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ASPECTS AND CAUSES OF COMPULSORY HOSPITALIZATION IN PSYCHIATRY BEDS

[1]Sirlei Favero Cetolin, [2]Eduarda Engroff, [3]Amanda Angonese Sebben, [4]Vilma Beltrame, [5]Ana Maria Martins Moser, [6]Lediane Trissoldi and [6]Ana Tais Zimmermann

[1]PhD in Social Work. Graduated in Psychology and Social Work. Professor at the University of the West of Santa Catarina – Unoesc; [2]Academic of the Psychology Undergraduate Course. Scholarship holder of the Scientific Initiation Program of the University of the West of Santa Catarina - Unoesc, Campus of São Miguel do Oeste; [3]Master in Biosciences and Health. Graduated in Psychology. Professor at the University of the West of Santa Catarina – Unoesc; [4]PhD in Biomedical Gerontology. Graduated in Nursing. Professor at the University of the West of Santa Catarina – Unoesc; [5]Master in Public Health. Graduated in Nursing. Professor at the University of the West of Santa Catarina – Unoesc; [6]Academic of the undergraduate course in Nursing. Scholarship holder of the Scientific Initiation Program of the University of the West of Santa Catarina - Unoesc, São Miguel do Oeste Campus

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****Corresponding author:***
Hélder Uzêda Castro, PhD

ABSTRACT

This article presents results of a research that aimed to identify the understanding of health professionals who work in general hospitals and have psychiatric beds, about compulsory hospitalization. The nature of the research was qualitative and an interview was used as a technique for data collection, with questions directed to knowledge about the researched subject. Participated in the study, professionals responsible for Psychiatric Wards installed in hospitals located in the Health Region of the Far West of Santa Catarina, with training in Psychology, Nursing and Social Work. The study reinforced the need for Permanent Education to take care of the demand in Mental Health. He noted that the main causes of compulsory hospitalizations are caused by chemical dependency and chronic mental illness. Hospitalizations for outbreaks, according to reports, happen due to the risk of life for the patient and threatens society. Participants' concern was observed in maintaining a welcoming environment surrounded by professional care for patients who require compulsory hospitalization. The importance of the role of the family, support of public policies and the assistance of trained multidisciplinary teams stood out, as well as the strengthening of the Psychosocial Care Network in the process of treating the disease and maintaining the health of patients undergoing compulsory hospitalization.

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INTRODUCTION

Compulsory hospitalization is a topic little discussed in the general scope of health professionals, and most professionals are aware of it only when inserted in the psychiatric context. Compulsory hospitalization occurs from the moment that the individual is resistant to establish a dialogue, presenting a deteriorated mental and / or physical state, either due to the use of any chemical substance or mental disorder. In order to avoid irreversible consequences, such as death, these individuals are hospitalized by their family and / or state (FIGUEIREDO, 2019).

After the Psychiatric Reform initiated in Brazil in 1970, changes began in the treatment of individuals with mental illness or chemical dependency. The basis of the Psychiatric Reform is to humanize care, providing adequate, dignified and quality treatment to the hospitalized individual. Thus, on April 6, 2001, Law 10,216 / 01 was enacted, which establishes three types of hospitalization in its article 6: voluntary, involuntary and compulsory, all subject to a detailed medical report that characterizes the reasons. Hospitalization will be voluntary, when the patient himself signs a declaration opting for treatment, as provided for in item I of the sole paragraph of art.

6th and art. 7 of the law. The sole paragraph of article 7 provides the possibility for the dependent interned himself voluntarily to request the end of treatment, however, such request is prohibited by ordinance 2,391 / GM / 2002 of the Ministry of Health, which now provides for the possibility of voluntary psychiatric hospitalization if make it involuntary, when the patient represents a danger to himself and / or third parties (BISCHOFF, 2012). Hospitalization will be involuntary when there is no consent from the dependent, and must be communicated to the Public Ministry within 72 hours and its termination will be at the written request of the family member or legal guardian, or by the responsible physician (art. 6, II and art. 8, §§ 1st and 2nd, of Law 10.216 / 01). Hospitalization will be compulsory when determined by the competent judge, and must take into account the conditions of security of the establishment, regarding the safeguarding of the patient, of the other hospitalized patients and employees (art. 6, III and art. 9 of Law 10.216 / 01). Its purpose is to intervene in the crisis and control it, in order to stabilize seriously ill patients and guarantee their own safety, as well as that of close people, such as family members, professionals, neighbors, and others. The reasons for the occurrence of Compulsory Hospitalization can be several, however, most of the times, they appear as a result of crises in people with mental disorders and / or use, abuse and dependence on alcohol and other drugs. According to Law № 10,216 OF APRIL 6, 2001, art. 4, Compulsory Hospitalization, in any of its modalities, will only be indicated when extra hospital resources are insufficient.

MATERIALS AND METHODS

A qualitative research was carried out with health professionals who work in General Hospitals with beds for psychiatric hospitalization in the Health Region of the Far West of Santa Catarina. As a technique for data collection, an interview was used and six professionals responsible for the Psychiatric Wards installed in regional hospitals participated in the study. The interview was applied in February 2020 in a reserved room at the participants' workplace. Study participants are aged between 25 and 44 years; 5 female and 1 male; 3 declared themselves married and 3 single; with regard to religion, 3 Catholics, 1 Evangelical Lutheran, 1 Spiritist and 1 atheist; as for the profession, 2 nurses, 2 psychologists and 2 social workers. In the presentation of the results, with a view to not identifying the participants, they are presented by the word "Participant" followed by cardinal numbers "1", "2", "3" and so on. The research project was submitted to the institutional Research Ethics Committee (CEP) and approved under Opinion № 3,677,784.

RESULTS AND DISCUSSION

Compulsory hospitalization is a type of hospitalization provided for by law, in which the patient is hospitalized against his will, without the authorization of the family or guardians being necessary, being determined by a competent judge, when the patient incurs risks to him and / or the society in which it is inserted. Through a specialized medical report, a formal request is made, attesting that the person has no control over the physical and psychological condition. In Brazil, Law 10.216 / 2001, which provides for the protection and rights of people with mental disorders and redirects the mental health model, ensures that there should be no discrimination as to race, color, sex, sexual orientation, religion, political option, nationality, age, family, economic resources and the degree of severity or duration of a disorder. According to Participant 2: *"There is a paradox regarding compulsory hospitalizations that, on one side, intend to protect life, but on the other, establish a violation of freedom and refer to punishment"*.

On the subject, other participants expressed themselves. Let's see:

> *To generate a compulsory hospitalization, there must be a detailed report made by a specialized doctor, that is, a psychiatrist [...]. They are hospitalizations, when there really are not many alternatives but to compulsorily intern, despite the need, tolerate the patient's freedom* (PARTICIPANT 3).

> *It is a hospitalization determined by the prosecution, for some reason, as a disorder. [...] Usually causing harm, in the social and family context. [...] When the patient has no critical sense to discern his actions and all other alternatives have been exhausted. Despite limiting freedom, it is a necessary option* (PARTICIPANT 4).

> *The patient hospitalized against his will. [...] It is a whole process that starts from the family, that mobilizes, because the patient does not recognize the severity of their health situation, and does not accept hospitalization* (PARTICIPANT 5).

> *The patient comes as a judicial determination, requested through family members and the risks it offers to society. [...]. This is because the patient does not recognize the situation, with intervention by public agencies* (PARTICIPANT 6).

In general, the participants report knowledge of compulsory hospitalization, being characterized by judicial determination from the moment that the individual presents danger to himself and to the people around him. Compulsory internment is based on the preservation of human dignity and the right to life and does not harm fundamental rights, being the State's duty to save life and restore dignity (GONÇALVES JUNIOR, 2011). It is seen as one of the deprivation measures, therefore, before the decision to compulsorily intern is established, all possible means of out-of-hospital treatment should be used. As for the main causes of compulsory hospitalizations in the surveyed places, the interviewees reported that it was due to chemical dependence and / or outbreaks, it is generally the patient who is resistant to remain hospitalized.

The causes of compulsory hospitalization are diverse, but generally, due to chemical dependence and alcoholism. And at first the patient does not want to stay as long as necessary for his recovery, he insists on leaving and abandoning treatment. But they end up staying and performing the treatment (PARTICIPANT 1).

They are admitted more frequently due to chemical dependence. But, I understand that compulsory hospitalization should be aimed more at a psychiatric patient, who is not aware of his actions, who is not even aware that he is sick. (PARTICIPANT 3).

According to Assis, Barreiros and Conceição (2013), article 4 of Law 10.2016 states that hospitalization is only indicated at a

time when extra-hospital resources are insufficient, therefore, psychiatric hospitalization should never be the first treatment option for users. However, if it occurs, the person's rights in the institution must be guaranteed. Hospitalizations for outbreaks, according to reports, happen due to the risk to society and to the patient himself:

> *They intern when they are in prison situations and in an outbreak, when they offer some risk to society, in the family context and / or for themselves* (PARTICIPANT 4).

> *Mainly outbreak patients [...] Patients who really do not recognize, who do not know how to distinguish reality from hallucinations. Patients who cannot recognize their severity, the severity of their health situation* (PARTICIPANT 5).

> *They intern for alcoholism, drugs, depression, sometimes schizophrenia. There are cases of suicide attempts, self-harm. Aggressiveness towards third parties, and social risk* (PARTICIPANT 6).

Respondents were asked about compliance with regulations in the places in cases of compulsory hospitalizations. In view of this, Participant 1 clarifies, *"it is the same as the other patients, although the patient is a compulsory hospitalization, the rules are the same for everyone"*.

There were also other manifestations:

> *There is an intensification of information, norms and rules, as it is noticeable that the person is having difficulties to understand the risks that he / she offers to others and to himself / herself. As a health professional, I try to encourage the person to continue the treatment by perceiving and reflecting on their needs for physical, mental, social and spiritual improvement* (PARTICIPANT 2).
>
> *All activities are explained to the patient, his rights and duties within the institution, within my area I look for, when the patient is being hospitalized compulsorily or involuntarily, explain what is the mode of hospitalization, what are the rights within that hospitalization, because, within the compulsory period the patient has the right to a lawyer, so I inform him* (PARTICIPANT 3).
>
> *After being admitted and examining the patient's condition, the institution's rules and norms are explained. The family also receives the same guidelines. Everything is discussed with patients and guardians, explaining what can and cannot be done in the hospital* (PARTICIPANT 4).
>
> *Sometimes they end up becoming difficult patients to work with, because they have a feeling of revolt, because they were brought into hospital against their will. As hospitalization time passes, they adapt, norms and rules adapt* (PARTICIPANT 5).

Considering the difficulty in the relationship with some patients, hospitals observe protocols, reported by Participant 6*:*

> *"when interning, the patient follows a service protocol in the initial registration, where the patient, family members and / or guardians are explained what is allowed or it is not allowed in the hospital. [...]*
>
> *Then, the service with the doctor and the Psychologist takes place, [...] and, afterwards, the entire team of professionals starts to care for the patient"*.

The term care can be used in different contexts, however, here we will approach in order to help others, promoting their well-being by preventing them from suffering from any harm. According to Waldow and Borges (2011, p. 415), "care is understood as a way of being; without care one ceases to be human. […] It is the shift of interest from our reality to that of the other. […] Care, therefore, encompasses acts, behaviors and attitudes". In this way, the act of caring for someone goes beyond helping them with their needs, it means being with them, it means perceiving beyond words, it is paying attention to behaviors and looks.

Let's see some manifestations regarding care:

> *I believe that care follows the same routine as voluntary and involuntary / compulsory patients. Nursing care for the patient is general, we have a closer contact. Generally, the nursing team remains in place for longer than other professionals. We talked, medicated, took care of personal hygiene and observed the patients' daily behavior. We are able to observe the changes that occur in the patient. […]. In our unit, we have meetings every Friday, so on Friday we discuss the cases. […] We exchange information with professionals from other areas* (PARTICIPANT 2).

> *We have a multidisciplinary team that observes that it seeks to care for the patient in the biopsychosocial aspects. We try to look at the patient not only in terms of medication and physical issues, but also in aspects, psychological, social and family, there are many factors that involve the patient* (PARTICIPANT 3).

> *The patient is assisted by a multidisciplinary team, doctor, psychologist, nutritionist, social worker, nurses. He does drug therapy, occupational therapy, rescue skills. Receives hygiene guidance, in addition to strengthening family bonds* (PARTICIPANT 4).

The participants were asked how the patient is referred from his home municipality to hospitalization, the answers were diverse. Let's see:

> *We received the patient accompanied by a document requesting hospitalization where the psychiatrist reports some general information. However, we need other information that is not always easy to obtain. There are cases in which the family is not present and the people accompanying the patient do not know how to respond. However, when the patient is discharged, we send a very complete report on the medications used, exams performed and discharge and maintenance plan that must be assumed in the municipality of origin by the existing health team* (PARTICIPANT 1).

> *The reference of the municipality of origin is the basis for providing guidance to the treatment during hospitalization and the preparation of the Individual Therapeutic Plan. When we are referred, we have the possibility of making a counter-reference, which is essential for the person to continue the treatment plan after discharge with the objective of social reintegration* (PARTICIPANT 2).

Few patients come to hospital with a report sent by the municipality of origin health informing the patient's history, what has been tried, what has already been approached, what has not worked for the patient. Automatically, when we don't have a reference, we won't have a good counter reference either. […] We don't work with healing, we work with stabilization (PARTICIPANT 3).

With regard to counter-reference, it is perceived in the statements cited the importance of post-discharge treatment and the support that the individual needs outside the hospital.

"[...] the patient when interned in a mental health unit, it is not only possible to deal with the issue of mental health, there is the social, family, housing issue, it involves everything. Having support after discharge, frequent readmissions are avoided " (PARTICIPANT 5).

Given the context under study, it is important to mention the characteristics of compulsory hospitalization, remembering that it is a type of hospitalization, where the subject is being subjected to a condition not chosen by his free choice. When the patient falls into a compulsory hospitalization, there are peculiarities that must be taken into account in the patient's discharge process, evidenced by the following statements:

The patient's evolution is evaluated and a report is made to the judge, when it is compulsory, the multidisciplinary team, with the family, discusses the patient's case, and if the family is able to receive this patient, he is released, and if no, a readmission is often necessary, so the patient remains in the unit longer or is transferred to another place (PARTICIPANT 1).

The length of stay is established by the Public Ministry. If there is no period, it depends on the patient, and the period of stay is defined by the team, analyzing the evolution of the treatment. (PARTICIPANT 4)

The discharge process of a patient hospitalized under the compulsory condition, follows a different process from other types of hospitalization, following a period established by the Public Ministry (PARTICIPANT 5).

It is communicated to the Public Ministry, the family and the Department of Health of the municipality of origin of the patient. During the process of compulsory hospitalization, it is analyzed whether he has nowhere to stay / live after discharge, or else he gets in touch with CRAS and CREAS, in addition to checking if he has someone responsible, already during treatment. During the treatment of the patient, work is carried out with the patient's families. After discharge, the patient is sent to the municipality of origin, and whoever brought him to the hospital usually comes to pick him up (PARTICIPANT 6).

Due to the Psychiatric Reform, in the Brazilian context, there were changes in the treatment administered to mental patients, replacing techniques that threatened the integrity of the individual, such as lobotomy, convulsoterapies (electroconvulster therapy and cardiac shock), insulin therapy (insulin shock), use of straitjackets and other means of containing the patient's aggressiveness (GUIMARÃES et al., 2013). In the context in question, psychiatric treatments must excel in patient care, based on more humanized methods, seeking the stability of the individual and their reintroduction in society. In view of this apprehension, there were some manifestations:

We seek to maintain individual assistance with all technical professionals, group therapy and operative groups, we introduce recreational activities, handicrafts, openness for the community to participate in projects related to self-care, prevention and reflection activities, involvement of hospitalized people in the daily activities of the place as care with dogs, maintenance of the vegetable garden and patio and among other things (PARTICIPANT 2).

We seek to develop activities in the area of leisure, in addition to walks, moments of reading, we seek social insertion in the activities of the municipality. We have the day of beauty, which seeks to rescue self-esteem, the day of the film, therapeutic activities such as Reiki (PARTICIPANT 6).

Among the reasons that lead to recurrence in compulsory hospitalization, there are highlights such as: *"[...], non-continuation of treatment, interrupting on their own, or due to a lack of adequate family and social structure, which can provide support"* (PARTICIPANT 5). In the Brazilian context, the Psychosocial Care Network (RAPS) was established through Ordinance MS / GM № 3,088 of 11/23/2011 which provides for the creation, expansion and articulation of health care points for the care of people with problems mental disorders, including the harmful effects of using crack, alcohol and other drugs. RAPS is part of the Unified Health System (SUS), being formed by various services and equipment, such as: the Psychosocial Care Centers (CAPS); Residential Therapeutic Services (SRT); the Community and Culture Centers, the Reception Units (UAs), and the beds of comprehensive care (in General Hospitals). The study participants spoke about the importance of the RAPS in maintaining the mental health of the compulsively hospitalized patient, and intensified the need to implement actions to strengthen it.

I have observed that recidivism occurs mainly because the Psychosocial Care Networks, which, theoretically, should offer support are not being effective. Many people do not continue treatment after discharge and there is no effective active search for support services (PARTICIPANT 2).

I believe that the Psychosocial Care Network needs to be strengthened to meet the demand for mental health. In the case of compulsory hospitalized patients, the services offered in the network can contribute even more to the recovery and maintenance of the individual and the family. But that is not the case. We do our work during hospitalization and there is no continuity of care when the patient is discharged (PARTICIPANT 3).

In general, patients hospitalized in the psychiatric ward already have a vulnerable condition, in the case of compulsory hospitalizations, the vulnerabilities are even deeper, so a strengthened RAPS could contribute to the rescue of these subjects who are fragile in all aspects. But for that it is necessary to unite the ties that make up the network (PARTICIPANT 4).

The statements portray a fragmented reality, with a mismatch of care between the different care services, where the

difficulties in continuing the treatment after discharge, contribute to the successive readmissions of patients. It is important to emphasize that, for mental health care, there is a need to implement training programs, aiming to raise the awareness of professionals in relation to the demand met (PAES, 2009). However, in the midst of routine activities, it becomes a continuous challenge for Public Health professionals to contribute to the implantation and implementation of networks that enable transformations in daily actions and in the production of care. In this context, there is the importance of investments in Permanent Education as a dynamic process, in the practices of the different levels of health care, among which, the hospital area and the demand for mental health stand out, due to its specificity.

> *In general, the professionals that make up the multiprofessional team in the health field, during the professional graduation did not have specific disciplines on mental health, much less on laws. In particular, I did not know what compulsory hospitalization would be until the moment I was put into practice. But, I realize that when the patient arrives for hospitalization, he is treated in the same way as any other patient, only having the differentiation that is involuntary / compulsory hospitalization. For this reason, Permanent Education in Health must be encouraged so that the team remains up to date and can offer even more qualified assistance* (PARTICIPANT 1).

> *If the multiprofessional team is qualified to attend cases of compulsory hospitalization, it is likely that health maintenance will be more successful, however, for this it is necessary to invest in Permanent Education and constantly update professionals* (PARTICIPANT 2).

Permanent Education in Health is based on learning through the daily practice of professionals, making it possible to establish a direct relationship between what is experienced and what it can mean in the construction of health care. This trend breaks with the traditional logic of technical procedures established in advance and refers to the singularization of care processes, built in a shared way (LÍRIO, 2016).

Conclusion

At the end of the research, it was realized that it is necessary to expand possibilities for the establishment of Permanent Education in Health in the hospital area, as well as, reinforce the implementation of the Psychosocial Care Network covering the demand for compulsory hospitalizations. It was identified, with regard to treatment, that the patient who is compulsorily hospitalized is cared for in the same way as other hospitalized patients in the places, trying to build a humanized environment. It is worth mentioning that, the professionals highlighted the relevance of family support in the recovery and maintenance of the patient's health, however, many times, the family that needs to take responsibility for the patient's situation, is in vulnerable relationships and also needs attention, in this sense, the support network needs to be attentive to support the existing weaknesses. We believe that further studies are needed to advance the understanding and problematization of compulsory hospitalization in the context of mental health care, especially with regard to the psychosocial and cultural aspects of hospitalizations.

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