

Nursing as a Profession in Brazil: Sociological Contributions

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Abstract

Aim: The objective was to analyze the content of Nursing Professional Practice Law and compare it to the content of papers addressing professional identity published in *Revista Brasileira de Enfermagem*.

Methods: Bibliographic and documental searches were conducted using qualitative analysis grounded on Eliot Freidson's *Sociology of Professions*. The corpus consisted of texts published between 1983 and 2012, and Brazilian Legal Documents.

Results: The thematic category "Contradictions of the nursing profession" emerged. A weakness of the professional project was identified, which is based on the fragmentation of work. This reductionist approach legitimizes the maintenance of nursing divided into professional and non-professional workers, restricting the practice of nurses.

Conclusion: The complexity of care requires social responsibility to construct a professional project that provides scientific, ethical, philosophical and political foundations to workers to support their practice.

Keywords: Nursing; Sociology; Laws; Nurse's role; Nursing care

Introduction

Nursing in Brazil is a discipline from the field of health, knowledge that is produced and reproduced in undergraduate and graduate programs and specialization programs, which make up the foundation of the work of professionals called nurses. The core identity of nursing is care [1-5]. Nursing is represented by an occupational group in the health field that is composed of workers with an undergraduate degree (nurses), those with a technical/vocational certificate (nursing technicians and auxiliaries) and also individuals with no specific education (nursing aides) [6]. Nursing is one of the 14 professions that compose the health field (CNS, 1998), comprising 60% of the total workers in the field, a figure that includes all multi-disciplinary team members. These data reveal the social importance of this occupational group to ensuring care is delivered to the population. The Federal Council of Nursing was created in 1973 to regulate professional practice [7] and in 1986, the regulation of professional practice (LEP) was the content of Law 7,498/86, which excluded all workers without specific qualification and established that nursing practice would be exclusively performed by nurses, nursing technicians and auxiliaries, in addition to midwives, according to their respective levels of qualification.

The scientific studies authored by Brazilian nurses address various problems faced in nursing practice, referred to as "contradictions of the profession," such as a lack of distinction between the tasks performed by nursing technicians and auxiliaries [8], a blurred definition of the scope of nurses' competencies [9], and the distancing of nurses from their core identity, coupled with a lack of appreciation for the profession on the part of society [10]. Most of these contradictions

have not been resolved by how LEP defined the profession and assigned responsibilities, with contributes to undermining the identity of nursing professionals.

In Brazil, according to the Federal Constitution, lawmaking concerning the organization of professions is a responsibility exclusive to the federal government. The Brazilian State, based on the 1988's Constitution, Article 22, Section XVI, spells out the commitment in which health is established as a fundamental right of citizens. In this constitutional context, health actions and services gained relevance to public interest. This "new order" establishes that the training and competence of healthcare professionals meet parameters that ensure the fundamental rights of the population do not remain at the market's mercy [11,12].

Considering that constitutional interests provide that health is a fundamental right of citizens, professional regulation becomes an integrating part of a larger project aimed to guarantee constitutional rights. Hence, discussing the potential contradictions of nursing's LEP is relevant to analyzing the current status and ensuring the right to health. The theoretical framework provided by the *Sociology of Professions* is one of the foundations that can ground this type of discussion.

Given the previous discussion, this study's objective was: to analyze the content of the Law of Nursing Professional Practice and compare it to the scientific studies published in *Revista Brasileira de Enfermagem* (Reben) [13] concerning the professional identity of Nursing, considering the theoretical propositions provided by the *Sociology of Professions* by Eliot Freidson.

This context was chosen according to certain theoretical assumptions, such as: that LEP and complementary acts that regulate the professional practice of different Nursing professionals in Brazil

(the most in the health field), created in the 1980s, has left many gaps and do not respond to current issues; the years that followed the establishment of LEP witnessed profound changes in public health policies when health became a right of every citizen and a duty of the State to ensure it; that professionalization requires self-regulation mechanisms and mechanisms to produce/disseminate knowledge; and that Reben is the oldest (1932) and one of the most qualified scientific journals for Brazilian Nursing, also responsible for disseminating the political thought of the Brazilian Association of Nursing, Brazil's first such entity (1926). Laws are supposed to express the will of the collective, resulting in a social agreement that harmonizes conflicts of interests and protects the fundamental, political, social and economic rights of citizens and institutions. The regulation of professions is a topic specific to economic and social regulation. Hence, laws regulating professional practice, among other purposes, serve as guidelines and boundaries of professional jurisdictions and responsibilities [12]. Therefore, a relationship of mutual influence is established between the law of professional nursing practice, in its specificity, and the configuration of professional identity.

Method

This qualitative study was preceded by bibliographic and documental research. The study's *corpus* was composed of scientific studies published by Reben between 1983 and 2012, and Legal Documents that regulate the professional practice of Nursing, Law 7,498 [14] from June 25th 1986, Decree 94,406 [15] from June 8th 1987 and Law 8,967 [16] from December 28th 1994.

Papers were collected from 1983 to 2012 because 1983 was the year in which the journal adopted standards for the publication of papers with mandatory abstracts. Having the abstracts and establishing this period of time was appropriate to create favorable conditions to deepen the analysis. The following inclusion criteria were used to select the papers: scientific papers addressing the topic; full texts; published from 1983 and 2012. Editorials and sections titled Student Page, Readers' letters, Abstracts of Theses and Dissertations, Book Reviews, and the publication of documents were excluded.

The papers were selected according to the relevance of the topics presented in the abstracts to the study question. This criterion was established while skimming the texts and after verifying that merely searching for the terms of legislation, professional regulation, professional practice, identity, professional identity, professional role, and professionalization, in the titles, abstracts and keywords, was insufficient, because papers that were relevant to the topic were being overlooked.

A total of 89 papers were selected and printed between May and September 2013. After reading, 34 papers were excluded for not being

relevant to the study so that a total of 55 papers composed the study *corpus* (Figure 1).

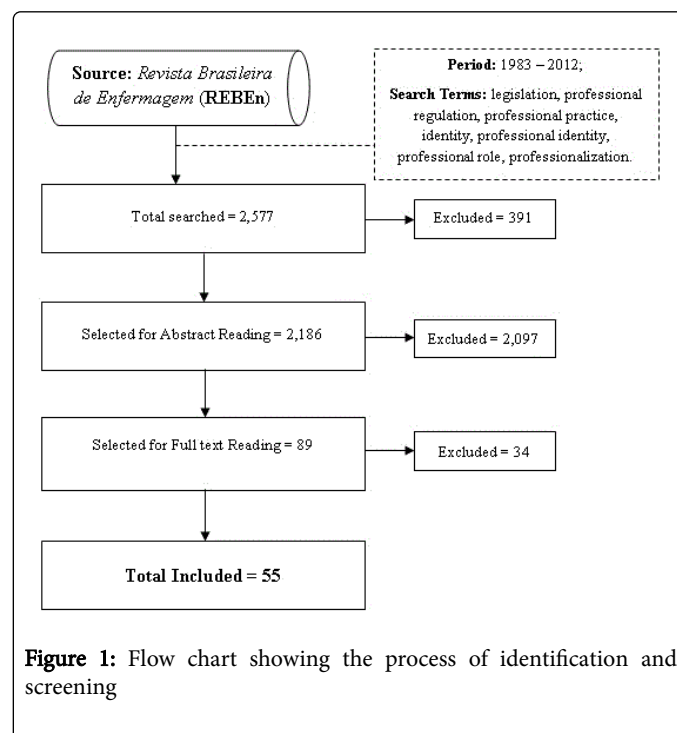


Figure 1: Flow chart showing the process of identification and screening

The periodical's full texts are available online on Scielo (Scientific Electronic Library Online) only beginning with 2003. Therefore, the physical collection available at the library at the Federal University of Santa Catarina was used to access the abstracts of papers published from 1983 to 2012. The texts were organized and systematized using content analysis, understood as a "set of techniques to analyze communication using systematic procedures and objectives of description of the content of messages". Thematic content analysis was chosen because it "seeks the core meanings that compose communication" [17].

The thematic analysis was developed in three phases. Pre-analysis, the first phase, includes skimming the text, composition of the *corpus*, and establishment of objectives. In the second phase, we explored the material, which was categorized according to "core meanings". The third phase included treatment and interpretation of results in light of Freidson's concept of professional identity and five concepts denoted here are thematic axes, which served as a "conducting wire" to understand and categorize the papers (Table 1).

Professional identity according to Eliot Freidson	
Thematic axes	Undergraduate program: accreditation via university degree
	Technical autonomy: the essence of work is established; specific expertise is instituted and controlled
	Socioeconomic autonomy: ability to provide social and economic organization of work
	Professional regulation: the State acknowledges professional jurisdictions

	Market shelters: monopoly of specific areas in the labor market
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Table 1: Professional identity and its thematic axes, Source: Author’s based on Reben [13] (1983 to 2012).

After the analysis of texts, we analyzed Law 7,498 [14] from June 25, 1986, Decree 94,406 [15] from June 8, 1987, and Law 8, 967 [16] from December 28, 1994. Finally, we compared the results from the analysis of the papers published in Reben with the legal framework that regulates professional nursing practice. This study used secondary data available from public domain sources.

Results and Discussion

The analysis of the texts published in Reben using the theoretical support of thematic axes based on the understanding of professional identity proposed by Eliot Freidson, resulted in the identification of the thematic category “Nursing Contradictions”, and three subcategories are shown in Table 2.

Subcategories	Category: Nursing Contradictions	
	1. Naturalization of nursing organization.	
	2. Work’s identity core is not defined	a. Object of knowledge is not defined;
		b. The core identity of the work of nurses is not defined: care delivery or services administration and team management?
c. The statement that Nursing is “essentially” divided between manual and intellectual labor, hindering understanding of its object.		
3. Systematization of the Nursing process as a strategy to legitimate market shelters.		

Table 2: Nursing contradictions identified in the papers published in Reben – 1983 to 2012, Source: Author’s based on Reben [13] (1983 to 2012).

These results were compared to the content of Law 7,498 [14], Decree 94,406 [15] and Law 8,967 [16], which constitute the Legal Documents regulating the professional practice of nursing in Brazil, shown in the discussion that follows.

1. Naturalization of the nursing organization

We present a synthesis of the content provided in Law 7,498 [14], from June 25, 1986, which regulates the professional practice of Nursing, describes its organization and lists the workers belonging to the profession, to facilitate understanding of our analytical approach and legally establish to whom we refer when we use the term “Nursing”.

According to LEP, Law 7,498 [14] from June 25, 1986, Nursing workers (or the Nursing staff) include nurses, Nursing technicians, Nursing auxiliaries, and midwives. There are also nursing aides, workers without specific qualification, described in legal texts as “an individual, without specific education regulated by law, who performs Nursing tasks due to a lack of human resources with technical education in the field” [14]. Later, Law 8,967 [16] ensured that Nursing aides, hired before the enactment of this Law, had the right to perform elementary Nursing tasks as long as supervised by a nurse. Hence, after the enactment of the Law, no workers could be hired under this condition who has only in-service training. Nursing technicians and Nursing auxiliaries are professionals with technical/vocational training; that is, they met technical training requirements (either completed High School or Middle School) for receiving accreditation for their practice.

Nursing leadership and those in the federal and state governments have proposed organizing and providing alternatives to train individuals already working in the field who lack formal education. Regardless, they are in fact legally authorized to work in the field without any “accreditation”. The law was enacted more than 20 years ago and this period of time should have been sufficient to extinguish this condition, either because old workers would have retired or acquired education in order to ascend to the condition of Nursing technician or auxiliary. In practice, however, nursing aides are still hired under new denominations, especially in private health services, as a way to circumvent Law 8,967 [16], which prohibits the hiring of this category of workers [18,19].

The focus of this study lies on Nursing, thereby there is a need to recognize there is a hierarchy grounded on differentiated qualification for performing the work, which is led by nurses, the only professional within the team who meets the professional requirements and has decision-making autonomy in regard to Nursing acts. Hence, in the Brazilian context, when one refers to Nursing as a profession, one refers to a heterogeneous group composed of professional and non-professional categories of workers; the latter exist only by the force of historical controversies and because individuals without professional qualification are still hired, despite standards regulating professional practice.

According to Freidson’s Sociology of Professions, the first contradiction in the Nursing profession was exposed here. As stated by Freidson, in agreement with the theoretical theories on professions, these are occupations that necessarily require a college degree [20,21]. According to Freidson, the heterogeneous organization of Nursing

workers consolidated by the law, weakens the professional project: “Decisive for the analysis of the success or failure of an occupation in achieving and maintaining its protections is the analysis of its internal stratification and segmentation [...]” [20].

The fragmented organization of Nursing is also identified in the texts published in Reben as a contradictory element; however, at the same time, the authors considered it necessary in the performance of the Nursing work. The content expressed in the papers and confirmed by law, was identified as the first subcategory – “naturalization of Nursing organization”. The division of the Nursing work between professionals and non-professionals, seen as “natural” or even “typical” in this occupational group, neglects the Nursing professional project and impedes a more critical position regarding its historical circumstances and propositions for the future.

2. The profession's core identity is not defined

The second category identified in the manuscripts published in Reben, “the profession's core identity is not defined”, includes: object of knowledge has not been defined; the nursing professional's core identity has not been defined: care delivery or administration of services and team management?; the statement that Nursing practice is “essentially” divided between manual and intellectual labor hinders understanding of its object.

The content of Law 7,498 [14] does not confirm what would be, from Freidson's perspective, the specific quality of Nursing expertise. Rather, it confirms a lack of definition of what the object of knowledge or what the profession's core identity is, as shown in the publications under study. The nucleus of professional competence, or the very quality that prohibits others from developing or performing it, is the core of the profession. This property is grounded on highly qualified knowledge and on social acknowledgment [20]. Law 7,498 [14], however, and confirmed by Decree 94,406 [15], states that the exercise of Nursing, “respecting degrees of habilitation”, is exclusive to nurses, nursing technicians and auxiliaries, in addition to midwives. That is, Nursing actions are shared by all the team members, but not all members have Nursing expertise, which is attributed by a college degree. This condition raises controversies in regard to the complexity of its object of knowledge.

Law 7.498 [14] acknowledges that some actions are exclusive to nurses only, such as: leading, organizing, planning, supervising Nursing services and issuing reports, in addition to giving consultations, prescribing Nursing care, directly providing care to critical patients at the risk of death and under care of high technical complexity that requires scientific expertise, and the ability to make immediate decisions. If, on one hand, the fact that planning actions and supervision are considered to be exclusive to nurses corroborates professional power that derives from expertise itself [20], on the other hand, it reveals another contradiction, as other members of the Nursing team also provide care though they are not professional colleagues.

The description of acts exclusive to nurses expresses the division of Nursing practice between manual and intellectual work. This proposition may refer to a symbolic boundary established by medieval universities in regard to the intellectual specificity of the nature of academic work [22], but which, in the publications analyzed, gains further meanings that refer to the technical division of work. This division corresponds to the qualification of its workers' actions according to the rank they occupy in the team's hierarchy. Intellectual

work is the responsibility of nurses who hold knowledge that is identified with “scientific management” and “complex care”, while manual labor is to be performed by the remaining workers; that is, most care actions that are “expropriated of the most valued knowledge”. Based on this understanding, fragmented care is legitimated by the law and the practice of care, and is often restricted to small tasks with little or no complexity.

Is it, however, feasible to accept Nursing work grounded on this fragmentation? How should we determine what “less complex” care actions dispenses with the need for the presence of a professional? What determines “greater technical competence”? How do we avoid a reductionist analysis that confounds “basic” action, in the sense of human condition, with “simple” action, that is, from fundamental to rudimentary? “El cuidado se encuentra en la raíz primera del ser humano y representa un modo-de-ser esencial, presente, irreductible, constituyente y base posibilitadora de la existencia humana” [23]. Nursing care, historically and ontologically, emerges as a basic condition to reestablishing human health or comfort [24].

Fully establishing social acknowledgment of this quality of Nursing care demands constituting authority of Nursing knowledge as a complex action, considering the totality of its acts, because the basic, in its fundamental nature, is closer to complex than simple. Hence, grounded in the Sociology of professions' propositions, we state that it is the professional condition that infers authority and social acknowledgment to Nursing care as a complex action that should be necessarily performed in accordance with scientific, technical, philosophical and ethical foundations. Recognition of care and its valorization simultaneously converge in the legitimacy of Nursing as a profession and affirms the value of human life and citizenship, because Nursing care has a “political-social dimension that reverberates in the lives of citizens”, so that, it is not “a merely instrumental and operational issue of labor, but rather a recognition of its purpose for human life” [4].

Nursing care in the 21st century cannot be learned in manuals or performed in static routines. It demands scientific and philosophically grounded training to respond to a working routine in which decision-making is urgent.

The law that regulates the professional practice of Nursing in Brazil seems insufficient to identify the allegedly distinct nature of the role played by Nursing technicians and auxiliaries [14].

Instead of a clear distinction of actions performed during care delivery, only hierarchical organization prevails, making use of a criterion that enables technicians to help nurses, also helping to supervise auxiliaries. In the legal text, the use of the adjectives “simple” and “repetitive” applied to hygiene care and comfort care is intended to qualify the type of care actions auxiliaries can perform, summarizing the alleged differentiation of tasks. But what qualifies as simple and repetitive? Considering the value of human life, are hygiene and comfort care actions devoid of complexity?

Relating hygiene to simple, repetitive, and valueless care actions compromises the meanings of right, beauty, and prevention. Representations of clean and dirty and hygiene practices are socially constructed and have complex meanings that even assign boundaries of social distances between individuals [25]. Anthropological theories support understanding regarding symbolic elements that serve as an amalgam of society and culture. Hence, the human being seems to be the only animal who is horrified at his/her own blood, vomit, sexual secretions, and who feels cruelly affected by them because s/he is the

only one to have Culture” [26]. Symbolically, hygiene care ranks the lowest among care actions, as do those who perform them. Aware of this fact, we identify another controversy in the content of the Law and papers published in Reben in regard to the assignment of hygiene care to Nursing auxiliaries, which could be seen as an affirmation of power of the professional elite – nurses – to avoid a symbolic identification with not-so-noble tasks.

This controversy is in agreement with Freidson’s studies on paramedic professions in the United States in the 1970s. The fact that American nurses distanced themselves from patients’ beds was the result of a search for professional legitimacy. By taking management positions within the hospital administration, nurses found a prominent position in the division of labor in order to achieve professional autonomy, “eradicating their relationship of dependency with Medicine” [27]. Therefore, similar to American nurses, Brazilian nurses distanced themselves from direct care provided to patients in order to become engaged with leadership [28]. This achievement, however, may come at a price, weakening the profession’s core identity and devaluing care.

The content of Decree 94,406 [15] from June 8, 1987, which regulated Law 7,498 [14], adds a more detailed description concerning the responsibilities of each team member, as shown below:

Art. 10. Nursing Technicians perform auxiliary activities, technical level tasks assigned to the nursing team, such as: I – assisting Nurses: a) planning, programing, orienting and supervising nursing care activities; b) providing direct nursing care to patients in severe conditions; c) preventing and controlling transmissible diseases in general in epidemiological surveillance programs; d) preventing and systematically controlling hospital infection; e) preventing and systematically controlling physical harm that may be caused to patients during care delivery; f) implementing the programs referred to in letter i and item II of Article 8; II – performing nursing activities except those exclusive to nurses, and those reported in article 9 of this Decree; III – integrate the health team.

Art. 11. Nursing Auxiliaries perform auxiliary activities, technical level tasks assigned to the Nursing team, such as: I – preparing patients for consultations, exams and treatments; II - observing, recognizing and describing signs and symptoms according to their level of qualification; III – performing specific prescribed or routine treatments, in addition to other nursing tasks like: a) ministering oral or parenteral medications; b) maintaining hydric control; c) applying dressings; d) applying oxygen therapy, nebulizer, enteroclysis, enema and heat or cold; e) performing tasks regarding the conservation and application of vaccines; f) controlling patients and communicants in transmissible diseases; g) implementing and reading tests to support diagnosis; h) collecting material for laboratory exams; i) providing nursing care before and after surgery; j) circulating in surgery rooms and, if necessary, instrumenting; l) working on disinfection and sterilization; IV – providing hygiene and comfort care to patients and taking care of their safety including: a) feeding or helping patients to feed themselves; b) cleaning and organizing material, equipment, and the health unit premises; V – integrating the health team; VI – participating of health education actions, including: a) orienting patients after consultations on how to follow nursing and medical prescriptions; b) helping Nurses and Nursing technicians to implement health education programs; VII – performing routine tasks related to patients’ discharge; VIII – participating of post-death procedures.

This text shows an exacerbation of the contradiction underlying the fragmentation of the functions of Nursing work. Item II of Article 11, for instance, describes observation, recognition and description of signs and symptoms according to “one’s level of qualification”. Identifying the signs and symptoms that typify a pathological state or other characteristics that may occur in order to establish a morbid process requires technical and scientific competence, thus, requires training. How should the addition to the text “according to one’s level of qualification” be understood? What signs and symptoms, which are not at the level of a nursing auxiliary’s qualification, will not be identified? Or, is this Nursing worker exempt from responsibility in case s/he is not able to identify signs and symptoms that are beyond his/her level of qualification? What is the situation of individuals/ patients/recipients of care, especially those in a large number of healthcare facilities that have a reduced number of nurses, and, for this reason, only occasionally participate in the direct delivery of care? [28,29]. Nurses depend on information provided by their auxiliaries to diagnose and plan care actions, but how is this information collected if these auxiliaries are not properly qualified to make observations that would support a Nursing diagnosis? These contradictions are appointed in the routine of Nursing practice and identified in the papers published in Reben, as well as by the content of LEP.

Item III of Article 11 also includes in the actions of auxiliaries “specifically prescribed treatments” or “routine treatments,” in the sense that such treatments are already known or habitual. Note there is a textual effort to discriminate the activities of the team’s auxiliary members as less qualified, activities that would demand less thorough theoretical knowledge or minimum learning, no decision-making ability or judgment to take actions, only compliance with prescriptions or following a manual. One should take into account that a less-qualified education provided by technical/vocational middle schools, in comparison to undergraduate programs, represents fewer costs. The economic interests of specific groups, however, should not trump the interests of the population and disregard their constitutional rights, promoting distortions in relation to the educational needs of healthcare professionals. The training and competence of these workers should meet quality parameters to ensure the fundamental rights of the population and cannot be at the mercy of the market [12].

The descriptions of some actions, which according to the law, are of a less-qualified or routine nature, make contradictions even more explicit. As in any sort of work intended to be professional, Nursing care is based on judgment and decision-making ability when in face of its object of knowledge. That is, the “authority of knowledge is decisive to define a profession” [20]. Therefore, in the professional organization of Nursing practice there is no justification for workers who lack the qualification to be responsible for performing such activities without the risk of harming those under their care. Even though LEP considers the decision-making ability of Nursing auxiliaries to be limited and subordinated, their field of work, as expressed in the tasks described, is broad and implies the existence of formal knowledge constructed by Nursing but which was not provided to them. It reveals disqualification of care as the object of knowledge and inadequate organization of Nursing’s occupational group to achieve its social purpose.

The State, through its definitions spelled out in Law 7,498 [14], reaffirms the contradiction concerning a lack of definition of the profession’s core identity identified in the papers published in Reben, a contradiction that weakens the professional project, posing a risk to the quality of care provided to the population and to the credibility of the authority of Nursing and the very government making the laws.

3. Adopting the systematization of the nursing process as a strategy to legitimate market protections

In the systematization of the Nursing process, nurses organize teamwork, planning care delivery to achieve desired results. The stages of Nursing care include: data collection, Nursing diagnosis, Nursing planning, implementation, and assessment [30]. Therefore, the systematization of the Nursing process should not be confounded with care delivery just because it is a tool that provides logical structure to the nurse's work [31].

Article 8 from Decree 94,406 [15], June 8, 1987, which regulates the exclusive acts of nurse, includes, among others: consultation and Nursing care prescription, based on care planning. The legitimacy of nurses regarding their professional competence "to establish a problem and propose a solution for it" is acknowledged; that is, nurses are responsible for establishing care. It confers professional status consistent with the power of authority of "authorized knowledge" and justifies nurses' prerogatives regarding the monopoly of professional Nursing services.

Therefore, the adoption of the systematization of the Nursing process as a strategy to legitimate market shelters is revealed as an important resource for the professional apparatus of Nursing to the extent it proposes the construction of an organizational plot in the context of the workspace. On the other hand, the papers published in Reben show the expression of ambivalent meanings regarding the efficacy of the functioning of this organizational structure. Conflicts are exposed regarding the prestige and power that the systematization of the Nursing process confers on nurses working as an exclusionary strategy, not integrating the team as a whole. What should be an organizational resource is revealed in the texts as the focus of contradictions to the extent to which it exposes a structure of inequalities upon which the organization of the Nursing team is based.

Additionally, content indicate that nurses are responsible for "providing tools" to the remaining members of the team, that is, creating conditions for the team to execute nursing prescriptions. But, how can nurses ensure that Nursing work is performed in accordance to the parameters learned within highly specialized university education when the remaining members of the Nursing team did not acquire the same training, knowledge, and education? As a consequence, conflict can erupt inside the Nursing team. According to content identified in the texts, the response to such conflicts would be to unify Nursing workers into one single category of professionals, understood here as a representative unit of workers, that is, unifying this class of workers via a labor union.

Thus, professional autonomy is constructed, among other aspects, based on the definition and construction of an identity that makes clear characteristics that are inherent to the profession. We observe there is a role assigned to class representativeness as a potential substitute for the power of expertise, which is the authority of professional power to ensure market reserve, in addition to an attempt to dilute inter-occupational conflicts and unequal education in Nursing through a proposition to equalize its unequal structure via the labor union struggle and by identifying Nursing workers as workers of a dominated class.

Therefore, the systematization of the Nursing process to legitimate market shelters is also revealed to be a contradiction of the profession and in the profession because it is based on reinforcing the structure of inequalities existing within the team and on the fact that nurses

distanced themselves from directly providing care to patients, rather delegating care actions.

Final Considerations

The Brazilian Nursing elite, composed in this study by the authors of papers published in Reben, as well as the State, represented by the Law on Professional Nursing Practice, has assumed the fragmentation of the nursing work to be "natural to the profession". The weight of the historical construction of Nursing allied with a reductionist view of care delivery underlying the content of papers, contributes to reinforcing this lack of definition regarding the identity core of the Nursing profession.

Reducing or simplifying care to legitimate fragmented care and less-qualified education reveals a lack of knowledge concerning the unstable and subjective nature of phenomena that occur during the delivery of care. This rationale supports the maintenance of divided Nursing, preventing Nursing professionals from applying their rich cognitive and interpretative capacity to judge, replacing it with technical regulations justified by academic rhetoric.

The fragmentation of Nursing work also reflects what sociologists identify as a structure of inequalities where the professional elite controls "the best opportunities in the market". Considering Freidson's propositions, we understand that internal disputes within the professional group itself are phenomena that move the organization of the profession, oscillating reorganization and transformation. The problem occurs when the structure of inequalities is established and weakens the professional project itself, as seems to be the case in Nursing.

Professional regulation, that is, the regulation of professions, is not static. It should follow the dynamic of social demands, as well as enlarged and more complex knowledge and practice of professions to respond to such demands. For Brazilian society to become the democratic and inclusive society it aims to become, it needs to participate in and deepen the debate regarding the parameters used to qualify our healthcare professionals.

It is essential that the Nursing profession construct its own professional project grounded on expertise acquired by all the team members in higher educational institutions, considering the responsibility of these workers with human care. The complexity of care requires social responsibility when constructing a professional project that confers to its workers scientific, ethical, philosophical, and political qualification and legislation that, in fact, substantiates the practice.

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