57 -THE CARE OF HEALTH PROFESSIONAL VICTIMS OF VIOLENCE IN THE EMERGENCY SERVICES: A REFLECTION

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INTRODUCTION

Currently the number of cases of violence has been responsible for a growing demand for care in public health services, especially in emergency units. For healthcare professionals this problem is not new, as they experience this reality in day-to-day clinics, health care or in emergencies, where the scarcity of resources for better care is more problematic (PINHEIRO, 1994; DANTAS et al., 2009).

These victims, often by the very severity of injury, require a fast, complex and efficient emergency services. However, institutions go through a series of difficulties that interfere directly in the care process, such as the shortage of human and material resources, increase the injuries caused by very powerful weapons that prevent the survival of the patient or even enhances the degree of morbidity , lack of staff training to meet this new model of health problems, high demand patients who require only outpatient services, along with an excessive calls from other states of the federation (DESLANDES, 2002, DANTAS et al., 2008).

Overcrowding in emergency hospital services is a worldwide phenomenon, characterized by: all the beds occupied, bedridden patients in the corridors, waiting time for care over an hour, sometimes even for those critically ill patients who can not wait to be assisted; high level of stress in the health care team; great pressure for new appointments. All this implies, ultimately, poor performance of the health system as a whole and the particular hospital, and leads to low quality care (BITTENCOURT; HORTALE, 2009).

Other authors add that, coupled with these factors are the difficulties stemming from the biomedical model itself, as the overvaluation of care and hospital-resistance monitoring in primary health care, stigmatization of patients within the hospital environment, the focus on disease or target organ result of violence, failure in the reporting of cases of violence, among other factors that trigger various conflicts involving verbal, physical and even death threats (MINAYO, 1994).

In this sense, were the following questions: what has been given the interaction between health professionals and victims of violence in emergency services? The process of care has been affected?

Responding to our questions, we developed the following objectives: to address the dynamic interaction between health professionals and victims of violence during the process of care in emergency rooms.

We believe that studies like this may help to better understand the daily violence in the individual and collective health of those involved, assessing the impact of this event on emergency services and enabling reflection on the practice of care to User, in the institutions.

MAIN CAUSES OF CONFLICT AND THE INFLUENCE OF FEAR AND PREJUDICE IN THE CARE FOR VICTIMS OF VIOLENCE

In practice, said Deslandes (2000) that the main causes of conflicts between health professionals working in emergency services and victims of violence are: the waiting time, companion or family member that requires preferential treatment for its victims, patient or family do you think that the care was of low quality and family or guardian under stress by the imminent death of a relative. Thus, the emergence manifests itself as an unsafe environment for professionals and, in many cases, there is a security service to the challenges.

However, the same author, in his book entitled "Fragile gods professional emergency between the damage of violence and the recreation of life", said the emergency assistance to victims of violence, health professionals, abolishing the guidelines of universality and equity in care, cases can lead to discriminatory practices that customers, mostly poor. And says:

This creates a tension between the vocation of saving lives and a tendency to a moral and social trial to determine which are most deserving of attention. Such choices, of course, can involve life and death of those who are at his mercy. (DESLANDES, 2002, p. 177).

In this sense, the care of health professionals with patients can be differentiated, depending on the placement of professional ethics, leading to major ethical and moral dilemmas in emergency services.

The fear and prejudice may affect the process of caring professionals to victims of violence, since depending on the beliefs and ethical position in which this relationship occurs can be derived several personal conflicts.

A common situation in these services is the underreporting of cases of violence, which most often are masked by a false report about the actual occurrence of the violent event. On this subject, a study in a unit of Emergency Service Municipal de Pouso Alegre / MG identified that the attacks were the third most important cause of morbidity identified, accounting for 10.8% of cases, not including possible cases subnotificáveis. Many of these victims were targets of domestic violence, sexual assault and abuse that are hidden in the search for health services for fear of reprisals by the offender, usually someone close, often by resident under the same roof (MESQUITA FILHO, MELLO JORGE, 2007).

The health professional who meets these victims, and meets the notification, it is often intimidated by an aggressor who is facing the possibility of being denounced to the police (MESQUITA FILHO, MELLO JORGE, 2007).

In these conflicts, the dynamics of the emergency services on the interaction between professionals and the subject is expressed differently according to the form of behavior displayed by the feelings of victims and professionals. In this sense, Deslandes (2000) states that the award of the role played by the victim of violence, such as assault or offender is not immediately clear. Except those who come under custody by the police and therefore inserted directly in the classification of offender, but all defend its role as victim assaulted.

The same author defines this process of taking care of these victims in two stages: the first is when the victim enters the emergency department and this will be received like any other, but the second time, as the professional approach, starting their technical processes of care, linking the kinematics of trauma with clinical presentations of injuries, is initiated discriminatory

procedure to that victim, depending on the moral-ethical position of each professional (DESLANDES, 2000).

In this context there is a paradox where professionals feel the need to rethink the ethical care that demand involved in acts of violence even to preserve their physical and moral integrity in the care process (Fisher, AZEVEDO; FERNANDES, 2006).

Deslandes (2000) adds that this feeling is related generally to care for child victims of abuse by relatives, the woman assaulted by her husband or partner or vice versa, victims of urban violence that robbed represented by the police or reacted targeted by the villain.

However, when the patient presents himself as the aggressor, health professionals often have other dilemmas that can be represented through fear or even the production of bias during the care process. The most common, cited by Deslandes (2000), are the burglar shot by police, the husband who assaulted his wife and was shot, or the murderer caught red-handed by the police, among others.

Fear is defined by Teixeira and Porto (1998) as a feeling that occupies a material in the body caused by external threats real or imagined, usually associated with images of the original distress due to the emergence of consciousness of time and death, and experiences ensuing negative consciousness.

From this perspective, the authors consider fear as a trans-historical condition, a social quality that emerges or disappears depending on the real or imagined relationship with the outside. Fear is part of human nature, but its objects are historically determined, as well as forms of social organization to combat it. Is in reality and representation, whose empirical basis is the basis and justification for the creation of an imaginary fear (TEIXEIRA, PORTO, 1998).

In this sense, Porto and Teixeira (1998) supplement saying that fear in the context of violence is seen as a negative balance of an anachronistic and barbaric order that needs to be controlled at all costs or in response to a company generating rejection, exclusion, expression of xenophobia and rejection of another. This situation has contributed to the development of an imaginary fear, the consequences may be influencing the increase in violence or inadequately treated, becoming then the bias.

Taussig (1999, p.159) defines bias as:

Attitude within an individual who violates the attributes and descriptions for the other subject, establishing the cognitive and perceptual contacts in error, split and traumatic, so always put to the test the capabilities and resources of the other symbolic.

Bandeira and Batista (2002) added that when the attitude of prejudice or that act or thought denotes a distinction between or the (s) other (s), then sets the discrimination, because it generates necessarily the differential treatment. Thus understood, this is essentially another type of violence, called covert or announced.

Some studies have shown the emergence of this stigma in the process of caring for patients involved in violent acts. Leal and Lopes (2005) found that the care of health professionals to patients under custody, ie individuals who have suffered some kind of injury in the confrontation with the police or other members of criminal groups, and were arrested, they produce a certain reaction / rejection in the professionals, causing another kind of violence, announced.

Deslandes (2000) further, saying that the biggest concern of professionals is not properly attended by the individual in the service, but the consequences of caregiving that the victim, once guarded patient carries the weight and the threat of police organizations and criminal. It is observed that the more criminally involved the patient is escorted by police, more disorder and fear cause your presence in the hospital. This implies that the presence of a patient is always guarded violence announced by health professionals.

In another study with students from the 3rd year of undergraduate nursing practices during the course of mental health, a University of São Paulo / SP, Junior Smith and Bueno (2006) found that the aggressive approach to patients, students had fear of being affected morally, to become aggressive with the patient or even being physically attacked by fostering a relationship of tension during the care process.

Continuing to approach, Sarti (2005) adds that in cases of violence, care for perpetrators becomes more complicated, in that your actions are contrary to the moral values of health professionals who are developing the care process. The same author concluded that the production bias is also shown when the patient or offender attacked the victim is under the action of some external factor such as alcohol and illicit drugs.

Concerned about these conflicts, the Ministry of Health (MOH) launched in 2004, the National Policy of Humanization (PNH) - "Humanized SUS" in order to strengthen the guiding principles of SUS. Among its strategies is included in the patient care units to emergency rooms designed to build strategies to achieve the qualification of health care, establishing the construction of ethical and political attitudes, with professionals and the strengthening of interpersonal bonds between these and users of services (BRASIL, 2004).

Among the general guidelines for the implementation of the HNP in the different levels of health care, the Ministry describes as one of the goals:

Raise awareness among health staff about the problem of domestic violence (children, women and elderly) and the question of prejudices (sexual, racial, religious and others) at the time of receipt and referral (BRASIL, 2004, p. 13) .

Another document that deserves mention is the Code of Ethics of Professional Nursing, recently redesigned and released under the resolution of the Federal Nursing Council (COFEN) No 311/2007. This document states that the care provided by nursing professionals should be focused on the person, family, community, and especially coupled with the users in the struggle for assistance without risk and damage to the entire population.

Among some of its fundamental principles (COFEN, 2007, p. 4-5), the Code of Ethics for Professional Nursing pointed out in Section 15, which is the responsibility and duty of every health care "to provide nursing care without discrimination of any kind "(COFEN, 2007, p. 7).

The Article 52 states that is considered ethical violations cause to cooperate or to collude with abuse, under penalties ranging from a simple warning to the forfeiture of right to practice (COFEN, 2007).

The document that guides ethical professionals in nursing, while not clarifying the term domestic violence, mentioned abuse. Here, it is understood that this expression should be interpreted broadly referring to all forms of abuse.

In the code of ethics of medical professionals, this reality is no different. Article 6 of Chapter I of this document, which discusses the Fundamental Principles, reports that the medical professional must have the utmost respect for human life, always acting in the patient. Also, do not use their knowledge to cause suffering physical or moral, for the extermination of human beings, or to enable and cover up attempt on his dignity and integrity (FEDERAL COUNCIL OF MEDICINE - CFM, 1988).

The CFM (1988) adds, in Chapter IV of Human Rights - Article 47 of this code, which is prohibited from discriminating

against medical man in any form or under any pretext.

The main concern of this document is the default, ie, agreeing with the situation of brutality. However, as important as the identification of violence is his complaint, which usually does not happen (SALIBA et al., 2007).

The same authors conclude their study stating that it is imperative that health professionals know and respect these rights, taking into account the ethical principles, respect for human beings, and their rights during their interaction with victims who are under their care.

CONCLUSIONS

In order to minimize conflicts between health professionals and victims of violence within the emergency services, we conclude that must be prioritized taking a series of strategies. It is essential that they identify the main obstacles faced during the care, establishing a support network of referral services for cases of violence and building a reporting these cases. Such conduct shall include notification of cases, development of institutional routines for each type of violence, establishment of better working conditions of health professionals, especially those in the emergency room, to regularize the relationship between patient demand and quantification of professional training and appropriate for them to acquire skills in dealing with different situations of violence.

Furthermore, we argue that the consolidation of care to the victims of violence depends on the formulation of policies that minimize the recurrence of cases involved and seek to prevent these diseases.

KEYWORDS: VIOLENCE, EMERGENCY SERVICE, HOSPITAL, NURSING.

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THE CARE OF HEALTH PROFESSIONAL VICTIMS OF VIOLENCE IN THE EMERGENCY SERVICES: A REFLECTION

ABSTRACT

Nowadays, the number of cases of violence has been responsible for a growing demand for care in public health services, especially in emergency units. This is an article of reflection, which aims to reflect on the dynamic interaction between health professionals and victims of violence during the process of care in emergency rooms. The process of taking care of health professionals suffers changes, which may be differentiated, depending on the placement of professional ethics, leading to major ethical and moral dilemmas in emergency services. Therefore, we conclude that the consolidation of a quality care for victims of violence is necessary to: identify the main obstacles faced during the care, establishing a support network of referral services for cases of violence, development of institutional routines for each type of violence, establishment of better working conditions of health professionals, especially those in the emergency room.

KEYWORDS: Violence, Emergency Service, Hospital, Nursing.

PROCESSUS DE SOIGNER DES PROFESSIONNELS DE LA SANTÉ AUX VICTIMES DE VIOLENCE DANS LES SERVICES D'URGENCE: UNE RÉFLEXION

RÉSUMÉ

De nos jours, le nombre de cas de violence est de plus en plus le responsable d'une demande croissante de rentrées dans les services publics de santé, surtout dans les unités d'urgence. Il s'agit d'un article de réflexion dont l'objectif est de réfléchir sur la dynamique d'interaction entre les professionnels de la santé et les victimes de violence pendant le processus de soigner dans les services d'urgence. Le processus de soigner des professionnels de la santé subit des modifications, pouvant être différencié selon le positionnement éthique du professionnel, entraînant de grands dilemmes éthico-moraux dans les services d'urgence. Pour ce faire, nous concluons que pour livrer des soins de qualité aux victimes de violence, il sera nécessaire: l'identification des principaux obstacles trouvés pendant la réalisation des soins; création d'un réseau de support de services de référence pour les cas de violence; élaboration de routines institutionnelles pour chaque espèce de violence; implantation de meilleures conditions de travail pour le professionnel de la santé, spécialement pour ceux du secteur d'urgence.

MOTS CLES: Violence; Service Hospitalier d'Urgence; Soins d'Infirmier.

PROCESO DE CUIDAR DE LOS PROFESIONALES DE SALUD A LAS VICTIMAS DE VIOLENCIA EN LOS SERVICIOS DE URGENCIA: UNA REFLEXIÓN

RESUMEN

Actualmente, el número de casos de violencia ha sido responsable por un aumento en la demanda de atención en los servicios públicos de salud, principalmente en las unidades de urgencia. Se trata de un artículo cuyo objetivo es reflexionar sobre la dinámica de interacción entre los profesionales de la salud y las victimas de violencia, durante el proceso de cuidar en los servicios de urgencia. El proceso de cuidar de los profesionales de salud sufre modificaciones, permitiendo ser diferenciado, dependiendo de la postura ética del profesional, causando grandes dilemas ético–morales en los servicios. Concluimos que para lograr la consolidación de un cuidar de calidad a las victimas de violencia es necesario: la identificación de los principales obstáculos enfrentados durante el cuidado; establecimiento de una red de apoyo de servicios de referencia para los casos de violencia; elaboración de rutinas institucionales para cada tipo de violencia; establecimiento de mejores condiciones de trabajo del profesional de salud, especialmente los del sector de emergencia.

PALABRAS CLAVES: Violencia, Servicio de Urgencia, Enfermería.

PROCESSO DE CUIDAR DOS PROFISSIONAIS DE SAÚDE ÀS VÍTIMAS DE VIOLÊNCIA NOS SERVIÇOS DE URGÊNCIA: UMA REFLEXÃO

RESUMO

Nos dias atuais, o número de casos de violência tem sido responsável por uma demanda crescente de atendimento nos serviços públicos de saúde, principalmente nas unidades de urgência. Trata-se de um artigo de reflexão, cujo objetivo é refletir sobre a dinâmica de interação entre profissionais de saúde e vítimas de violência durante o processo de cuidar nos serviços de urgência. O processo de cuidar dos profissionais de saúde sofre modificações, podendo ser diferenciado, dependendo do posicionamento ético do profissional, causando grandes dilemas ético-morais nos serviços de urgência. Para tanto, concluímos que para a consolidação de um cuidar de qualidade às vítimas da violência será necessário: a identificação dos principais obstáculos enfrentados durante o cuidado; estabelecimento de uma rede de suporte de serviços de referência para os casos de violência; elaboração de rotinas institucionais para cada tipo de violência; estabelecimento de melhores condições de trabalho do profissional de saúde, especialmente os do setor de emergência.

PALAVRAS CHAVE: Violência, Serviço Hospitalar de Emergência, Enfermagem.

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