

Evidence of power expressed in architectural projects of the Hospital Santa Catarina (1974-2002)¹

Evidências de poder expressas em projetos arquitetônicos do Hospital Santa Catarina (1974-2002)

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Abstract

Hospital architecture is a disciplinary element that contributes to the categorization, classification and individualization of social actors that share this space. This historical study analyzed the authorship trajectory of the projects, flow of people, things and information, in addition to the disposition, naming and dimensions of the compartments at the Hospital Santa Catarina. We used the academic literature on the matter as well as Michel Foucault's theoretical framework to interpret the results and understand the power disputes of these social actors. Nursing, one of the groups present in this space throughout the analyzed period, oscillated between increasing and decreasing control over the space. This occurs because their control was assigned privately at times, moved to areas where surveillance and observation were more difficult, or their previously confidential spaces started being shared. This power dispute dynamics affected the quality of care and the working conditions of the evaluated health professionals.

Keywords: Hospital Architecture; Hospital Legislation; Power; Nursing; History.

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Resumo

A arquitetura hospitalar é um elemento disciplinador que contribui para a categorização, a classificação e a individualização dos atores sociais que compartilham esse espaço. Este estudo histórico analisou a trajetória da autoria dos projetos e do fluxo de pessoas, coisas e informação, além da disposição, da denominação e das dimensões dos compartimentos do Hospital Santa Catarina. Os achados foram interpretados à luz da literatura científica encontrada sobre o tema e do referencial teórico de Michel Foucault, o que permitiu compreender como se deram as disputas de poder por esses atores sociais. A enfermagem, um dos grupos presentes nesse espaço ao longo de todo o período estudado, ora ampliou ora teve reduzido o domínio sobre ele, pois ora a enfermagem foi destinada a esse espaço privativamente, ora foi deslocada para áreas onde a vigilância e a observação eram mais difíceis, ora passou a compartilhar espaços antes exclusivos. Essa dinâmica de disputa de poder impactou a qualidade da assistência prestada e as condições de trabalho dos profissionais de saúde.

Palavras-chave: Arquitetura Hospitalar; Legislação Hospitalar; Poder; Enfermagem; História.

Introduction

The focus of this work is the intersection of architecture and nursing sciences, concerning the organization of the physical hospital space and the interaction among the social actors struggling over power in there. A way of comprehending how the transformations in the hospital space took place is by analyzing the legal regulations for the building and renovation of healthcare facilities (EAS). We considered the regulation as the expression of the social pact, having in its background the power struggle among social actors, and chose to analyze the legal dispositions concerning the EAS physical spaces, to comprehend how the struggle over power took place throughout time. In Brazil, the publishing of *Normas de construção e instalação do hospital geral* (General Hospital Building Code) (Brasil, 1974) marked the establishment of legal instruments regulating the physical structure of modern hospitals, followed by the Regulation no. 400, in 1977, and the publishing of the *Normas e padrões de construção e instalação de serviços de saúde* (Healthcare Facilities Building Code) (Brasil, 1977). In 1995, a new statute, the Ministry of Health Regulation no. 1884/1994, replaced the previous norm, establishing the *Projetos físicos de estabelecimentos assistenciais de saúde* (Healthcare Facilities Physical Projects) guidelines (Brasil, 1994). Lastly, in 2002, the Brazilian Health Regulatory Agency (ANVISA) enacted the Collegiate Board Resolution (RDC) no. 50 (Anvisa, 2002), currently in force. It is noteworthy that the dynamics of producing norms in the period was intense, considering the existence of conflicts concerning this space.

However, analyzing the legislation only limits the analysis of space as a representation of power. Power is complex, dense, and diffuse (Foucault, 2012), and it is beneficial to complement the discussion by studying documents that record the power struggles relations within the hospital space at the time. With this purpose, we had to select an institution which had experimented intense spatial modifications recorded in historical documents, in addition to accept sharing these documental

sources. The elected institution, called “reference-model,” is located in *São Paulo downtown*. *It is centenary, private; has an open medical staff, Catholic origins, and maintains a great collection of documents, among which architectural drawings* (Pastro, 2006). *The institution suffered deep and significant structural transformations within the mentioned period, including the change in the service profile, in the assistance model, organizational structure, and architecture, among others*. Thus, we justify its election for the study, as it is an ideal model to observe the relations between the regulations and its practical interpretation, enabling us to appreciate the conflict over space and, therefore, the power distribution among the social actors that coexisted there, nursing in special.

For this professional group, this work may stimulate reflections on their practices and stands in this field of conflict, that is, their “profits and losses,” in this scenario, very relevant for the health and the illness, given that the relations among social actors also disciplines the physical space, as argued by Foucault (2012). As the main responsible for surveillance and discipline, nursing was responsible for these actions even before the conception of modern hospital. For all other health professionals and management in this field, the study may indicate places of struggle and stimulate investigations that examine how these social actors behaved over time, which influences they suffered, and why. This study also expands and deepens the understanding of architecture paradigms and tests its potentiality for comprehending the contemporaneity (Brandão, 2012).

Thus, this study aims to describe and analyze information concerning the hospital physical space, through the analysis of confrontation between the health facilities building codes expressed in the architectural projects executed between 1974 and 2002 in the Hospital Santa Catarina, considered a reference-model for this work, focusing on the power struggle among the social actors interacting there.

Method

An architectural project is a document/monument (Le Goff, 1996), a research source

capable of informing and problematizing disciplinary and other questions related to the society, economy, and politics, types of real estate investment, culture, and the technique of a certain period. Thus, by analyzing the architectural production from several standpoints, we may gather a complex historical view, capable of raising new hypothesis, enlightening the research sources, and contributing to other interpretations of a certain time (Silva, 2014).

The Hospital Santa Catarina granted access to 1,407 architectural projects issued between 1906 and 2015, saved in JPEG files, and listed in Excel spreadsheets, which allowed us to select projects from 1974 to 2004, resulting in 14 analyzed architectural projects. Based on this, we created a new spreadsheet listing the following variables: location of the architectural project in the building; floor plan; year of the architectural project; and a link to the respective drawing.

For each of one of the 14 projects, we used an analytic record adapted from Cellard (2008). It listed: (1) the document serial number (codification); (2) date of architectural project, to place it within the timeframe; (3) data related to the social, political, and economical context in which the document was produced; (4) authorship - indicating the document interests, its motivations and those of who the document was directed to, and whether it speaks for itself or on behalf of a group, - an information found in the signature present in the stamp on the architectural project; (5) nature of the document, type of drawing and what it portrays; (6) key-concepts and internal logic, in which we described the flow, disposition, denomination, dimensions, among others; and (7) preliminary analysis of the document, listing data concerning the transformations in the physical space, the legal regulation applied to them, in addition to the power struggles over them.

After finishing the analytical records, we grouped the data in each project by relevance and thematic similarity, resulting in the following categories of analysis: (1) authorship of architectural projects; (2) flow and disposition; (3) denomination; and (4) compartment dimensions. We attached

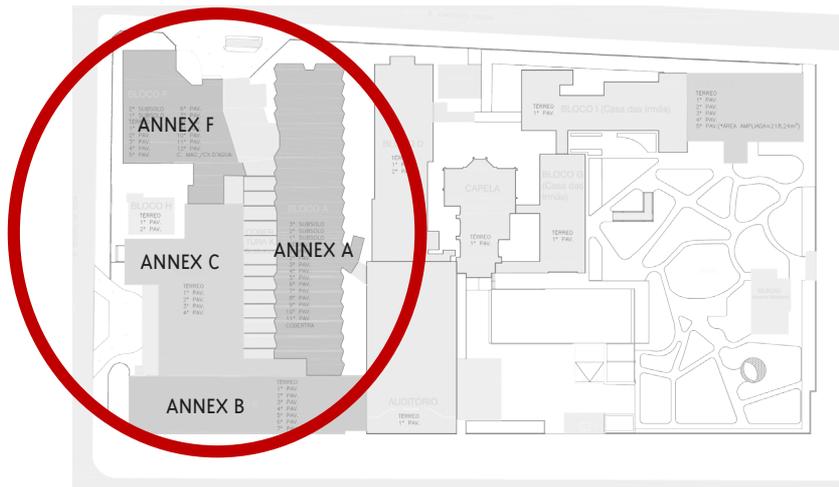
each analytical record to the Excel spreadsheet, paired to its respective architectural project. Lastly, we described and interpreted the findings based on the scientific literature available on the subject and on theoretical framework produced by Michel Foucault.

Results and discussions: the hospital physical space and the power relations

The reference-model consists of ten buildings, called annexes. Letters A-I identify the annexes,

being the chapel the only building without an ID letter. These annexes house the healthcare service areas, in addition to administrative and support services. We selected the A, B, C, and F annexes for this study, which correspond to the healthcare service and administration areas. The healthcare service annexes consist of a floor plan sector, hospitalization units, emergency room (ER), intensive care units, obstetrics unit, operating room, and central sterile services department. The blueprint in Figure 1 highlights the mentioned annexes.

Figure 1 – Areas blueprint, disposition of A, B, C, and F annexes in the reference-model institution, the Hospital Santa Catarina, São Paulo, 2015



Source: Hospital Santa Catarina (1974-2002)

Authorship

Between 1965 and 1977, architects Adolpho Rubio Morales and Fábio Kok de Sá Moreira, winners of a contest for designing the building of the São Paulo State Legislature in the 1960s, designed and executed the renovation and expansion projects of the reference-model hospital.² In 1992, the hospital commissioned the Bross & Leitner Arquitetura e Consultoria company, specialized in healthcare facilities, with a renovation in the B annex. In

1994, the hospital hired a company called Leitner Arquitetura e Consultoria, owned by Elizabeth D'Angelo Leitner and Eduardo Alexandre Soubhia, to legalize the renovation projects of facilities assigned to the board and the connections between annexes. The engineer Eduardo Alexandre Soubhia also served as engineering manager in the study institution between 1989 and 2001.³ In one of the projects from that year, we observed the signature of Sister Lia Maria, then hospital general-director, who approved it.

2 According to information available on the MHA Engenharia website. Available from <<https://bit.ly/39P2Y4q>>. Access on May 11, 2018.

3 According to the Eduardo Alexandre Soubhia profile on LinkedIn. Available from <<https://bit.ly/3o1QL1e>>. Access on May 11, 2018.

The renovation process ended between 1995 and 1996, culminating with the 8th floor of the A annex and the placement of board in the industrial annex. In 1999, projects for extension and integration of A, B, and C buildings, authored by engineer Armando Latufe, from the MHA Engenharia de Projetos company, took place.⁴

Lastly, in 2001, the project for the ER renovation, single-authored by the institution, implicates that the Architecture and Engineering Department likely had its department in the institution back then, just as it currently does, and took sole charge of its projects. This last project, first designed in 2001, presented approval signatures, differently from the previous projects, with the legible signature of nurse, and then administrative coordinator of the Image and Diagnosis Center, Luiza Papaleo, standing out. It was likely in response to the health public policies and the legislations that support the professional practice - such as the Nursing Practice Law (Brasil, 1986) -, which prescribe such participation.

Designers from high-profile companies in the civil construction area and religious people from the institution exclusively signed renovation and construction projects in this EAS up until 2001. Afterwards, we observed the engagement of a multi-professional team in the approving process, which included nursing. To Foucault (2012), the scientific authority classifies and orders the knowledge about human groups within the hospital space and, for 27 of the 28 study years, representatives from the Catholic Church sole ordered the division of spaces within the reference-model institution, even though they have left the areas rendering healthcare to patients, as we will see next.

Compartments assigned to certain groups, such as the sisters, existed in the architectural projects between the 1970s and the 1990s, in the central area of the units rendering healthcare services. To Foucault (2012), the existence of a central point defines the place for exercising power and recording knowledge. This central

point is a field of total visibility, which allows controlling and disciplining the space and the people circulating in it. This finding means that, over these decades, the religious authority in the hospital still had its power space to classify, order and observe.

The Sisters of Charity rendered medical care to the ill for many centuries, however, by the end of the 18th century, with the medicalization of hospitals, both the health and the agents promoting it professionalized themselves. Because of it, this group gradually left medical care and its power spaces. As an example of it, we have the records of a disagreement between the higher administration and the Sisters of Charity from the Hospício Nacional de Alienados (National Asylum for the Mentally Ill) - the seed of psychiatry and modern nursing in Brazil - that resulted in the sisters leaving the asylum, back in 1890. Actually, such dynamics involved political, social and economic relations, thus, power relations. (Oguisso; Schimidt, 2017).

Architectural projects components

The creation of the Ministry of Social Security in Brazil, in 1974, centralized and reinforced the dominance of the curative clinical model in the offer of healthcare services (Braga; Paula, 1987). The *Normas de construção e instalação do hospital geral* (Brasil, 1974) also dates from the same year. This code ensured that the EAS program, project, building and implementation enabled a safe, efficient, and economic healthcare service in the general hospital. This code presented EAS areas as “stations,” “consulting rooms,” and “patient rooms,” among others, without providing further detail about the professionals occupying it.

In 1975, the Law no. 6229 created the National Health System, defining the responsibilities of several institutions, placing the individual and curative assistance under the responsibility of Social Security, while preventive and collective

4 According to the company's website. Available from <<https://bit.ly/3iy7Tug>>. Access on May 11, 2018.

care were under the responsibility of the Brazilian Ministry of Health, in addition to state and municipality health secretaries (Brasil, 1975). In this context, the Regulation no. 400/1977 (Brasil, 1977) came into force, being more specific than the 1974 code in regard to the groups occupying the compartments, and giving a great emphasis to nursing. Thus, we observed that in the study hospital, nursing, according to the regulation, seemed to occupy defined physical spaces and gather recognition for its administrative (“nursing management office”) and assisting roles (nursing unit”), being such occupation being distinct in terms of location and scope.

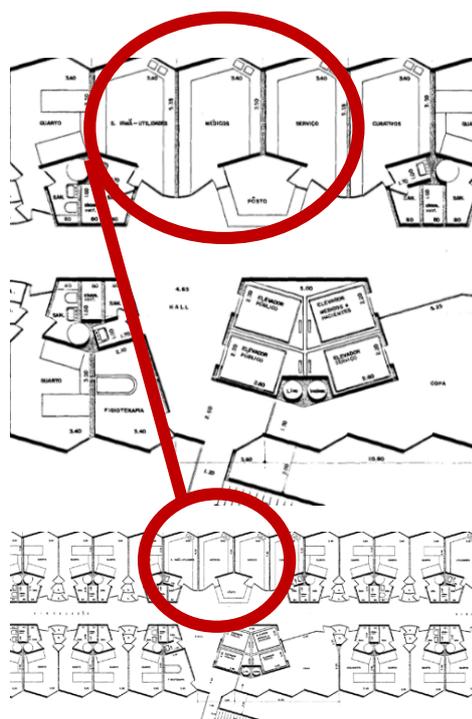
At the time, the Geisel government marked the end of the “economic miracle,” and the health sector suffered the effects through a crisis in the standard of service provided in the public and social security network. The epidemiological panorama started to highlight the coexistence of chronic-degenerative and contagious diseases, which moved on to hit the cities (Braga; Paula, 1987). Because of it, health national programs emerged. The private health sector received public investment and, thus, the reference-model hospital was fast-growing, a fact noticeable through the study architectural projects.

Concerning flow and disposition, the drawings shown in Figure 2, dated between 1965 and 1977, presented compartments placed face to face in their layouts, in a way of allowing central circulation, called horizontal. The vertical circulation, that is, the communication to other floors was through staircases and an elevator, centrally located in the floor plan.

As for designation, in projects between 1965 and 1977, hospitalization units in the A annex had the following compartments: patient rooms, sitting room, physiotherapy room, sister’s office and clean utility room, doctor’s office and station, also called “service station” - the last three centrally located. In addition, the annex also housed a dressing room, hall, pantry, isolation, staircases, and elevators, distributed in a way of segregating the population into “public,” “service staff,” and “doctors and patients,” as shown in Figure 2.

Regarding dimensions, projects between 1965 and 1977 in the A annex had patient rooms around 12m², located in the floor plan margins. The central compartments (sister’s and doctor’s offices) had the same dimensions. The station was smaller, around 6m², half the dimension of previous compartments, but with a 12m² service room in its annex. Although not named as such, the areas used by nurses to organize their work were likely the station and the service room that, together, amounted to nearly 18m². The station followed the Regulation no. 400/1977, then in force, although the denomination failed to call it “nurse station,” as per the regulation guidelines. Such failure foreshadowed the struggle over the space. The physiotherapy room had 7m².

Figure 2 – Flow and disposition of compartments in the floor plan, Hospital Santa Catarina, São Paulo, 2015



Source: Hospital Santa Catarina (1974-2002)

Between 1965 and 1977, the A annex project had its infirmaries distributed similarly to the Nightingalean model, but also considering the architectural progresses of the time and the verticalization trend of the hospital, once that installation of the elevator and of the artificial heating systems had

already occurred (Draganov; Sanna, 2017). Thus, part of the flow remained horizontal and the floors had their patient rooms and other compartments distributed oppositely, with elements of observation, surveillance and control situated at the center of the physical plan, where also was the vertical circulation through elevators and staircases, even allowing to watch who and what entered and left the floor. The denomination of certain compartments were not those recommended by the regulation for EAS building and renovation in 1974, but were in accordance with the 1977 regulation, as they had group identification in some compartments, such as the sister's and doctor's offices, and the physiotherapy room. We were unable to find the nursing and the nurse figure in the compartment denominations in the projects analyzed at the time, that is, no space received the "nurse" or "nurse station" denomination.

The use of discipline in spaces marked the emergence of hospitals, according to Foucault (2012). Such technique of distributing individuals through the insertion of bodies in individualized, classificatory and combinatory spaces is a form of disciplinary power relation associated to the control of time, in a sense of demanding speed and efficacy, also associated to the meticulous control of operations, that is, to a permanent surveillance, also enabled by architecture, based on the panopticon model. Thus, introducing discipline within the hospital space is what made it medicalized and therapeutic, and is the architecture intervention in the hospital environment (ventilation, lightening, dimension, flows, among others) what allowed to surveil, observe and control, and therefore, discipline the space (Foucault, 2012).

The disposition in the floor plan, presenting Nightingalean principles, favored assistance but also surveilling, observing and controlling, incremented by the central location of the command compartments (sisters, doctors, physiotherapist, and nurses). Thus, the placement of certain groups exceeded the care objective, that is, their occupants had a strategic view of who arrived or left, in addition to seeing the attended customers.

Furthermore, according to Batista (2015) and Pires (2009), the administration model at the time

had its basis in the theories by Taylor and Fayol, valuing rationalism and the productivity resulting from discipline and hierarchy of duties and persons. For the hospital and its social actors, that made sense, both the scale and hierarchical way of work and the autocratic command, characteristics of that and the following time. It is noteworthy that the administration model at the time was explicit in creating rules in which the struggle and the exercise over power operated, corroborating the architectural proposition.

Under this point of view, at that time, the sisters dominated power in the hospital, side by side with doctors. Physiotherapy had a role in this conflict, and nursing, who certainly occupied the station and services area, remained besieged by these dominant groups, all of them surrounded, of course, by the patient figure, who occupied most of the space, but stayed in the margins of the unit and was under surveillance from the professionals.

We need to understand, the real standing of the "besieged nursing" in this context. In Brazil, nursing acquired professional status in the 20th century. Although the Report no. 163/1972 from the Federal Education Council set the Minimum Syllabus for the Nursing and Obstetrics Courses (Brasil, 1972), the phase for renovating the scientific knowledge and recognizing the nursing professional under a new law was yet to come. A law to relevantly rule its professional practice and enable the teaching of management contents in its education (Brasil, 1994a). According to Foucault (2012), only those holding discourse and knowledge struggle over spaces, and a consistent law, that ensured specificity to the professional practice, was one of the requirements attesting that the nursing body of knowledge was socially recognized.

However, we have evidence that nurses, at the time, already occupied high-ranking positions, engaged in strategic decisions, and produced knowledge, as it was the case with the *Normas de construção e instalação do hospital geral* (Brasil, 1974). The code had the effective participation of Nurse Clarice Della Torre Ferrarini, one of the health professionals in the team who wrote the document, which comprised a list of technical terminologies to facilitate the communication

between the actors integrating the health scenario at the time (Sanna, 2002).

Thus, it seems contradictory to consider that nurses engaged in relevant decisions concerning health facilities and the codes for building hospitals, while these professionals were never mentioned as professionals who master the knowledge, nevertheless as users of these spaces in the study institution. Perhaps, because it is a private institution, with the predominance of a curative clinical model, bound to the Catholic Church - who founded it -, then the doctors and the religious representatives may have been favored by the institution. This is likely to explain the designation of the space under the applicable regulation - despite the regulation clear statement that nurses had to have private spaces, we could not observe that in the analyzed architectural projects. In short, the nursing was disputing spaces in the hospital, but still lacking importance and relevance, that is, still lacking a materialized body of knowledge, capable of entering the conflict and power dominance game. In fact, it was besieged, observed and surveilled by the sister and the doctor, the latter being valued in the social, political and economic context at the time, for having the power of prescribing, which induced the consumption of products and services, which, in an Western and capitalist country made, and still makes, much sense.

In the early 1980s, during the term of President João Batista Figueiredo, the financial crisis hitting the health sector, which up to that point had its basis on the curative model, condemned this choice. Thus, a proposal for a sanitary movement towards the reformulation of the health system emerged, based on the adoption of the natural history of disease paradigm and, with it, the valorization of the priority primary care model, followed by secondary and tertiary prevention, arguing for the need of investments in promotion of health and specific protection, which would allow cost-reductions (Teixeira, 1989).

In 1983, the Interministerial Committee for Planning and Coordination (Ciplan) Resolution no. 3/1981 took effect. It brought the maintenance of spaces allocated to nursing, providing detail of these services and emphasizing the investments

on support personnel and in space allocation, in order to perform nursing duties with a better quality and security (Brasil, 1981). The nurse and other nursing professionals, then, engaged in a struggle over the private portion of the station against the medical professionals. As for the administrative activities, a single administrative sector houses them.

In the same decade, health professionals concerned with public health and questions related to the practice, aimed their scientific works towards shedding light on their work models and articulations to the social reality and their historical development. Research projects addressing nursing greatly increased at the time (Vietta et al., 1996). They also focused on the professional autonomy, the conquest of the market through the enactment of the professional practice law between 1986 and 1987 - a response to the claims for rights from the category and its interests - and to the control of the professional life and its circumstances through the Federal and Regional Nursing Boards (Paiva; Teixeira, 2014).

With the win of the Democratic Alliance and the election of President Tancredo Neves, who fell ill and died from a hospital-acquired infection shortly after taking office, replaced then by his VP José Sarney, the New Republic started. This transitional political process echoed in health, and, in 1986, the Ministry of Health organized the 8th Health National Conference (CNS), themed "Right to Health." The conference resulted in the proposition for the Sanitary Reform and the creation of the Brazilian National Health System (SUS), having as guidelines the universality, integrality of actions, and social participation, in addition to extending the concept of health, approaching it as a right of the citizens and a State duty (Paiva; Teixeira, 2014).

The society mobilization process, present at the 8th CNS, continued in the elaboration of a new democratic Constitution. It culminated with the approval of an entire chapter addressing health - the universal right to health, health as a State duty, and the establishment of SUS, integrating all public services into a network, in addition to the participation of the private sector, in a complementary

manner (Escorel, 2008). Despite the progresses, the curative model remained untouched, hence the greater relevance of the doctor figures.

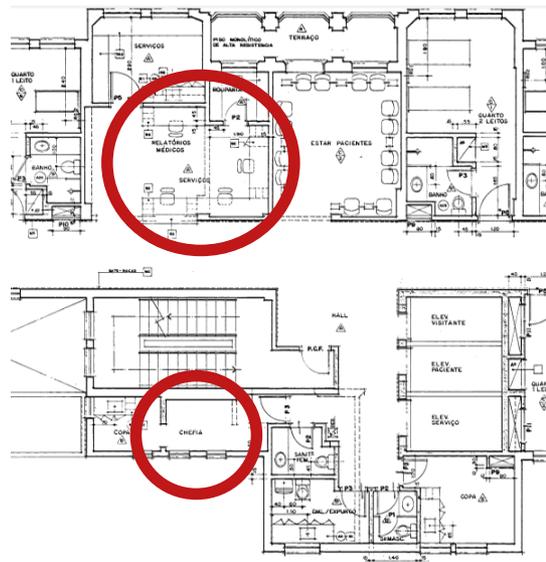
In 1989, during the term of President Fernando Collor de Mello, and later, his impeachment, the offer of health services was highly discriminatory and fragmented, selecting citizens according to their social status and based on medical attention, being evident, after nine presidential vetoes to the Law no. 8080, the process of preventing progress in implementing the SUS. In the health sector, the chaos took place with a brutal funds reduction and a full cut in the investments directed at maintaining and expanding the service network (Paiva; Teixeira, 2014).

The social, political, and economic panorama at the time was quite unstable and favorable to paradigm changes. However, perhaps due to a critical and unsafe social context, from 1977 to 1992, no relevant physical change occurred in the nursing spaces within the study hospital. However, the institution was building a reputation in the mother and child health, as it conducted the first procedures for in-vitro fertilization in Brazil (Pereira, 2011).

Finally, in the 1990s, the SUS moved on to an operation based on the health organic laws (Brasil, 1990a, 1990b). The contrast to the health model in place brought tardiness to the process of expanding SUS, which carried out with the outpatient network throughout the country, by the creation of the Primary Healthcare Units (UBS), regional outpatient facilities, secondary and tertiary hospitals, and the implementation of the Family Health Program, emphasizing a multi-disciplinary approach and the primary attention (Bertolozzi; Greco, 1996). Although these changes have mostly hit the EAS directed to primary assistance, they also affected the hospital environment.

Regarding the study architectural projects, specifically concerning flow and disposition, a renovation project approved in 1992 for the B annex, which housed an infirmary, incorporated to the service station a space to medical reports. The project abolished the sister's office and contemplated a room for the nursing management office, as stated in the law, however, its location had a disadvantaged position for observing, surveilling and controlling the floor plan, as it was behind the stairwell, as shown in Figure 3.

Figure 3 – Station with medical report area and location of the nursing management office, Hospital Santa Catarina, São Paulo, 2015



Source: Hospital Santa Catarina (1974-2002)

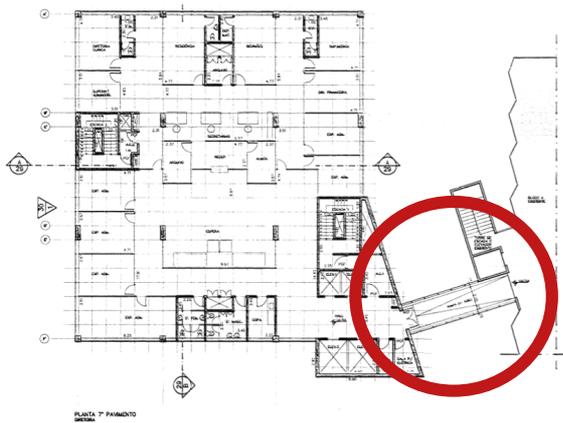
In 1992, we observed that the B annex turned part of infirmaries into patient rooms and several new support services, attending the new assisting model. As for the dimensions of these compartments, in 1992, in the renovation project for the B annex, the space for medical report inside the station was of 1.2m², the nursing management office had around 3.4m², without identification of the space as a nurse only area, as the Ciplan Resolution no. 3/1980 established.

The nursing, still hidden in these drawings, was already working under the nursing professional practice law (Law no. 7498/1986), which recognized the existence of a body of knowledge corresponding to this professional group. The law considers, in its Article no. 11, that “a nurse performs all nursing activities, being responsible for [...] II - as a member of the health team: [...] d) engage in building or renovation projects in hospitalization units” (Brasil, 1986). Thus, the legal provision, in theory, fueled the standing of nursing regarding the hospital physical space, yet the repositioning and interaction of the social actors caused a change in the actual use of the spaces, including those that previously belonged exclusively to the nurses. While nurses conquered a new administrative space in the assisting sector (head

of department), they also lost a space, once exclusive to nurses, to the doctor (medical report at the station). Such spatial movement clearly set the dynamic game of struggling over power, making the law a fragile instrument for guaranteeing achievements, while architecture was a strong instrument.

Two years later, in 1994, the architectural projects, had flow and dimensions similarities to the B annex floor plan projects dating from 1992. In 1994, the hospital approved a renovation project for the board facilities, which was then located in the F annex, where a ramp would facilitate the administrative processes, ensuring connection with the A annex and allowing the access to the caring, observing, surveilling and controlling spaces, as Figure 4 shows. The board facilities had a square-shaped plan, presenting a central flow and opposed compartments assigned to administrative work, front desk and waiting area, hall, file room, pantry, warehouse, meeting room, medical supervision room, administrative supervision room, medical board room, residents room, storage, and financial board room. As for the dimensions, we had no comparative element for the sizes, as nursing lacked mention as user or holder of its own *locus* within this space, thus excluded from strategic decisions.

Figure 4 – Board compartments and access to the A annex, Hospital Santa Catarina, São Paulo, 2015



Source: Hospital Santa Catarina (1974-2002)

In 1995, the new proposal for the regulating the EAS physical spaces brought deep changes (Brasil, 1994b). The physical spaces assigned to nursing, in what is normatively called nurse station, remained

with the same size suggested in the previous regulation, however, the compartment suffered an important change concerning its concept, then comprehended as an environment assigned to “the nursing and/or doctors for the performance of technical and administrative duties.” This meant that the space had necessarily to be shared, rather than being predominantly used by nursing. The regulation also mentioned, for the first time, the room for the nursing practice, and the offices, previously called “consulting rooms,” had no distinction anymore, reinforcing, thus, the participation of a multi-professional team in the healthcare offered in EAS.

Complying with the regulation in force at the time, the 1995 project presented new elements, such as the nursing secretary, obstetrician office - which later became “obstetrician on-duty” -, pantry, information desk, and the resuscitation room, with a milk preparation room attached to it. As for dimensions, the project added a 9.6m² service station, totaling two stations; it also added the nursing secretary, with nearly 7m² the obstetrician office, adding another 13 m²; a 3m² information desk, and the resuscitation room, which allowed the implementation of the milk preparation room, with 3m² fulfilling the service demand in the location.

The added space and the new positioning and architectural elements - such as the obstetrician office in a central position and the location for the nursing secretary - with the unprecedented figure of the clerk - indicate a valorization of the administrative and financial processed connected to the nurses, pointing to an unequivocal sign of conquest of space and power, fueling new disputes.

To Foucault (2012), the hospital is a place of confrontation, of separation between those holding power and those who do not, generating dynamic processes of dispute. When the nursing started to stood out in the hospital space through the head of nursing office, the nursing secretary, and the obstetrician office in a central position, the nursing management moved to a place that prevented it from observing, surveilling and controlling, that is, behind the stairwell. Meanwhile, and the station privileged space, before exclusive for the nursing, found itself “trespassed” by the doctors, who gained a new position that enabled them to surveil and

In 1999, the Law no. 9782/1999 created ANVISA, boosted by the progress in the SUS implementation and other regulatory agencies progresses (Brasil, 1999). Thus, the rules for architectural projects and the physical healthcare network would be under its oversight. To cater this need, the Healthcare Services Technologies General Management Department, from ANVISA, promoted a study, later consolidated as the RDC no. 50/2002, in which the flow and compartments dimensions received the most attention. Almost concomitantly, in the reference-model study hospital, 2001 marked the beginning of the Adult and Pediatric ER renovation project, located in the C annex. Flow and dimensions were the highlights in the project, aiming to favor the customer service provided by the professionals, consisting of customer service typical compartments, likely anticipating the RDC no. 50/2002 guidelines, under discussion at the time.

The Pediatric ER had the following flow: entrance and front desk, waiting room, toilets, diaper-changing facility, cashier and pediatric screening/observation, oral rehydration, inhalation therapy, pediatric emergency unit, station, and three pediatric consulting rooms. The adult ER consisted of: entrance for adults, screening, cashier, front desk - shared with the pediatrics ET -, two operating rooms for minor surgeries, plaster room, suture room, adult and pediatric resuscitation room, pantry, cleaning supplies storage, soiled utility room, medication room, linen storage, three stations, pharmacy, sitting room, on-call room, adult observation room, isolation, inhalation therapy and three consulting rooms for adults. The architectural project focused on compartments for providing care services, with their respective dimensions and flows, complying with the 1995 rules, also presented in the RDC no. 50/2002, almost finished at the time. The ER project focused on the patient comfort and well-being, its flows and compartments dividing the care process according to demand and risk.

The Regulation GM/MS no. 554 issued on February 21, 2002 put into force RDC no. 50/2002 (Anvisa, 2002), addressing the good hospital aesthetics and focusing on the building quality,

attending the users' expectations, and also attended to the Federal Constitution, the Health Organic Law, and the standards by the Brazilian Association of Technical Standards (Limeira, 2006).

This regulation privileged users, empowering them, meaning the emergence of a new group in the struggle over power, supported by the easiness of access to the scientific literature concerning health and its respective "dialect," and by the legislations that supported the popular engagement in the health management, in addition to the consumer rights. The regulation also supported the multi-professional team, based on the in-force legislation that grounds it, yet, as we said before, the rule is fragile in face of the relations in the dispute field.

Thus, the fact is that the curative and hospital-centric model persisted in the Brazilian society, even in face of a proposal privileging the primary care and the role of users and multi-professional teams. Several political, economic and social matters explain the persistence of such paradigm, which caused and causes consequences to the quality of offered services, the work conditions of health professionals, and to the Brazilians lives and, the physical-spatial organization of EAS expresses such conformation. To Foucault (2012), legal instruments are insufficient to cause a shift in power; for this to happen, the requirement is higher: the field where the dispute occurs. As we can see from the results of this work, the philosopher was right.

Final remarks

This study revealed the changes incorporated to the study hospital building before and after the regulations that disciplined its use at the time, reinforcing the affirmation that a regulation is the result of a previous "agreement." The regulation, however, is a guide only and, because of it, the compliance to it may sometimes fail. The space suffered a reorganization in face of the relations among the social actors inhabiting it, motivated by the social, political, and economic context to which the institution belonged, and by the struggles these social actors and their corporations fought in the health environment.

The first regulations ensured private spaces for nursing, especially when the nursing professional practice had the support of a more structured law, as the one enacted in 1986. Later, with the health organic laws and the valorization of a multi-professional team, the spaces became, in theory, of diffuse ownership.

The nursing behaved, through the study period, sometimes expanding, sometimes reducing its domain spaces, but remaining perennial, in a manner. Every time nursing had an exclusive space assigned to it, later we could observe the moving of such space to areas preventing the surveillance and observation practices, or such spaces were trespassed and besieged by the religious and medical groups, which created new disputes and new conquests.

In the hospital, the nursing circulated in the patient care spaces (which receives the largest square footage), more than any professional throughout history, and yet failed to gather the therapeutic power practiced in there, as the doctors did. Thus, the medical knowledge incorporates economic and political questions, covering a sphere more complex than the hospital structure and extending itself to the cultural structure of society, thus, society remains assigning it privileged spaces, which stimulates fierce disputes between these two groups. The nursing, on its turn, faces it within its possibilities, building its history based on the strategic decisions chosen by this social segment for their stands, in the context of EAS.

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Authors' contribution

Draganov conceived the research project, analyzed and interpreted data, and wrote the article. Sanna performed the critical review of the intellectual content. Both authors approved the final version for publication.

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