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RESEARCH PAPER

Managing the difference: power relationships and professional boundaries in the mobile emergency care service

Gerenciamento da diferença: relações de poder e limites profissionais no serviço de atendimento móvel de urgência

La gestión de la diferencia: las relaciones de poder y los límites profesionales en el servicio móvil de emergencia

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Abstract

Background: The Mobile Emergency Care Service (*Serviço de Atendimento Móvel de Urgência* - SAMU), which is provided by the Brazilian Health System, is influenced by economic, political and symbolic determinants, making it a system of interests and an area of conflicts.
Objectives: To understand how power practices shape relationships and professional boundaries at the SAMU of Belo Horizonte, Brazil.
Methodology: This is a qualitative case study based on the post-structuralist framework.
Results: From the perspective of professional and territorial boundaries in the work performed at the SAMU, there are difficulties in recognising the group as a work team, while its discourses reinforce the historical dominance of the medical profession over the other professions.
Conclusion: SAMU professionals struggle to identify and understand the thin line between their workspace and the workspace of others as their area of activity corresponds to the city as a whole. Setting its limit is a huge challenge due to the fragmentation of health services and the existing conflicts, which promote individualistic interventions that undermine the proposal to integrate the health care system.

Keywords: emergency medical services; search and rescue team; professional practice; interprofessional relations.

Resumo

Enquadramento: Serviço de Atendimento Móvel de Urgência (SAMU), um serviço do Sistema de Saúde Brasileiro, é influenciado por determinantes económicos, políticos e simbólicos, tornando-se um sistema de interesses e uma arena de conflitos.
Objetivos: Compreender como as práticas de poder configuram as relações e os limites profissionais no SAMU de Belo Horizonte, Brasil.
Metodologia: Trata-se de um Estudo de Caso qualitativo que se utilizou do referencial pós-estruturalista.
Resultados: Sob a ótica dos limites profissionais e das delimitações territoriais no trabalho do SAMU, percebe-se as dificuldades para reconhecerem o grupo enquanto equipa de trabalho, enquanto os seus discursos reforçam a histórica dominação da classe médica sobre os demais profissionais.
Conclusão: Para os profissionais do SAMU um dificultador é identificar e compreender os tênues limites entre o seu espaço de trabalho e o dos outros, já que o seu espaço de atuação corresponde a todo território da cidade e tentar delimitá-lo é um desafio maximizado pela fragmentação dos serviços de saúde e dos conflitos existentes, os quais favorecem ações individualistas prejudiciais à proposta de integração do sistema de saúde.

Palavras-chave: serviços médicos de emergência; equipe de busca e resgate; prática profissional; relações interprofissionais.

Resumen

Contexto: El servicio móvil de emergencia (SAMU), un servicio del sistema de salud de Brasil, se ve influido por factores económicos, políticos y simbólicos, lo que le convierte en un sistema de intereses y un escenario de conflictos.
Objetivo: Comprender cómo las prácticas de poder dan forma a las relaciones y los límites profesionales en el SAMU de Belo Horizonte, Brasil.
Metodología: Estudio de caso cualitativo que utilizó el marco posestructuralista.
Resultados: Desde la perspectiva de los límites profesionales y los límites territoriales en el trabajo del SAMU, se observan dificultades para reconocer al grupo como un equipo de trabajo, mientras que sus discursos refuerzan el dominio histórico de la profesión médica con respecto a otros profesionales.
Conclusión: Para estos profesionales es un factor de complicación identificar y comprender las tenues fronteras entre el espacio de trabajo y el de los otros, ya que su espacio se corresponde con el territorio de toda la ciudad, y tratar de delimitarlo es un desafío que se ve aumentado por la fragmentación de los servicios sanitarios y de los conflictos, los cuales favorecen las acciones individualistas que perjudican la propuesta de integración del sistema de salud.

Palabras clave: servicios médicos de urgencia; personal de rescate; práctica profesional; relaciones interprofesionales.

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Introduction

The organisation and division of labour are a social process of ongoing negotiations, in which participants are continuously engaged in attempting to define, establish, maintain and renew their daily tasks, as well as in the relationships which their tasks presuppose. However, these negotiations are not entirely free as social interactions are constrained by different aspects, such as the power relationships experienced by individuals and the features of the interaction context itself (Freidson, 1976; Allen, 2000).

Health care work emerges as a particularly rich environment for the study of the world of work and occupations, as well as the very nature of its structure, taking into account its dynamism, the technologically-rich environment, and the incorporation of multiple social interfaces such as the public, private, philanthropic and voluntary sectors. These factors also entail a complex division of labour comprising several professions, occupations, a management system, and technologies (Allen & Pilnick, 2005).

When analysing the Mobile Emergency Care Service (*Serviço de Atendimento Móvel de Urgência* - SAMU), in Belo Horizonte, Minas Gerais, Brazil, as something relatively new in the health care context, it is first necessary to analyse its work organization and demarcation of professional territories as it allows to identify the weaknesses and potentialities of the Service.

The proposal for implementation of a SAMU in Belo Horizonte arose from the need to comply with the new federal law on emergency care, Ordinance no. 2.048 (Portaria nº 2.048/GM-MS de 5 de Novembro, 2002). The Brazilian SAMU model is a combination between the French model, which has specialised health professionals and the mandatory presence of an advanced life support physician, and the American model, which has emergency medical technicians or paramedics trained to provide emergency care. Thus, in Brazil, the functions of each professional were organised based on international references which are very different from the ethical and legal context and the skills of Brazilian health care professionals.

However, due to the characteristics of pre-hospital care services, it is important to consider that professional relationships at the SAMU are multidirectional, since the Service provides temporary assistance, i.e., it is not the patients' final destination, but is intended to refer them to their destination. Identifying the best destination for the patient is a constant negotiation and definition of territorial boundaries both within the SAMU itself and in the levels of care of the municipality's network of health services.

This study aimed to understand how power practices shape relationships and professional boundaries at the SAMU of the city of Belo Horizonte.

Background

Health production in a particular system involves not only human resources, but also the management of technologies, information and the organisational structure itself. In such a complex scenario, task division between professionals is not based on their technical qualifications for performing a specific function within the organisational structure. Social context, and professional regulations and norms are also considered. Moreover, the rules adopted by different groups are dynamic, thus reflecting the continuous changes in the health care structure, technological advances and new ways of working. Such dynamism leads to the creation of new rules, while others, even if obsolete, are maintained (McKee, Dubois, & Sibbald, 2006).

In recent years, concerns over health care cost-containment have led to the introduction of new modes of organisation and management. These have had a profound impact on the social organisation of work, challenging traditional lines of professional territory demarcation and prompting the development of new rules and work methods. In addition, these changes have been buttressed by ideologies of citizenship which point out to the need for redefining the relationship between health professionals and clients/patients/users in health care services, as well as introducing new technologies which change the working environment and, consequently, its division of labour and practices (Allen & Pilnick, 2005).

Therefore, the importance of the interactive and inclusive participation of the various components, such as human resources, management and technological tools, among others, in setting up its working organisational structure is acknowledged. It is important to consider that constant social changes have had a major impact on organisations in general, including health organisations, which need

to identify the new requirements to be able to adapt to the new demands of health care systems' users (Cruz & Ferreira, 2012).

The organisation and division of labour are a social process of ongoing negotiations, in which participants are engaged in maintaining and renewing their daily tasks, as well as in the relationships which their tasks presuppose. Negotiations tend to be facilitated in conditions of change, uncertainty, ambiguity, disagreement, ideological diversity, newness and inexperience (Allen, 2000).

There are interests that should be protected in each negotiation, which causes boundaries to be constantly defined and redefined in a continuum of power relationships, thus interfering directly with the SAMU working process. In this relational context, power relationships, which in fact can be interpreted as relationships of power, will be developed. Hence, it is worth considering that power has no centre; power is a network system, which is strengthened by its links and expressed in its cultural relationships. Every link in the social chain produces, reproduces, and transforms power (Foucault, 2008).

Methodology

This article is part of a doctoral thesis entitled *"Settings of Power Relations in the Mobile Emergency Care Service"*, which was a qualitative case study carried out at the SAMU of Belo Horizonte. Using a qualitative design and based on detailed descriptions of a specific reality, we aimed at overcoming initial conceptions, by providing a basis for descriptions and explanations of specific contexts (Miles & Huberman, 1994).

The convenience sample was composed of 31 professionals: 5 physicians, 11 nurses, 7 nursing assistants and 8 drivers. The inclusion criterion was the consent to voluntarily participate in the study. For data analysis, subjects were identified by the initial letters of their professional category (nurse – N, nursing assistant - NA, physicians - P and drivers - D) and listed consecutively, according to each category. Data were collected from March to May 2010 using a semi-structured interview with the following questions: Why did you choose to work at the SAMU? What is your perception of the relationship among the professionals of the SAMU team? How is the relationship between the SAMU team and the professionals from other units of the health care system? What is your perception of the organisational structure of the SAMU based on management styles and hierarchical structure? Interviews were recorded on an MP4 device and transcribed in full.

Discourse analysis was applied to the dataset, which allowed us to discuss the evidence and explain its ideological nature, as well as identify the concealment of ways of political domination in its content (Fairclough, 2006; Capelle, Melo, & Gonçalves, 2003). Regarding data operationalization, the steps of data sorting, data classification and final analysis were followed (Minayo, 2004).

The research project complied with the principles in Resolution 196/96 on research involving human subjects (Resolução nº 196 de 10 de Outubro, 1996). It was approved by the Research Ethics Committee of the Federal University of Minas Gerais, under the number 105/2009. All participants signed an Informed Consent Form.

Results and Discussion

During the implementation of the SAMU in Belo Horizonte, the joint work of SAMU professionals and rescuers from the Fire Department in pre-hospital care was a cause of conflict as tasks were not clearly defined. This reflected the need for the definition of territories for each service (Rescue and SAMU) as both were possibly unaware of how they could complement their actions, and had many doubts about the future.

The following account refers to the SAMU's implementation period in the city: *During the rescue, I used to argue with the fireman, we had a power struggle. I often joke that I was like a dog marking territory. He peed and I I'd go and peed after him because I also had a saying.* (P4).

This account shows how the work organisation of the recently created Service allowed for a strong fight for territory demarcation during the SAMU's implementation. This points out to a micropolitical scenario, where the emphasis is placed not only on the arena of professional activity, but on a service that seeks to be recognised for its practices. These practices are imbedded in a heroic aspect of care, since the service is considered to be a link with the other network services and has the responsibility

to improve access to emergency services and users' survival rates.

There is a struggle for supremacy in pre-hospital care settings, in which the combination of efforts towards a common goal is not clear. Although this account refers to the history of the SAMU's implementation in Belo Horizonte, there is still a constant struggle for territory demarcation in the SAMU's current structure. In addition to involving its own professionals, who struggle intensively for space, it also involves workers of other health care levels who, though allocated to other areas of the structure of the health care system, relate on a professional basis with SAMU workers.

However, it is important to consider that the division of labour should create social solidarity. When that does not happen, there is not a division of labour, but a simple differentiation of tasks, where the individual is limited to a task, isolated in his/her special activity, without feeling that other individuals are working with him/her on the same task. As shared functions are maximised, solidarity becomes a remarkable effect of the division of labour. In addition, when there is solidarity in the division of labour, individuals complement one another as they are incomplete when isolated. Although the economic benefits of the division of labour are acknowledged, they are surpassed by its importance in establishing a social and moral order *sui generis* (Durkheim, 2008). Thus, it is still premature to discuss the issue of solidarity in the SAMU's work process since what these accounts clearly describe are situations in which the respect itself among professionals is questioned, as well as the understanding of the actual purpose of the Service's activities, as reported in the following account:

Based on my experience, I think that there's a lack of respect, sometimes mutual, you know, from the regulation doctor to the primary care staff and the UPA staff (*Unidade de Pronto Atendimento* - Emergency Care Unit). *And also from the UPA staff to us. Because ... I see it this way, there is a new advanced primary care unit in the sector and, if the person knew how it worked, he/she would make that ambulance available as soon as possible, because he/she would know that it would be needed for other situations. But, they think that you're just giving them more work. So I feel a huge lack of respect, but it is mutual.* (P3).

The interviewee calls into question the lack of knowledge of professionals from other health care services about the SAMU's work, though recognising that the lack of respect is mutual between the participants in this relationship. It is also important to consider that, despite it being a physician's account, the issues raised do not refer to a specific professional group; instead, they provide an overview of the relationships between professional groups. It is clear that the lack of knowledge about the various processes of health care work is one of the factors that promote the fragmentation of the health system. The interviewee considers that this leads to a lack of mutual respect, with an impact on the teams' solidarity, and turns itself into opposition and struggle.

With this in mind, it is important to consider that the division of labour is a process of social interaction. This process occurs as participants continuously engage themselves in attempting to define, establish, maintain and renew their own activities, but also as they engage in relationships with other participants in the process. This interaction is coordinated with the rest of the system and may be affected, for example, by the individuals' relative power in the structure (Allen, 2000), as observed in the following accounts: *... it works this way here: might is right, and obey whoever is sensible. If anyone disagrees, both sides are not consulted. Generally, it's only the side with, let's say, more power here, and that is the version that counts. So, it's very rare for people to have a discussion like:* what happened? (NA8); *Medical coordination here is extremely closed for nurses. Extremely closed. The relationship here: might is right, and obey whoever is sensible.* (N5); *... they* (the teams) *are well separated, okay? Like, technician with technician, physician with physician, nurse with nurse. ... I get along with everyone, regardless of their category. But I feel and I see that sometimes people almost ran us over and don't even have the courage to just say hello?* (NA4).

Initially, the heterogeneity of these accounts stands out as there are very contradictory perceptions of the professional relationships within the team. This shows that the work division and organisation encompass social interactions that interfere with the perception of the organisational structure. However, at the same time, this social interaction can be made up by each individual's relative power within the context of possible and necessary negotiations (Freidson, 1976). If, on the one hand, an interaction points to the understanding of a balanced

relationship based on the assumption of shared responsibilities, on the other hand, it is possible to analyse that, in the structure of health services, the roles and responsibilities of each professional are not defined and, therefore, end up being defined contingently in his/her daily practices.

The work organisation structure, with teams that have already been established, promotes the divergence of perceptions about the work and activities carried out by each team. Most daily experiences happen among the professionals of a specific team without encompassing the daily exchange of experiences between the different teams. Both divergences and convergences are located in microspaces and are not generalised to the SAMU as a whole. Thus, when questioned for this study about the relationship between the SAMU professionals, interviewees focused their answers on the relationships within their team, disregarding the possibility of team relationships including all professionals.

Thus, when analysing these accounts from the perspective of professional boundaries and territory demarcation in the work of the SAMU, a certain difficulty is found in considering the group as a work team. There is, indeed, a sense of team within groups working in ambulances, but also a mutual exclusion from the other groups or teams. Furthermore, there is a certain tendency towards professional group segregation. The idea of an institution with several isolated teams leads to the fragmentation of the work processes. These are developed in a unique way by each professional group, which modifies the power and work relationships. It also creates a diversity of professional boundaries, even between similar groups, such as physician-nurse, nurse-nurse assistant, among others, thus setting the power relationships within the team itself.

In an attempt to understand the relationships between professionals, it is important to consider that power has no essence; rather, it is an attribute, where dominant individuals are those who, at a given time, hold that power. On the other hand, dominated individuals are those over whom power is exercised. Power is, thus, something operational, where the set of strength relationships defines power relationships (Deleuze, 2006). However, the interviewee argues that *[...] it works this way here: might is right, and obey whoever is sensible. If anyone disagrees, both sides are not consulted. Generally, it's only the side whit, let's say, more power here, and that is the version that counts. So, it's very rare for people to have a discussion like: what happened?*

The reference to the popular saying *might is right, and obey whoever is sensible* refers to an organisational structure where certain individuals, regardless of the situation, hold an absolute power. It also suggests the possibility of a type of relationship that is settled by the submission to an imposed condition, with no questions, arguments or resistance against the power exercised. Considering this possibility as real would be to remove the individual from his/her own work process, which is not feasible, since the organisational success permeates the existence of individuals connected with the social demands in question, as well as the skills required in a particular historical moment (Marques, 2006). Thus, it is important to consider that, even in a scenario where the individual is denied the right to clearly express his/her resistance to the established power structures, he/she will do so in other ways.

This brings us to the docilisation of bodies studied by Foucault in the last century. According to Foucault, working with obedient individuals would be working with docilised or well-trained bodies, which would be more useful for organisations. Thus, from a rational and economic perspective, we aim at an increasingly controlled adjustment between productive activities, communication networks and power relationships in an attempt to train the bodies (Dreyfus & Rabinow, 1983). In this disciplining apparatus, some hold greater power, while others have to obey and follow the rules, even if there is room for resistance.

When analysing the SAMU's work process, some traits of this attempt to docilise workers are observed. These aspects may be expressed in a constant proposal to participate in refresher courses, use clinical protocols intensively, and detail the description of work routines, i.e. an efficient disciplining apparatus. In this way, by using disciplinary mechanisms to accurately define the actions, it is possible to categorise, compare, homogenise and exclude "good" and "bad" individuals in a mutual relationship (Foucault, 2008). Therefore, the interviewee mentions that *... I'm sometimes very unhappy with the system. The way it is, you know? ... The fact that others don't understand how you work. Sometimes, you also don't understand how others work and that creates disagreements.* (P3)

The interviewee mentions dissatisfaction to express her feelings regarding the fact that her colleagues do not accept how she carries out the activities. At the same time, the interviewee assumes that the fact that she does not understand another person's work causes disagreements between colleagues. Her responsibility is transferred to the system that is generic, non-personalised and, therefore, more difficult to be accomplished. This suggests that professionals acknowledge the need for a set of rules to define how daily activities should ideally be performed as a way to facilitate group acceptance and, more than that, as a strategy not to be socially excluded in the work relationships.

Thus, the reference to the docility and training of the bodies (Foucault, 2008) may seem a pejorative and outdated jargon in contemporary society; however, reflecting on its essence is reflecting on the institutional reality of many organisations which, at different levels, crave for an ideal of productivity that focuses on the bodies' control and discipline as necessary instruments to achieve results.

This does not mean that these structures formally worship the relationship dominant-dominated in their organisational designs. In western culture, and particularly in Brazil, the relationship of domination has still not been overcome by people working in organisations, so this type of attitude is still very present in individual behaviours. In addition, working in the health area brings with it the relationship of domination and supremacy of some professionals over others, as may be exemplified by the physician's supremacy over the other team members and by the nurse over the other nursing team professionals, as it has been mentioned by some professionals: *It* (the relationship) *is difficult. They are the famous CRMs* (reference to the register in the Regional Council of Medicine), *aren't they? ... They are disrespectful, yes. One or the other respects, you know? But most of them are arrogant, so above God, above the law, above everything here.* (D1);

Some [physicians] sometimes want to impose views and obligations on nursing technicians. Not so much on nurses, because nurses are always with them at the USAs [Units of Advanced Support]. (P1);

The power relationship even over the other: Oh! I'm a physician, I'm in charge. Oh! I'm a firefighter, I have supremacy over the SAMU, I'm going to stay. I don't know where this exists anymore, you know? (N6);

Yes, I think the SAMU's physician is still very arrogant and dominating, he needs to lose this, right? We, generally speaking, the SAMU's physicians... (P2).

These accounts reflect the traditional position of domination of the medical profession over other health care professionals, which is clearly recognised by physicians themselves. Relationships and the work related to building professional boundaries between physicians and other health professionals have been a constant concern and, considering the dynamic nature of the work and their performance in primary health care settings, this relationship will probably continue to suffer constant changes (Allen & Pilnick, 2005).

Thus, in a first moment of observation, the homogeneity of the SAMU team resulting from the use of identical uniforms by ambulance team members may promote the notion of a homogenous group, with a balanced distribution of forces. However, this notion of very balanced relationships can be deconstructed when observing the Service more closely and in more detail. Daily relationships are highly marked by a constant need for demarcation of professional territories, which is manifested through practices showing heterogeneity in the fight for professional spaces.

If, on the one hand, the way in which professional relationships occur is questioned and criticised by many professionals, on the other hand, the reference to precariousness is unanimous among all interviewees who mentioned their relationship with the Medical Cases Regulation Centre (*Central de Regulação* de Casos Médicos). It is interesting to observe that physicians working at the Centre are the same who work in ambulances, although criticism is not limited to a particular professional category. In general, most interviewees report a good relationship of the work team, although they occasionally make some comments in this regard. In addition, whenever issues regarding the Centre are discussed, many complaints and criticisms are made to regulation doctors.

He who works on the streets, the physician, he is with us in the ambulance complaining of the Centre's work. The following week, he comes to the Centre and does the same thing that he complained that the guy did to him the week before. That he sent something that he didn't need to. Everyone complains about everyone.... (N5);

... there's a regulation centre that decides where you go or not. Then, sometimes, you get frustrated to go on a service that wasn't meant for you. (N9);

I'm tired of going with the USA [Advanced Support Unit] *to meet a USB* [Basic Support Unit] *to provide care in a situation that the Regulation said to be serious. And then we arrive there and it's nothing like they said.* (NA8).

These accounts reflect how power is established and circulates in relationship networks, taking into account that power relationships are closely dependent on the individuals' position in the structure. Power is transitional; it circulates and changes hands according to the circumstances. The physician, as regulator, holds the decision-making power over what the other professionals, including ambulance physicians, should do, when they will do it and with what resources. By taking on the position of ambulance physician, the professional also becomes submissive to the regulation physician, having to abide by his/her decisions.

However, although physicians assume both positions (regulation and care provision in ambulances), there is a certain difficulty in considering one position while performing the other. In other words, when working on the street, the physician does not see himself/herself as possible regulator, whereas when he/she is working at the Centre, he/she cannot picture his/her performance in care provision *in loco*. This results in a lack of sensitivity towards the colleague whenever he/she is in a different position from the other professional and raising doubts about the decisions taken by the regulation doctor.

Job satisfaction may be one of the factors associated with this behaviour of questioning the colleagues' attitudes and keeping similar attitudes, since physicians prefer to work in ambulances, instead of being restricted to a single room, answering phone calls and making decisions, without having opportunity to really evaluate the patient who asks for their intervention. This can be illustrated by the following statement: *It really is that adrenaline thing. Sometimes, it's very high and sometimes it causes an excessive tension. Here at the regulation centre you have many ... How can I put it? A high volume of care for a single person, you know?* (P1).

The fact that a single regulation doctor answers to a high number of requests is also a cause for dissatisfaction. This forces him/her to work the whole time under extreme pressure and deal with a variety of simultaneous situations. In addition, as shown by the interviewee, in many situations, physicians are not fully prepared to act as regulators since the curricula of medical degrees do not offer, among their course subjects, contents related to this type of care. *... because this [medical regulation], we don't have that at the faculty, the pre-hospital care. There's no regulation. How to proceed, right? Diagnosis over the phone, everything, and we are placed on the system even without previous training. I have already spoken about it. I've discussed it with the coordination board; I think that is a major flaw.* (P3).

The internal structure of the SAMU still presents many challenges in the search for more harmonious and less problematic professional relationships. However, when these relationships are analysed in other levels of care, the complexity is multiplied. Although there is reference to a feeling of little sympathy from workers of other health services towards the SAMU, in general, the analysed interviews highlight the professionals' discomfort with the relationships established with the Emergency Care Units (UPA). This relationship is classified as bad, especially because the professionals in the UPAs consider that the SAMU is responsible for an increase in the amount of work in those Units.

It [the relationship with other services] *is much more problematic, because there is a... Mainly from UPAs, hospitals, a... Nobody likes the SAMU, right? Because the SAMU takes their problems to them.* (P1).

However, the same interviewee points out another reason that can be associated with the conflict between both services. It is the Brazilian legislation in the area of emergency care, which defines the SAMU as Vacancy-Zero, i.e. any health service needs to offer vacancies to receive patients transported by the SAMU, regardless of availability of vacancies (Portaria nº 2.048/GM-MS de 5 de Novembro, 2002). However, the biggest problem is not in the legislation itself, but in the reactions that it causes in the different health services. Thus, SAMU professionals consider that the legislation in itself should open doors.

We wouldn't even have to ask to get in. We have to come and enter. However, then, we still make contact, do it all. We try to talk (P1).

This account shows a perception of superiority of the SAMU professional in relation to other health services. The professional considers the contact with the Unit that will receive the transported patient as an

additional kindness and not an obligation. In addition, the professional has difficulties realising that, because of the vacancy-zero imposition established by Ordinance 2.048 (Portaria nº 2.048/GM-MS de 5 de Novembro, 2002), the possibility of dialogue is actually quite restricted, since the response to SAMU requests must always be accepted.

Conclusion

Given the ubiquity of power relationships, their analysis in the SAMU context was an important factor to understand the service's role in the relationships established. The analysis of the relationships between professionals has allowed for a better understanding of the strategies used to manage their effects and how professionals are positioned in their daily practices in an attempt to find a more comfortable position within the network of relationships.

It was also possible to understand the circular movement of power in the SAMU professionals' practices. Although there is a formal and well-defined structure which is recognised by SAMU professionals, the dimension and complexity of the relationships transcend these formally established boundaries, thus highlighting tensions emerging in daily practice.

Understanding the specific tensions in SAMU practices implies searching for answers that may clarify how these practices are organised in a given context. For SAMU professionals, it is difficult to identify the thin line between their workspace and the workspace of others, since their own space corresponds to the whole city of Belo Horizonte and trying to restrict it is another challenge to be met. This challenge is even more difficult due to the internal and external fragmentation of health services, i.e., these services' networking deficits. Thus, conflicts are exacerbated, leading to individualistic actions which affect the intended integration of the health care system and generate situations that compromise the work environment of health care teams in general.

Although this study has been carried out in Brazilian pre-hospital care settings, the complexity of the power relationships in this Service, as well as the practical dimensions achieved by these relationships along the structure may contribute to reflections on other scenarios. In addition, considering the complexity of the SAMU of Belo Horizonte, further studies should be carried out to increase the understanding of this phenomenon and complement the discussions presented so far.

References

Allen, D. (2000). Doing occupational demarcation: The "boundary-work" of nurse managers in a district general hospital. *Journal of Contemporary Ethnography, 29*(3), 326-356.

Allen, D., & Pilnick, A. (2005). Making connections: Healthcare as a case study in the social organization of work. *Sociology and Health & Illness, 27*(6), 683-700.

Capelle, M. C., Melo, M. C. O. L., & Gonçalves, C. A. (2003). Análise de conteúdo e análise de discurso nas ciências sociais. *Revista de Administração da UFLA, 5*(1), 69-85.

Cruz, S. G., & Ferreira, M. M. F. (2012). Perceção da cultura organizacional em instituições públicas de saúde com diferentes modelos de gestão. *Revista de Enfermagem Referência, 3*(6),103-112.

Deleuze, G. (2006). A new cartographer discipline and punish. In G. Deleuze, *Foucault* (pp. 21-38). London, England: Continuum.

Dreyfus, H. L., & Rabinow, P. (1983). *Michel Foucault: Beyond structuralism and hermeneutics* (2nd ed.). Chicago, IL: University of Chicago Press.

Durkheim, E. (2008). *Da divisão do trabalho social* (3ª ed.). São Paulo, Brasil: Martins Fontes.

Fairclough, N. (2006). *Discourse and social change* (11nd ed.). Cambridge, England: Polity Press.

Foucault, M. (2008). *Vigiar e punir: História da violência nas prisões* (35ª ed.). Petrópolis, Brasil: Vozes.

Freidson, E. (1976). The division of labor as social interaction. *Social Problems, 3*(23) 304-313.

Marques, A. A. M. (2006). O conceito de poder em Foucault: Algumas implicações para a teoria das organizações. In *Anais do 3º Congresso Virtual Brasileiro de Administração*. Retrieved from de http://www.comvibra.com.br/2006/artigos/74_pdf

Mckee, M., Dubois, C. A, & Sibbald, B. (2006). Changing professional boundaries. In C. A. Dubois, M. McKee, & E. Nolte (Eds.), *Human resources for health in Europe* (pp. 63-78). Berkshire, England: Open University Press.

Miles, M., & Huberman, M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). London: Sage.

Minayo, M. C. S. (2004). *O desafio do conhecimento* (11ª ed.). São Paulo, Brasil: Hucitec.

Portaria nº 2.048/GM-MS de 5 de Novembro (2002). *Regulamento técnico dos Sistemas Estaduais de Urgência e Emergência*. Ministério da Saúde, Brasil.

Resolução nº 196 de 10 de Outubro (1996). *Diretrizes e normas regulamentadoras de pesquisa envolvendo seres humanos*. Conselho Nacional de Saúde, Ministério da Saúde, Brasil.