

EVERYDAY PRACTICES OF PROFESSIONAL IN THE MOBILE EMERGENCY SERVICE

PRÁTICAS COTIDIANAS DOS PROFISSIONAIS NO SERVIÇO DE ATENDIMENTO MÓVEL DE URGÊNCIA (SAMU)

PRÁCTICAS COTIDIANAS DE LOS PROFESIONALES DEL SERVICIO DE MÓVIL DE URGENCIAS (SAMU)

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ABSTRACT

Objective: To analyze how to configure the daily practices of professionals in the Mobile Service (SAMU) of Belo Horizonte-Minas Gerais. **Method:** Qualitative Case Study and Post-structuralist framework. There were 13 semi-structured interviews with professionals from different functions, being served all ethical questions. **Results:** In everyday life, discourses legitimize relations of power, making the maintenance of truth, control and surveillance discourses. The discourse of utility and essentiality keeps the imagery about SAMU, as a service that cannot stop and fail. **Conclusion:** This analysis of the SAMU in a more reflective and critical stance, showed the need to overcome the descriptions of health services, recognizing the presence of relations of power and dominance in the every day and the perpetuation of hegemonic discourses.

Keywords: Health knowledge, Attitudes, Practice; Emergency Medical Services; Dominance-Subordination; Power.

RESUMO

Objetivo: analisar como se configuram as práticas cotidianas dos profissionais do Serviço de Atendimento Móvel de Urgência (SAMU) de Belo Horizonte, Minas Gerais, Brasil. **Método:** estudo de caso qualitativo, com referencial pós-estruturalista. Realizaram-se 13 entrevistas semiestruturadas com profissionais de diferentes funções, sendo atendidos todos os quesitos éticos. **Resultados:** na cotidianidade, os discursos legitimam as relações de poder, fazendo a manutenção dos discursos de verdade, de controle e de vigilância. O discurso de utilidade e essencialidade mantém o imaginário sobre um SAMU, como um serviço que não pode parar nem falhar. **Conclusão:** essa análise do SAMU, numa vertente mais reflexiva e crítica, apresentou a necessidade de se superar as descrições dos serviços de saúde, reconhecendo a presença das relações de poder nos cotidianos e a perpetuação de discursos hegemônicos.

Palavras-chave: Conhecimentos, Atitudes e Práticas em Saúde; Serviços Médicos de Emergência; Dominação-Subordinação; Poder.

RESUMEN

Objetivo: analizar cómo son las prácticas cotidianas de los profesionales de los servicios de atención móvil de urgencias (SAMU) de Belo Horizonte, Minas Gerais. **Método:** Estudio de caso cualitativo, con referente post-estructuralista. Se realizaron 13 entrevistas semi-estructuradas con distintos profesionales. **Resultados:** en el día a día los discursos legitiman las relaciones de poder haciendo que se sostengan los discursos de verdad, control y vigilancia. El discurso de la utilidad y esencialidad mantiene el imaginario del SAMU como un servicio que no puede ni parar ni fallar. **Conclusión:** este análisis más reflexivo y crítico del SAMU muestra la necesidad de superar las descripciones de los servicios de salud, reconociendo la presencia cotidiana de las relaciones de poder y la perpetuación de los discursos hegemónicos.

Palabras clave: Conocimientos, Actitudes y Práctica en Salud; Servicios Médicos de Urgencia; Dominación-Subordinación; Poder.

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INTRODUCTION

Everyday practice consists of a set of procedures organized socially, in a given space and time.¹ The setting in which these practices are established is the place where the discourse can be objectified, that is, it becomes an object, and it is understood.¹² It is assumed that a study that contemplates everyday life should be done considering what is beyond what establishes the regularities of social life, normalization, and routinization, including what disturbs it.¹ Then, daily practice is then a scenario to be analyzed through the discourses constructed there, in which certain discursive practices promote ruptures in daily life, making it unstable and breaking certain social, real or expected regularities.²

In the pre-hospital mobile services area, the understanding of everyday practices goes beyond the understanding of the actions limited to the normalization predominant in the routine of health care established in protocols and manuals of the service. The Mobile Emergency Care Service (SAMU) is one of the mobile components of pre-hospital care in Brazil. Its emergence and growth are associated with the need to minimize deaths and secondary sequels to the inadequate care of emergency situations in the out-of-hospital environment.^{3,4} SAMU has a fixed structure, in which the organization of the service is centered, and of a mobile structure, which corresponds to the ambulances that meet the demands of the place.⁴ The service operates 24 hours through the uninterrupted operation of the Regulation Center, both for emergency care, as well as for inter-hospital and intra-hospital sanitary transportation.⁴

The structure of the SAMU has ambulances of the basic support unit (USB) and the advanced support unit (USA), motorcycle ambulances, decentralized bases for ambulance support, Medical Regulation Center (CRM)⁶ and the administration. SAMU must be analyzed as an integral part of the Unified Health System (SUS) to understand its local and decentralized, flexible and rigid dimensions. The SUS, created in 1990, is characterized by the organization of health care networks that seek to overcome the fragmentation of care provided by health services aimed at acting in acute conditions, seeking to consolidate integrality, equity and universality.^{5,6}

The organization of the emergency services network began with the Technical Regulation of the State Emergency Systems of 2002 and the National Emergency Care Policy (PNAU) of 2003.^{7,8} PNAU proposed the creation of state, regional and municipal emergency care services, guided by SUS principles.^{5,6} The emergency regulations also provide for the organization of local and regional networks of integral care to emergencies as interconnected parts of the maintenance of the organized in the components: fixed pre-hospital, pre-hospital mobile, hospital, and post-hospital.⁶

The SAMU was implanted associated with rescue services in the national territory with the Medical Regulatory Centers

accessed by dialing 192 and the Emergency Education Centers.⁷ The defense of the implementation of SAMU as the first stage of the PNAU was based on the argument that regulatory centers would be important for the organization of flows of integral care to emergencies since they could play the role of observatories of the care networks in the health system.⁵

In 2011, GM/MS Ordinance Number 2,395/2011 determined the organization of the hospital component of the emergency care network in the SUS, with a focus on humanization of care, the definition of back beds for referrals, and counter-reference to be performed.⁹ That same year, Administrative Rule Number 1,600/2011 reformulated the PNAU, establishing a network of emergency care in SUS.¹⁰

In Belo Horizonte, the organization of the SAMU took place in a different way from other municipalities, since the Rescue, an Emergency Care Service, was already in place in the city under the responsibility of the FireDepartment.¹¹ SAMU was organized following some of the national guidelines, such as trained professional staff, Central Regulation and basic and advanced care units. However, there were also some rearrangements due to the installed and functioning structure of the Rescue. At the SAMU of Belo Horizonte headquarters, the only CRM is located in Belo Horizonte and the metropolitan region, although the ambulances are located in their cities of origin, in the metropolitan region of Betim, Contagem, Nova Lima, among others. Such a model resembles the regional SAMU proposal, where there are polo-cities and host-cities responsible for the regulation of cases.¹¹⁻¹³

In Brazil, SAMU was created based on a hybridization of the North American and French Prenatal Care Models (APH), with a legal framework that establishes general norms for its implantation throughout the country, disregarding the contextual differences existing in Brazil, the United States, and France. The French model admits an early onset of therapy, which is fundamental for clinical emergencies, but criticized in the care to trauma for the delay in transport to the definitive place of care, while the American model, which has international influence, proposes the rapid removal of the patient from the place of care, with an intervention made by technicians in medical emergencies and by paramedics. However, the Brazilian model creates tactics of subversion of the two models, and at the same time, sought to overcome these models and adapt them to the reality of a country with continental extension and important sociodemographic diversity.^{5,11,13}

To provide the necessary care, SAMU mobile service units have professionals from different categories such as driver-rescuer, doctor, nurse, and nursing technician, who develop their daily work practices in a wide geographic territory, establishing relationships with several others health services.^{3,4} Because of its peculiarities, it is considered that SAMU is a bold project,

requiring specific skills of its managers and workers trained by the MS and partner agencies since attendance to emergencies does not necessarily end up in independent and self-limited procedures and actions. This service is based on the link with several other services and professionals of the health network, which is essential for guaranteeing its effectiveness.^{12,13}

In everyday practices, relationships of power and domination are established, as well as tactics and resistance strategies. It should be noted that power relationships are the sum of power and resistance, and this composition is the primary condition for the existence of these relationships. However, both power and resistance work in the opposite way to domination, which presupposes the absence of freedom for its existence.

In the relational perspective, power is understood as a productive force, neither good nor bad, enabling to trace its effects and its particular arrangements, producing subjectivities and results, whether expected or not.¹⁴ Thus, the study of this productive power depends on an analysis of how things happen in local practice through discursive relationships that allow many hegemonic discourses to be propagated and to model everyday actions.^{2,14}

The daily practices of SAMU reflect the uniqueness and conflicts inherent in the work of a heterogeneous team, articulated to other professionals allocated at different levels of the healthcare network. It was opted for using the post-structuralist reference to understand these practices, based on the assumption that workers' discourses are socially constructed, in a way that creates and influences these practices. Post-structuralism allows questioning reality, how it is constituted, who the constituent individuals are, how these individuals have their constructed subjectivities, and what social relationships are established in the scenario.¹⁵

This study aimed to analyze how the daily practices of SAMU professionals from Belo Horizonte, Minas Gerais, Brazil, are configured.

METHOD

It is a qualitative case study, of post-structuralist theoretical-philosophical reference. In the poststructuralist perspective, the realities and truths of each moment are considered to be social constructions produced from the tension between dominant and emerging discourses aimed at the maintenance or modification of established social practices.^{14,15}

The research scenario was the SAMU of the city of Belo Horizonte (SAMU-BH), capital of the state of Minas Gerais, which is the fourth most populous municipality in Brazil, with a population of 2,238,526 inhabitants. The population of the Metropolitan Region of Belo Horizonte is 4,819,288.¹⁶ The municipality is administratively divided into nine regional and 81

planning units, facilitating its management in a more decentralized way.¹⁷

SAMU-BH operates in its own administrative headquarters, in the northwest of the city, where it has a base for the ambulance, warehouse, administrative and human resources sectors and the Regulation Center. SAMU also has 23 bases strategically distributed throughout the city, 21 with ambulances and basic support unit teams and six with advanced support units in 2016.¹⁷ The SAMU Emergency Regulation Center is accessed by the population through dialing number 192, widely distributed to the community. At the Regulation Center, the sorting and the attendance of all requests for service are made.⁸

After being attended by SAMU, patients are referred primarily to the partnership units. There are eight emergency service units (UPAs), six hospitals and seven Reference Centers for Mental Health (CERSAM) located in the different regions of Belo Horizonte.¹⁷ According to the Detailed Report of the second quarter of 2016 of Belo Horizonte-MG in 2015, the number of telephone calls received was 640,076 and the number of ambulance assistance was 96,937, with a daily average of 265.6 ambulance assistance.¹⁶

The participants of this study were 13 professionals from the SAMU of Belo Horizonte, including dispatchers, telephone assistants, regulators, medical and nursing coordinators, administrative manager of the building, administrative assistants, warehouse manager, warehouse assistants, driver, nursing technician, nurse, and physician. The choice of participants was for convenience, including those who had been in the service for more than a year.

The data collection was done by the research nurses of the project, through a semi-structured interview, from December 2011 to February 2012. The script covered the following questions: tell me how is your day-to-day work; What do you think of the organizational structure of SAMU?; what do you understand about the management and hierarchical structure of SAMU?; and how do you see the relationship between superiors and subordinates?

The results and the discussion were based on the analysis of the discourse extracted from the interviews. Discourse analysis was used because of its ability to provide a data analysis more suitably intertwined with the idea of post-structuralism discourse and language. Discursive practice is understood as a daily social practice, those factors may be resonant to social change¹⁰ and with both epistemological and ontological agreement with the scope of this research. For Foucault,¹⁸ this type of analysis puts into practice the principle of inversion in discourses, that is, it seeks to surround the forms of exclusion, limitation, and appropriation. It also seeks to show how discourses have formed and to respond to their needs, how they have changed and moved, what forces have effectively exercised and to what extent they have been circumvented.

All interviewees of the study voluntarily signed the Free and Informed Consent Term (TCLE). The study complied with the requirements of Resolution 466/2012/19 of the National Health Council, and the project was approved by the Ethics Committee of UFMG (COEP/UFMG), under Opinion CAAE-0147.0.203.410-11.

RESULTS

Of the 13 interviewees, there were eight men and five women, ranging from 25 to 51 years old, with a mean age of 39 years old, two of them between 25 to 34 years old, eight of them between 35-44 years old and three between 45-50 years old. Regarding the average time of work in the emergency center, it was approximately 11 years, with an interval of one to 35 years. As for the working time in the SAMU, an average of approximately five years was identified. As for the form of admission, six subjects were hired by administrative process, four of them by public tender and three were hired by a selective process. Academic training ranged from full secondary to specialization. However, some subjects did technical and graduation courses, not necessarily in the same area; most of the subjects that have undergraduate also attended specialization and only one of them had only technician courses. In terms of professional category, not necessarily the role assumed in SAMU, there are two drivers, three nursing technicians, three nurses, two doctors, two administrative technicians and one administrator.

The data were organized and analyzed with a focus on everyday practices whose discourses identified the existence of power relationships in SAMU. These relationships were found both in the discourses referring to the internal practices of the service and in those with other services of the network. In the external context, the relationships of power are expressed in the discourse of resistance:

no resistance, they know they have to do their duty. [...] the Secretary of Health gives us support in everything, in every sense, only the entrance [in the health services network] it has some resistance with SAMU [...] if there is no vacancy, they know they have to accept (E20).

In the internal context, it was observed the discourse related to the institutional hierarchy:

[...] so, we have to obey this internal hierarchy, right? I think, here, everyone tries to put on their own shoes (E12). But all this should not be questioned, we are here to work, so they have to go where they are asked (E21).

Exercising power by the production of truth is to exercise it less by confrontation and more by resistance.

The denial of local knowledge coming from practice is observed, to the detriment of an institutionalized and legitimized knowledge by the system. This makes the interests of the population and the various professionals often diverge.

People are willing, but they are not interested in putting into practice what SAMU knows, we have to do what the population wants (E4). We get the feeling that health policy is a little more weighty, favoring some points, sometimes to the detriment of other points that we think are more important (E6). [...] the central comes to me and say take them there to the Emergency Service Unit (UPA), another thing is this, because if I am there, I am being the eyes of the system at that time, I turn and speak that the patient has nothing and the central get the patient and take him the UPA, understood, so it's because the center is not believing me. Me saying: "the patient has nothing, he can go by his own means". No, you will get him and will take him (E14).

The lack of knowledge of the population is considered as one of the barriers to organize the service and to guarantee qualified service by the professionals. It is perceived transference of the responsibility of the problems of the service to the patients, arguing that they do not know how to use it, disregarding problems of the institutional structure:

[...] we work within a logic of urgency, priorities, patient referrals, but I think that the way SAMU works is not widely publicized, so the population mainly does not understand that SAMU is not a taxi (E17) One of the things SAMU needs today is to educate the people on how to use SAMU and build a structure with the whole, with the UPA and hospital and all [other health services] (E4).

Professionals are called upon to sacrifice in the name of a service that cannot stop, which is essential. They are inscribed in the interest of the other, and their concerns are translated into actions for the realization and maintenance of daily practices, without a clear awareness of the dominant interests.²⁰

When they need anything, they call me any time of the day or night. Weekend too. If I need to, I have to come [...] not necessarily I'm here every day, but I'm always involved with SAMU, right? (E20). Because SAMU is supportive because SAMU is on the street, it's in the face of [...] the problem, do you understand, it's not the UPA, that's ready, waiting, that it can close the door. SAMU has no way. SAMU has to go there and collect and go there to open that door again. Did you get it? (E4)

Another discourse presented is the vigilance of the peers among themselves, but also of the population towards the service, which by its essentiality and usefulness and it cannot stop:

[...] so, just like that, if we stop there to buy water, the people already look at us in a weird way. They think we do not drink water, that we do not go to the bathroom, that we do not eat, right?! (E12). We see, no, we listen on the radio some situations that you realize that USB is making a request and not always the regulation is listening or going according to what they are thinking, and vice versa (E17).

DISCUSSION

Traditionally, power is studied as a perceived, negative, object that can be used by someone to maintain control and levels of hierarchy, passed from one person to another, depending on their social position, being exercised by means of orders and rules, that is, command and control. In this study, the understanding of power was used as something more complex that has its origin in the relationships.²

Besides power, domination is also a form of relationship in society, which occurs in the absence of freedom, but in resistance.^{14,20,21} The discourses analyzed reveal that the daily practices of SAMU are not necessarily structured from the formally established organizational structure, but of empirically created discourses, based on the experiences and daily experiences of professional practices. SAMU is a privileged place of power relationships that reflect the uniqueness and conflicts inherent in the work of a team that develops its practices in an environment of close relationships with several members of the multi-professional team allocated at various points in the healthcare network.¹³

The exercise of power is not simply a relationship between individuals or collectivities, but a way in which the actions can modify others. Thus, for the patient no longer needs to go to the emergency service by his own, SAMU modifies the traditional path of health care. By subverting the established order, meeting the patient to meet his needs and taking him to a fixed service, creates another type of relationship with the patient and the professionals, who cannot refuse to receive him. This service logic leads professionals from other services to have a negative representation of the work of SAMU. In general, these services work with demand overload, and SAMU contributes to increase it further, with legal backing to require that the patient brought in by his ambulance be received, regardless of the conditions of the service.¹³ This situation causes relationship conflicts between SAMU and the other health services in the network.

In external relationships, the professionals of SAMU believe that they have an important role in the health practices of the municipality and therefore, must be recognized by the

other services of the network. They understand that, whenever they arrive with the patient, the same must be attended without question. In affirming that the other services do not create resistance to receive their patients, SAMU reaffirms its authority, with the support of the Health Department. This authority is based on the "zero vacancies", which was determined by Administrative Rule 2,048/2002 and refers the autonomy of the SAMU to decide the fate of the patient transported, even in situations where there are no beds available for the hospitalization of patients in the institution of the referral. When they understand this situation as natural, SAMU professionals assume the posture of facing an absence of resistance, in the face of non-refusal of service.²² However, in this case, it must be considered that care will occur due to normalization. This does not imply that there is no resistance since it can be manifested from other expressions,²³ such as delay in receiving the patient, retention of materials such as stretchers and cervical collars, among other tactics of the services received by the patient.

Regarding internal relationships, there is also a reference to the need for obedience to the rules and hierarchy as a way of avoiding the conflicts, which are seen in a negative way, and to keep the service functioning. This can be interpreted as a consensus that maintains the relation of the binomial domination-resistance, although the resistance is not something clearly perceptible.

From the data collected, the power relationships organize the work, interfering with the performance of professionals and propagated in their daily discourses. The professionals refer to having to comply with the hierarchy, norms, and routines to maintain the operation of the service, denying the existence of resistance in the service. Given the hegemony of the discourse of the norm and the utility of the SAMU, the possibility of a struggle for the defense of professionals' interests is limited whose discourses assume less importance in the scenario of daily practices.

For Foucault³, the existences of power and resistance are concomitant. Power relationships produce conditions of resistance since the forms of external governability cannot be imposed on individuals, since there is always the possibility that this relationship may be broken. Subjects always have the possibility to react to power, refuting the prescriptive and deterministic logic of dominant discourses and practices of a given historical period.^{14,15} Some of the ways to recognize this resistance in SAMU are the criticisms and the questions mentioned by professionals about the ways in which the service is structured in the health network and how it is used by the patients.

In the construction of the subjectivity, when the professional questions and criticizes his practices, he is called to modify his relation with who governs it. Also, he is invited to change his relationship with himself and, then, making him more aware

of the ways that power affects his life. The palpable changes in work environments are the result of a relationship built on the other, the exercise of power relations and resistance from the ethical point of view, that is, the joining of collective possibilities that promote interpersonal relations and the maintenance of professional values in the coping with daily difficulties.²³

However, the Brazilian health policy attributes the responsibility of working in a service of utility recognized by the population that uses it to the SAMU professional.²² At the same time, it denies local knowledge and highlights the knowledge of the system to maintain it functioning, in its universal and integral logic of health care. The local knowledge of SAMU professionals, the one built in everyday practices is sometimes set aside in the face of the need to obey the rules of the system and to work in alignment with what is prescribed. In this sense, Foucault³ defends the union (instead of an opposition) of historical-academic knowledge and specific local knowledge. From this union, it is believed that particular historical events and forms of contestation of power produce certain forms of knowledge, discourses, and subjects.

Universal and equal knowledge for all is defined as truth. However, the localized and fleeting knowledge can respond according to the interests at stake, by the diversity of existing truths, linked to context, time, place, and language.²³ In this understanding, a blank space between the knowledge formed by the SAMU workers, who participated in the construction of the knowledge, the operation, and organization of this peculiar service, and the one placed as technical-scientific and legal knowledge for the service. The knowledge of these professionals is among the various issues relegated by institutional knowledge, such as those instituted by the Ministry of Health and/or the State and Municipal Health Secretaries for the operation and organization of services.

For Foucault,²⁴ social practices can engender domains of knowledge that not only bring up objects, new concepts, new techniques but also give birth to totally new forms of subjects and subjects of knowledge. The subject of knowledge is historical and its relation to the object or, more precisely, to truth itself, has a history. Thus, behind all knowledge, what is at stake is the power struggle.

Also on the importance of knowledge, it is necessary to consider how it can be understood in different ways. Some professionals claim that it is necessary to educate the population to know how to use the service correctly. Therefore, there is the discourse that an educated population could help them to organize their demand, although this is questionable because, by the very nature of SAMU's work, its demand-for-service scenario is unpredictable.

From the perspective of the professionals, if the population understood and used the service properly, they would fill

several system gaps, that is, solve the problem of demand organization and network overload conflicts. Thus, professionals understand that if the SAMU does not work as it should due to the lack of understanding of the patients, it is ignored the fact that, when being a network, the health system needs to be analyzed in a broader perspective, the various micro and macro-political points of this network.

In this sense, disciplinary power circumscribing daily life in the SAMU, seeks to work towards normalization and individualization of responsibilities, that is, it instills in the subjects, professionals, and patients the idea of co-responsibility for the fluidity of the system, shifting responsibility for the few investments in health for the large patient population of the service. Discipline is a specific power technique that refers to individuals both as objects and as instruments of their exercise, for the purpose of training individuals.^{24,25} To this end, three instruments are used – hierarchical vigilance, normalization, and examination – present in the daily work of SAMU.

The spatial and architectural structure, legislation and work organization in SAMU allow a different level of observation and control over professional actions. The professionals are submitted to intense processes of work in the name of a speech of maintenance of a service that cannot stop. These professionals emphasize the commitment to maintain the service, but at the same time, show that their limits are in most cases subjugated. The work is carried out in a picture that disregards the individual interests of its workers because they feel so involved in the process of maintaining the service that they cannot separate from the whole. It is the discourse of the gear that keeps the functioning of organizations, each individual is a key piece. They are inscribed in the interest of the other (patient and service), their concerns being translated into actions for the unconscious realization and maintenance of dominant interests.²⁰

Because they provide care on public roads and in people's homes, professionals are under pressure from society because they are more visible and act without the delimitation of a specific space for care. When working on the street, passersby stop to observe what happens and sometimes try to intervene, somehow, in the service provided.

Although the professionals who provide care in public roads are considered the eyes of the system⁴, this view is often overlooked by those who are in the Regulation Center, establishing a paradox between what is seen and experienced by those who are on the street and those who are working, based on protocols and operating procedures. Again, local knowledge is discredited in favor of knowledge established in protocols, that is, scientific knowledge. This can lead to conflicts between teams and demotivation.

These two perspectives – from the service location and the Regulation Center – are linked by questions that cross a

relationship of trust between professionals constituted in the daily work, is a challenge for the team. It is interesting to note that SAMU doctors intercalate their shifts between ambulance assistance and care at the Regulation Center. However, what should guarantee a better understanding of these paradoxical situations to strengthen the partnership between the central and the ambulance staff, in fact, seems to contribute negatively, leaving the professionals of the central most critical and questioning about what, in fact, is the place of care.

In the perception idealized by society, the SAMU is seen as a heroic service, which confers the impossibility of error and misuse of behavior, is also the target of surveillance of society. The interviewees emphasize their visibility vis-à-vis the population, due to the use of the uniform and the standardized ambulance. The use of standard uniforms constitutes a power device as it establishes a normalization standard.^{24,25} In the case of SAMU, this pattern becomes even more pronounced, since all ambulance crew members, regardless of their function, training, or performance, wear the same uniform.²² Uniformed staff often prevent them from going unnoticed in everyday activities, such as going somewhere to have a meal, drink water, or use the restroom. Their visibility favors they be constantly watched over by the population and by their own peers.

This surveillance of the society leads to questions about, for example, the delay of the ambulance to make calls, because they consider that the ambulance is not being used for the purpose for which it is intended. Even if improperly, these professionals agility in the care is charged that depends on other factors, such as the classification of risk and the type of commitment made by the Regulation Center, as well as the transit in the ambulance circulation routes.

Thus, visibility becomes a constant surveillance device, which is nothing more than a control mechanism not provided in the prescribed work, but being part of everyday work. The view of the population is conditioned to see the SAMU as a service that does not stop and is in constant care, forgetting that it is made up of human beings.

CONCLUSION

The daily practices in the Mobile Emergency Service of Belo Horizonte and the traditional formats on the discourses present in the daily work of this service were analyzed, as well as seeking to advance in the judgments of evaluative dualities of this service that classify it as good or bad, important or not, useful or useless.

SAMU is part of a bold project of emergency care, whose professionals travel to the patients to serve them in their needs, in different areas of the municipality, being the time of arrival at the place and transportation to a place with level of assistance necessary to the patients care as a quality criterion for patients

and professionals. Their specificities require multiple skills of their managers and health workers, since emergency care does not end in time with independent and self-limiting actions, but must be anchored and continue to determine the horizontality of care and the creation of a link to be effective.

In the analysis of the daily practices, it was possible to find the predominance of a hegemonic discourse, with the maintenance of relations of power, external and internal to the service. This discourse deals with the usefulness and essentiality of the service that simultaneously mobilizes SAMU professionals, not letting them stop because of difficulties, but also generates external conflicts with other services.

This research identified points that should be more deeply analyzed and discussed, such as daily surveillance of work and the recognition of service by society. It is expected that these paths may serve as inspiration for other research not only on SAMU but also on other services in the health services network in Brazil. This study had as limiting factor because it was performed in only one service, which makes any generalizations difficult.

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