as a member of society, is expressed throughout the text[3].

...we consider that responsibility locates us in a time of living nursing linked with the values and interests of a society that privileges the health market. And, at many times, these values and interests lead us to a paradox between the responsibility of should be and autonomy with the ability to choose...

We justify the accomplishment of this study based on the belief that we consider that responsibility locates us in a time of living nursing linked with the values and interests of a society that privileges the health market. And, at many times, these values and interests lead us to a paradox between the responsibility of *should be* and autonomy with the ability to choose – an exercise of autonomy is linked with knowledge on a given topic, which turns into a condition for the ability to choose. One can talk about adequate knowledge when understanding exists: about the nature of the action, the foreseeable consequences and possible results of executing the action or not[4].

Thus, instead of producing the erasure of the paradoxical relation between professionals' responsibility and autonomy at health institutions, we decided to explain the multiple combinations of autonomy and responsibility levels in detail. The idea is to qualify the paradox, demonstrating that intensive care professionals work on the borderline, in a space that articulates, touching a bit more or less, depending on the case, the bioethical discourse, legal discourse, moral discourse, scientific discourse and economic and administrative discourse. In this perspective, we developed a Foucaultian analysis and focused on the discussion about techno-biomedicine in its articulation with bioethics and intensive care nursing, signaling and mapping some processes in which a set of governability practices was intensified, maximized and improved, which we call care responsibilities, which are establishing (for intensive care nurses) ways of being and doing.

OBJECTIVES

To analyze the articulation between techno-biomedicine and bioethics, as contemporaneous discourses implied in nurses' production of subjectivity in the context of the Intensive Care Unit (ICU).

To address responsibility in care as one of the strategic and technological developments of different discourses, producing certain ways the nurse subject conceives and intervenes at the ICU.

LITERATURE REVIEW

Care responsibility will be addressed her through governability practices, constructed in the relations nurses establish among themselves, with health institutions and with clients and in relation to the profession. The intent is to problematize, produce estrangement about a daily reality that may be perceived and valued as normal and, who knows, as unquestionable and permanent.

Updating Foucaultian thinking, we present representatives from philosophy, law, the techno-biomedicine industry, theology, ethics committees, professional associations, hospital managers, medicine and nursing itself as some of the – what we call – unambiguous authorities in bioethics and techno-biomedicine discourse. We consider unambiguous authorities as subjects who are capable of saying and doing what they say and what they do, precisely because they operate a discourse that incorporates other discourses from different knowledge areas. Hence, that is whom we should ask how to behave, and they also say how we should conduct other subjects. Therefore, these unambiguous authorities present themselves as capable of governing subjects, of governing the people that govern the subject and of constituting, thus, a general government practice: government of oneself, government of others. So, how do these unambiguous authorities, how do bioethics and techno-biomedicine articulate the need for their own presence with the constitution, devel-

opment and organization of the individual, of the practice they develop in intensive care nursing? What instruments do they propose? Or, better, through what institutional mediations does bioethics intend the unambiguous authorities, in their existence, in their practice, in their discourse, in the advice they will provide, to allow listeners to develop practice, take care of themselves and reach what they are proposed as an object and target, and which they are themselves? In short: *how does one establish, set and define the relation between true-saying (veridiction) and the subject's practice?*[5]

In that sense, Foucault, through the governability notion, makes the most of the subject's *freedom*, discovering the matter of ethics at the heart of all social relations[5]. In governmentalized societies, power is expanded because it is directed at free men, who perceive themselves as autonomous individuals[6]. Hence, political power is increasingly exercised through delicate alliances among a range of authorities, permitting the aggregation of realities that range from economic relations to individual conduct. And these individuals are not addressees, but intervenient in power games and operations. Thus, power has less need to repress us than to administer and organize our daily reality.

Foucault, when considering political power, establishing this topic as the most general governability question – as a strategic field of mobile, transformable and reversible power relations[6] – theoretical and practically discusses an ethics of the subject, defined by the relation to oneself and the other. This means that power/governability/government relations to oneself and others compose a network, and that it is around these notions that one can articulate politics and ethics.

This articulation, in turn, is called governability of ethical distance, as an *intervallum* between the activities the subject practices and what constitutes him/her as a subject of these activities. Required by self-care, this *intervallum* promotes a retreat from the activities we are involved in, continuing, however, to maintain the distance for a necessary state of surveillance between ourselves and our actions. An ethical subject never coincides perfectly with one's role; this subject exerts sovereignty over oneself and that is what defines the tangible reality of political power[5].

Hence, self-care, far from producing inactivity, makes us act as proper, where and when proper. Far from isolating us from the human community, it appears, on the opposite, as what articulates us with that community, as the relation with oneself should allow the subject to discover him/herself as a member of a human community. The subject uncovered in self-care is totally opposite to an isolated individual: it is a citizen of the world. Self-care is, hence, a principle that regulates activity, our relation with the world and with others. It constitutes the activity, provides its measure and form, and even intensifies it. Finally, the self-culture should be conceived as a way to keep up political civil, economic and family activity within the limits and forms that are considered convenient. Self-culture is not the alternative to, but a regulatory element of political activity[5].

METHOD

This paper is part of a thesis in which the articulation between techno-biomedicine and bioethics was analyzed, as contemporary discourses implied in the production of nurses' subjectivity in the ICU context. The study was developed in two phases: one literature review and one empirical phase. In the literature review, the *documentary corpus* comprised Brazilian nursing papers published between 1984 and 2007. Papers were included if they were published in Brazilian nursing journals that reached, during any year between 2000 and 2007, classification A or B International according to the Qualis system (*Revista Latino-Americana de Enfermagem; Revista Acta Paulista; Revista Texto & Contexto Enfermagem; Revista Escola de Enfermagem USP*). In addition, *REBEn* was also included, as it represents an emblematic Brazilian Nursing journals, as well as *Revista O Mundo da Saúde*, aware of the fact that many nurses publish in journals that privilege the discussion of bioethics themes. In these journals, we delimited 113 papers through a manual and broader search, addressing themes that could enrich the discussion about bioethics and ICU issues. Hence, the search went beyond the descriptors bioethics and ICU and nursing, ethics and ICU, bioethics and nursing as, although papers did not explicitly mention the term *bioethics,* the addressed topics reproduced themes directly related with bioethics and ethics. Among these 113 papers, we delimited 27 that allowed us to address responsibility in ICU nursing care.

In the empirical phase, an exploratory study with a qualitative approach was accomplished. The population comprised 20 nurses working at different ICUs in the Metropolitan Region of Porto Alegre. Therefore, semistructured interviews were recorded with one or two nurses per institution, with at least six months of experience. First, we contacted them by phone and asked about the possibility of answering an interview. In case they accepted in advance, a day, time and place were set, according to their availability. Approval was obtained from the Institutional Review Board (Opinion No 186/07/CEP/UFSC) and subjects manifested their acceptance through the Informed Consent Term, in compliance with Resolution 196/96. Then, they answered two guiding questions: 1) Describe one workday at the ICU during which positive situations happened; 2) Describe one workday at the ICU during which one or more situations happened you perceived as bad.

The theoretical and analytic perspective used in this study is based on Foucault and joins the results of both phases (literature review and empirical research). In that sense, papers and interviews were addressed through the narrative about a given historical period. On the one hand, the histories we were told through the interviews turned into documents produced in the culture through

language, during the meeting between the researcher and research subjects; documents that gained different meanings were analyzed in the context of the theoretical framework, the age and the social and cultural circumstances. On the other hand, the papers, also as narratives, complied with what was exposed above, but perhaps showed a number of authorized subjects in a more decisive way, supported by institutional status or as specialists that disseminate an academic discourse, when talking about themselves and others, when describing and characterizing the others. Thus, mainly with regard to the papers, building a general panorama helped us to orient the rereading of the texts, and possible changes in the ways of developing thematic groupings, granting them meanings based on the framework considered for the analysis. In short, we work with the interviews and papers as a connection between articulating, overlapping, joining or, also, differing or contemporizing discourses.

RESULTS

Based on the selected papers and interviews with the nurses, we unfolded our analysis into *Responsibility towards new discourses* and *Responsibility that maintains nursing as a guardian of certain ICU attributes.*

It should be explained that, in the section *Responsibility towards new discourses* in particular, we analyzed the papers instead of the interviews. And that makes sense here, as the papers allow us to reveal greater confluence between what the nurses who write and act, respectively, on themselves and other nurse subjects, say and leave unsaid. Besides, the issue of 'new' discourses could make us select much more than the 27 papers already chosen. Thus, the criterion was that these papers should certain a certain discursive regularity pattern regarding the expression *responsibility in nursing* or *responsibility in care*.

DISCUSSION

Responsibility towards new Discourses

The complex situations that demand decision making at ICU require nurses prepared to cope with ethical problems[7]. In this context, the principle of care delivery is underlined, providing goods and servicing that enhance clients' satisfaction as much as possible, with a minimum, if not total absence of risks and errors that can compromise the desired quality and safety. Thus, nurses are responsible for preventing, detecting and acting on complications early, immediately and effectively. In short, to respond to technological, social and economic transformations, nurses have been gaining responsibilities that have also reallocated them as unambiguous authorities. And, through this position, they need to work with interdisciplinary language.

Some of the selected papers detail the nurses' responsibility or, better, justify nurses' necessary and pertinent insertion in each of the possible phases of an entire structure, organized for the development of the organ capturing, donation and transplantation process. They limit this pertinent insertion through statements like: nurses are the professionals with the profile and conditions to perform and participate actively in the different phases of the organ donation, capturing and transplantation process[8]; women, with a notion of morality different from most men, perceive responsibility towards others more, as well as the importance of relations and solicitude[4]; nurses can humanize the organ donation, capturing and transplantation process in different ways[9].

Two papers were found that orient nurses to problematize some of the current health discourse. One of them[10] evidences nurses' conduct of omission in patient information, this nursing works much more with aspects related to the benefits, to the detriment of the risks and consequences of the organ transplantation process. It also focuses on the high social cost and technology used in transplantations, bringing to mind the need for studies that assess the problems met. In that sense, it guarantees that professional practice, within ethical-legal principles, should makes nurses' intensify their attitude of surveillance, participating with clients and the community in discussions about discrete manipulations by corporatist groups. The other paper[11] addresses the association between *total quality* and ethics, evidencing the ideological nature of ethics when considering this association. It analyzes that the possible concordance between the words *quality* and *ethics* centers around a type of discourse with idealistic conceptions, to the extent that the proposed quality in Brazil has justified, in education as well as health, excluding actions, which privilege some few to the detriment of different majorities. Finally, arguments are presented in favor of constant and attentive reflections, as naïve actions can provoke socially harmful results, in which people get involved in certain professional responsibilities, seeking the intended *total quality,* but what happens is once more a process of conditioning, so intense that the subject only experiences the search for total quality in his/her production and work.

In another group of papers, a hospital humanization discourse is required as a prerogative for nursing to 'balance' the premise that current technological advances in hospital care seem to be more associated with proposed investment in the physical structure of buildings and with other processes that do not necessarily imply changes in the organizational culture, enhancing the humanization of work and care as ethical expression. They refer to the need for the CEPE to establish accountability for promoting this humanized care.

Another combination of papers explores nursing's responsibility in the palliative care team and in its adequate communication with patients in terminal conditions, hospitalized at ICUs or in hospices. One of these papers[12] reinforces that it is at the time of death that we should be

nurses in the full sense of the word, as it is the time of solitude, of abandonment, when all safety in life disappears. Another paper[13] analyzes nurses' omission to inform patients about the prognosis, beyond therapeutic possibilities. The article justifies this omission by the feeling of paternalism, to the extent that nurses somehow attempt to protect the patient against this harmful information.

Some of the papers under analysis explicitly advise nurses to seek support from bioethics to minimize such diverging attitudes and, with little or no scientific foundations to deal with the problem at stake, merely based on personal experiences and values.

This represents responsibility in care translated based on an articulation among 'new' discourses. Hence, in the papers, one can acknowledge a particular articulation of discourses produced based on current social demands (organ donation, capturing and transplantation, terminality, palliative care, total quality, leadership and hospital organization) and, at the same time, producing other discourses (ethical dilemmas, safe practices, hospital humanization, total quality, terminality, palliative care, leadership and hospital organization). In other words, discourses produced based on demands and which generate or reallocate other demands. To give an example, the discourse of organ donation and capturing articulates techno-biomedical, bio/ethical and legal discourses and, in turn, its practice as a process triggers the articulation of at least one more discourse: that of hospital humanization. The bio/ethical discourse itself represents an effect of techno-biomedical discourse demands.

When considering the humanization discourse in the context of intensive care therapy, one can signal its ambiguous and problematic nature. That is, when intensified, techno-biomedicine has been used as something capable of dehumanizing care. But, dealing with intensified technology in daily reality at an ICU implies dehumanization based on what referent? Or also, should the increasing unfeasibility of offering technology at the service of life and health to public health system users not be considered an important form of humanization as well?[14].

The way Foucault discusses humanism, which we could use to discuss the ambiguous and problematic nature of humanization discourse, can serve as an example to show these articulations. According to the author, humanism is a set of themes that reappear on different occasions over time in society; themes always connected with value judgments and with a critical principle of distinction (humanism as critical to Christianity; humanism hostile and critical to science; or another that, on the opposite, puts its hope in the same science). Hence,

> one should not conclude that everything demanded as humanism should be rejected, but that the humanistic theme is by itself very malleable, very diverse, very inconsistent to serve as an axis for reflection. And, it is true that, at least since the 17th century, what is called humanism has always been obliged to rest on certain conceptions of man that are borrowed from religion, science, politics. Humanism serves to color and justify man's conceptions, which he was definitely obliged to turn to[15].

In short, this articulation makes us see that

> what we know and consider as a unit is in fact the always provisional result of a historically situated connection among many different discourses or some of their elements, a network woven by and based on multiple correspondences, power relations, incongruences and conflicts[16].

Thus, we map discursive articulations that put the responsibility for care on the agenda, which in turn reflects some of the ways of being and doing intensive care nursing. Now, let us move on to the analysis of the responsibility that maintains nursing as a guardian of certain ICU attributes.

Responsibility that maintains nursing as a guardian of certain ICU attributes

May one say that nursing, like other health areas, is fundamental for a given society? In a way yes. Nursing works for health issues that correspond to what is of interest at that time[17]. Sometimes through a form of historical cooperation attributed to women (through some theoretical branches), which is a way of assuming responsibility and taking care of the other; sometimes through charitable ethics, linked with the religious feeling of compassion and abnegation, through which the client is seen as dependent and submissive, reinforcing professional duty. Also, through philanthropist ethics, mobilized by the State, to attend to the needy and, in return, the same State determines the subject's conducts, generally by controlling care agents' actions[18]. Also, a final and more subtle option, and therefore more 'compatible' with the discussion form based on the governability concept, in which nurses join: sensitivity to assume responsibility, because they see to human needs that refer to nursing particularities; accountability for the health and wellbeing of the subjects under their care; communication skills with a view to considering patients as valid interlocutors; ability to enhance people's autonomy[19]. In other words, nurses are a group that, besides creating policies and knowledge, helps the State to govern at a distance, or society to govern itself. Nurses perceive themselves as responsible for organizing the work environment[20].

In this context, it is evidenced that bioethics has joined nursing, providing perspective to deal with the challenges deriving from the combination between ethics and technique. In principlism, they seek contributions to understand the importance of encouraging and protecting professionals and patients' autonomy in care practice, respecting the limits of beneficence, non-maleficence and justice. Through the care focus, they aim to enhance confidence and mutual accountability. Thus, bioethics is presented as a bridge that can interconnect care-technique

with care-ethics; integrating principles and technical competency, in a climate of care and accountability to the other. Care providers move along with the people they take care of to promote their health and deal with their suffering, in a double function: that of experts and counselors; experts as, with different personal and professional knowledge, they master a picture of competencies that allow them to recommend the necessary interventions and glimpse alternatives, increasing the range of possible routes; counselors, not because they recklessly distribute advice and orientations but because, provided with a true discourse, they clarify patients about the opportunities, risks and difficulties associated with each option, nurturing an autonomous choice and contributing to put the decision made in practice[19].

Based on these initial arguments, it is inferred that nurses constitute their subjectivity, also as guardians of certain ICU attributes; guardians that use different resources. Below are some situations nurses experience in care practice:

> Bad situations are common and translated in different ways: a nursing team that acts automatically, without thinking of the individual they are taking care of; this same team that does not remember that they are part of a larger group and need to serve as collaborators; with the medical team, often uncommitted, not granting proper attention to the patient, postponing care and the sudden loss of a patient they were taking care of. All of these situations occur almost every day, to a greater or lesser extent and, despite attempts to revert them, they are repeated (S2).

> Nowadays, nurses are greatly involved in accountability for actions practiced on the patient. At our ICU, we were trying to put in practice the CVP [Central Venous Pressure] establishment and verification routine in patients with their headrest at 30° or 60°, as there are different studies signaling that this form is more adequate and safe for them. The medical team was divided; but one female and one male physician insisted on the level headrest. Look, it was difficult to argue against them, as both are well represented at this ICU. Nevertheless, nursing defended its understanding about CVP establishment and managed to alter that routine (S11).

These statements reveal that nurses are guardians of a commitment to take care of the other. In other words, in the first statement, nurses police other health team members' professional commitment, also highlighting other members' *lack of responsibilities* and possible consequences; in the second statement, the nurse assumes the commitment, based on specific and technical competence, to alter ways of doing nursing, provided that she believes she can sustain a truer discourse.

In other words, to highlight lack of responsibilities and signal best practices, nurse subjects need to turn themselves into subjects that say the truth. That would mean making true discourse subjective[5]. But these subjects do not need to tell the truth about themselves in any way; they do need to say what is true to themselves: they need to believe in what is true.

Paradoxically, based on the governability concept, the guardian's conduct, with a true discourse, makes nurses identify, 'quite' easily, situations to invest and apply technical resources to patients with negative clinical conditions without conditions for recovery, tests, procedures and other doubtful treatments. In these situations, nurses assume an inquisitive attitude towards these doubtful treatments and, at the same time, exempt themselves from responsibility through the collective[21]. That aspect, in a way, is translated in the statement below:

> A good workday at the ICU is when a patient arrives with a reserved prognosis, in come and hospitalized for a long time, achieves clinical improvement, recovers consciousness, interacts positively with the team and is discharged, going to the hospitalization unit, and is grateful for the care delivered during his ICU stay (S7).

What calls our attention in this statement is precisely the peculiarity in which a society (including physicians, family members, patients, nurses and other individuals and professionals) expects from an ICU. IN other words, this statement is by no means separated, detached from a world that *worships* a health ideal and hopes for recovery possibilities and care potential.

> Sincerely, I find it *very interesting* this oscillation in nurses' autonomy at the ICU, according to the work shift. During the day, they are supposed to perform exclusively their tasks as nurses, which by the way already demands great responsibility; during night shifts, this same nurse should do and know everything and even more, so that they do not need to call the physician on duty. I would not like to be unfair to some physicians who are very responsible in their activities independently of the work shift, but some physicians on duty, if called to see to some situation with a patient, get out, saying that nursing is very dependent and does not manage to solve anything by itself (S5).

The latter statement refers to a mix-up of the borders between medicine and nursing and between autonomy and responsibility in the ICU context. One of the results of the change in an environment that enhances the use of current medical technologies is that knowledge about science and the principles of medicine, which were relatively unimportant until some years ago, have become indispensable in the care process. Hence, at the ICU, sometimes it is difficult to say the specific and strict functions of physicians as well as nurses. It is almost impossible to deny that, in the strictly legal interpretation of the expression *medical practice,* many nurses are practicing act that technically and legally fit into the medical area. Thus, in *some* situations, nurses simple perform interventions beyond their technical competency and are concerned with performing them *meticulously* and *friendly*, thus sustaining a conduct as guardians. In short, nurses assume other professionals' responsibilities with a view to *problem* solving[22].

We cannot ignore that professions like nursing and medicine have distinguished experiences in coping with the tensions of their situations as knowledge and practice field, nor the degree to which these differences were historically established, to the extent that they represent distinct subjects, despite their neighboring objects. At this point, a subtly demonstrated perception of fragility/precariousness should also be acknowledged here though, of what show to be solid and legitimate statutes of professional action at other times – the moment when these distinctions do not seem to respond to urgent needs, to what needs to be done, to what is simply agreed upon in the silent agreement among the stakeholders. In short, yet another paradox: between a strict movement that attempts to maintain strictly professional and corporate interests or to guarantee knowledge and practice monopolies and the *flexible* movement that presents a field of knowledge and practices, necessarily open to dissemination among professionals.

CONCLUSION

Writing about such a complex theme, based on the reading of 26 papers and statements from 20 interviews, would be impossible in so few pages if it were not for the fact that, despite assuming the risk of simplifying and reducing the wealth of the corpus, an exercise is proposed: that of demonstrating, through the polysemy of themes found, not just the burden put on intensive care nursing, but what this nursing has apprehended from this 'burden' as something characteristic, something it Is linked with, or which permits a bond between the required action, the calculated responsibility and the subject one is.

Also, when drawing a current map of what we call responsibilities in ICU nursing care, the complexity of these different events the same nursing is involved in is surprising; by the way, have academic and clinical nursing, realized this? Therefore, we consider that the time that drives us to live as intensive care nurses also delegates us the responsibility of reflecting on our way of being, trying to understand the causes that influence them and their consequences. It is only based on broader understanding of the situations that we can act critically. At each moment, if we ask ourselves a question, if we should act like that, and seek answers in the belief that what each of us does entails consequences not only for him/herself or only for others, we will be modifying our history.

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