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Work in the Healthcare Field: Artisanal or Industrial Models?

Hugo Spinelli¹

Work in the healthcare field: artisanal or industrial models?

This text analyzes work within the health field and the differences and similarities with artisanal and industrial work models. In this framework, we consider the object of work, the worker, the work process, relational and organizational aspects, industrial logics, and ways of acquiring knowledge, influence of the general management theory, the role of language, symbolic aspects and enjoyment. The humanizing elements that care work maintains as a type of artisanal work are highlighted, and the costs, not just economic, of reducing care work to industrial logics, with a subsequent depersonalization of the process not just for the worker but also for the user, health teams, health institutions, and social groups are discussed.

Key words: work; industry; health personnel.

El trabajo en el campo de la salud: ¿modelos artesanales o industriales?

Este texto analiza el trabajo en el campo de la salud y las diferencias y similitudes con los modelos de trabajo artesanal e industrial. En este marco se abordan el objeto, el trabajador, el proceso de trabajo, lo relacional, la organización, las lógicas industriales, las formas de adquirir el conocimiento, las huellas de la teoría general de la administración, el lenguaje, lo simbólico y lo lúdico. Se rescatan las dimensiones de humanización que mantiene el trabajo de atención/cuidado, en tanto trabajo artesanal, y los costos, no solo económicos, de reducirlo a lógicas industriales con la consecuente despersonalización del proceso tanto para el trabajador, como para el usuario, los equipos, la institución y los conjuntos sociales.

Palabras clave: trabajo; industrias; personal de salud.

O trabalho no campo da saúde: modelos artesanais ou industriais?

Este texto analisa o trabalho ao interior do campo da saúde e as diferenças e similitudes com os modelos de trabalho artesanal e industrial. Neste marco se abordam o objeto, o trabalhador, o processo

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de trabalho, o relacional, a organização, as lógicas industriais, as formas de adquirir o conhecimento, as impressões da teoria geral da administração, a linguagem, o simbólico e o lúdico. Resgatam-se as dimensões de humanização que mantém o trabalho de atendimento/cuidado, em tanto trabalho artesanal, e os custos, não só econômicos, de reduzi-lo a lógicas industriais com a consequente despersonalização do processo tanto para o trabalhador, como para o usuário, as equipes, a instituição e os conjuntos sociais.

Palabras chave: trabalho; indústrias; pessoal de saúde.

Introduction

Artisanal work accompanied the history of mankind almost since its beginning until the 18th century. Craftsmen worked in small shops installed in homes or near them and spent many hours on each of the products, which they carried out in their totality and without the idea of obsolescence. Thus, each one was original and, hence, different from others. Their production was low and was destined to the local market. Craftsmen worked alone or in small groups, performing their tasks by hand and using their own very simple tools. They had, in general, apprentices to whom they taught the occupational hazards. The group of craftsmen who shared the same occupation received the denomination of guild. As of the 18th century, the application of hydraulic energy bolstered the development of the Industrial Revolution, consolidated factories as places of labor, and changed the work processes.¹ The work instrument went from the tool to the machine, and from a man's hand to a piece of a mechanism. Use of machines was generalized and the division of work was installed. Capital was put at the service of this logic, while the artisanal seemed destined to become a part of history. Man ceased to be the driving force to become a natural force routed toward automation.

Two centuries later, Taylor was in charge of taking away "leisure" from workers by timing their movements and Ford, of "extracting leisure from the materials" by making them circulate in production lines.² Thereby, the rhythm came to be imposed by machines and workers became

objects in the organizational logic, which ignored the psychosocial dimensions of the work. What were the consequences? On the one hand, there was the decline of artisanal work and, on the other hand, alienation of the worker. In 1936, Charles Chaplin wrote and directed *Modern Times*, a film that brilliantly summarizes the meaning of the Industrial Revolution and the consequences of the advent of machines for work and for workers.

It was supposed that machines and the logic that emerged from them would dominate work processes, lower costs of goods, and increase profits. All this would bring wealth and progress; science would have an important role in this. These were times of modernity and the height of the Cartesian subject. In the organization's upper management, managers were called on to think; the rest of the personnel only had to obey, given that they were not paid to think. That is what Taylor taught entrepreneurs^{3,4} and it became common sense. Ideas of productivity, effectiveness, efficiency, supervision, control, and quality originated in industrial models were substituting the freedom offered by the artisanal work. Many decades later, the Technological Revolution reinforced those limitations through informatics and robotics, to the point of dispensing with the worker. The idea of the *golem* (an anthropomorphic creature created from inanimate matter), contained in Jewish legend and which Borges recreated in one of his poems, took on overtones of reality at the same time that it answered Henry Ford's question: why is it every

time I ask for a pair of hands, they come with a brain attached?⁵

The model of industrial work cannot be extrapolated to the healthcare field⁶ or to its paradigmatic organization: “the hospital”. In spite of that, efforts are made to introduce industrial logics into the healthcare field as forms of organization. If we analyze the work process within the healthcare field, we will recognize work dimensions more related to the artisanal than to the industrial and an organizational design quite removed from that pyramidal structure present in the social imaginary that was installed with the idea of the factory.⁶

Why is health work artisanal?

Tensions between artisanal models and industrial models run through the healthcare field, responding to distinct logics and interests. We will outline the principal characteristics of health work, analyze how much of it is artisanal (by its nature) and how much is industrial (through political-economic/ideological-cultural imposition).

1. The definition of the object to produce

It is difficult to agree on a definition on what “health” is. The constitution of the World Health Organization (WHO) defines it as: “a state of complete physical, mental, and social wellbeing and not only the lack of affectations or diseases”.⁷ The WHO takes in this definition ideas by Henry Sigerist (1891-1957), a referential figure of social medicine in the American continent.⁸ But that definition is impossible to confirm in practice. Readers are invited to think if they know any person who can be included therein. Do you feel included? Then, let us think: How many organizations in society cannot define the object they produce or upon which they work? Or, in how many organizations is the definition of that which they produce contradictory?

2. Intangible product

In most healthcare work processes in the healthcare field⁶ the product is not tangible, given

that it is consumed while it is produced. Has anyone ever been able to touch an emergency shift or a consultation? This intangible nature is not an intrinsic property of the healthcare field alone, but rather of the production of services in general. And this further complicates the domestication of a work process through the logic of industrial work without analyzing its singularity. The intangible nature of medical work – among others – was pointed out by Adam Smith who classified all the professions based on interpretations as those of lowest and unproductive labor, given that they did not produce any value.⁹

3. The object interacts

Taylor sought to domesticate the gorilla (the worker), but never thought of having to domesticate the object of work. In the healthcare field, the object tends to resist, interpret, question, and discuss the indications of the professional. An object that is also not subjected to the rules of logistics and is capable of moving beyond its area of residence, seeking attention and arguing with the most varied of explanations. The material on which industrial work is done is inanimate, which is why it meekly submits to the indications of the worker. In healthcare, the material is animate and interacts and defines processes and conducts. The patients participate so actively that they are often almost co-responsible for the work and even condition the results.¹⁰ A true heresy for industrial logic.

While books in public health insist that the first level of care is made up by health centers, first-aid stations, or similar entities, medical anthropology describes the family or household group as the true first level of care¹¹ and that, in general, it is the woman – within those spaces – who decides on attending a health organization. It is also the woman who reinterprets the indications received and decides/suggests/counsels whether or not to comply with them and for how long, whatever the scientific foundations of the indication.

4. Subjective dimensions in the work process

The work process in health can capture different subjective dimensions of the worker, whether political, religious, or affective. Have we not been part of moments in which a situation reached us at the emotional level and made us laugh or cry? Do we not see workers who, given certain vital situations of a patient and in function of their beliefs, pray or implore? Do we not act in certain moments immersed in ideological questions at work? How many workers can put these dimensions into play in their work process? If we think of common situations we will find it absurd to suppose, for example, that a baker places those dimensions in play in selling bread, or that the greengrocer does so when selling fruits and vegetables; we could continue with other examples without finding the subjective implications of health work.

5. Work is relational

Health organizations are based in interpersonal relations.¹⁰ The care process is a relational process in which subjects interact through verbal and non-verbal language, and the connection produced is fundamental to establishing a good care process. It is a subject-subject relation quite removed from the Cartesian subject and from the *res extensa*.^{12,13} Ignorance of this relational nature affects the connection and opens the door to a poor relationship and the possibility of violence. Much of the work product depends on communication and on the connection established in that relationship. Could we extrapolate this to any industrial example?

6. The factory that isn't, or who flipped the pyramid?

The pyramid, used traditionally as a figure that expresses the logic of power within manufacturing organizations, does not find in the healthcare field a fertile space to be reproduced, given the nature of work in these institutions. It is the freedom of the worker on the ground – the operational nucleus, as Henry Mintzberg calls it –¹⁴ that makes the pyramid flip; a displacement unimaginable to the factory

worker who endures the power accumulated at the apex of the pyramid. However, in health organizations, power is distributed; nobody concentrates all the power.^{10,15} This facilitates the creation of closed spaces of poor governability for the authorities. The aforementioned underscores the great dependence of the authorities within the organization itself. This knowledge – technical power – is not shared by the authorities and it is almost impossible for the authorities to acquire such knowledge, given that it makes up the core of the worker's specialty.

Workers use their knowledge – technical power – to escape from “supervision” and use that freedom in two ways: self-referenced in their subjectivity or engaged with the organization. In the first, from that self-referenced position they make their work in the public institution a place where they earn a salary without complying with the assigned schedule, a place from which they expect a future retirement, while at the same time obtaining “clients” and increasing their social and cultural capital. In their private work they will accumulate profits and will work the hours necessary to do so. This logic was strengthened by the cultural patterns imposed by the society of risk and multiple employment that resulted from neoliberal policies.^{16,17} In the second, engagement in the organization marks a difference in the quality of the work individually or collectively, which explains the high standards achieved in certain situations by the conformation of teams who manage to excel over the institution's median so long as that commitment lasts. A limit to autonomy is represented by the dependence of workers on resources – mainly economic – that are controlled by higher levels of public administration, which often obligates them to negotiate.¹⁰ The model of industrial work within the healthcare field⁶ can only be observed in some diagnostic and treatment areas, where machines were able to enter and replace human work. Neoliberal policies try to correct the pyramid's mutation – that is, its inversion – with the flexibilization of labor relations at the base of the organization – the operational nucleus – seeking to limit the existing margins of autonomy.

7. A very complex organization

Health organizations are quite complex, very different from other organizations in society.¹⁰ These organizations work 365 days a year, 24 hours per day. The demands faced in the work, in general, are based in pain, disease, anguish and/or suffering. Death is a – possible – event within the work process, as is accompanying the lives and births of people. Their workers – professionals and non-professionals – accept working 24 hours straight in emergency shifts, which are carried out every day of the year, and unions rarely take issue with that labor situation bordering on absolute surplus value. A situation in which, for example, during the 23rd hour of a shift, professionals may have to perform a complex and delicate operation that requires their greatest attention, although it is possible that they have gone for over 20 hours without sleep. Or, sometimes, after having worked for 24 hours, workers will continue seeing patients for another four to six hours in that institution or in another, where it is not unlikely that another 24-hour shift is assigned.

The complexity of the organization is also expressed in the diversity of professionals, technicians, and trades working in it. A publication from the early 1990s identified no less than 300 employment positions distributed in the different spaces of a hospital.¹⁸ Hospitals today no longer have just physicians, nurses, and social workers; they now incorporate odontologists, administrators, biochemists, psychologists, lawyers, sociologists, communicators, accountants, information technologists, biologists, nutritionists, pharmacologists, bioengineers, translators, architects, chemists, kinesiology professionals, and teachers, among others, each profession with its own logic and technical language. But, additionally, a hospital may have among its staff gardeners, barbers, drivers, cooks, electricians, carpenters, maids, telephone operators, elevator operators, managers, laundry staff, waiters, etc. Many of those professions and trades function in society as individual organizations, but in the hospital they are all together – and must be directed!

8. Quantification of production does not reflect success or quality

If we observe the work of any professional from the healthcare field we will see that it is dominated by the artisanal, and behind the illusion of “scientific objectivity” the daily practice seems more like that of the craftsman than that of a machine. Hence, in terms of industrial logic, their work appears chaotic because it is almost impossible to standardize and/or measure productivity objectively, so much so that we cannot predict what will be produced, how much will be produced, how much will be spent in that production or ensure that the actions of workers are correct. Industrial work has, in the quantification of production, an objective element of control over work. Processes must be standardized so that they can be controlled and evaluated, which is considered a basic pillar of the industrial organization. However, in health organizations processes are quite diversified, present unstable or varied input-product relations, and implicate different sectors that generate products and results difficult to specify.¹⁰

What is carried out cannot always be measured, or that which is measured is not synonymous with quality. Therein the old adage that “measuring the efficacy of a hospital by the number of discharged patients is akin to measuring the efficacy of an army by the number of bullets fired”. Nevertheless, with industrial logics persist and 15-minute consultations per patient are imposed, as if all demands were equal, involving the same problems, within a process similar to manufacturing nuts and bolts. When the industrial model invades the healthcare field and establishes set times for tasks, in general, it does so at the expense of the professional’s ties with the patient and with the community, with no guarantee that the time assigned expresses efficacy or efficiency.

The singularity of health work makes the elaboration of costs quite complex, given that it is not known what will be produced, because the demand itself is unknown and/or imprecise in its complexity. Thereby, it cannot be affirmed that a healthcare model executed through a Fordist

conception always controls costs and increases profits independent of time.

Richard Sennett states that workers from the National Health Service (NHS) in Great Britain believe that the measuring processes they are subjected to affect the quality of their work. The entrance of Fordism into the NHS led to the division of the work process and affected the quality of care;¹⁹ inventing diagnoses and/or procedures was how workers managed to create more time for their patients beyond that stipulated by controls.¹⁹ Physicians and nurses from the NHS do not suffer so much from the work they do, but from the way it is organized.¹⁹ The purpose of scientific management was always to put an end to trades so as to end worker control of production times, which is achieved through automation.¹⁹ Artisanal work, as the model of health work, requires time not of these times.

9. Capital is not in the machine but in the worker

Industrial development made machines the core of the factory, which became the logic of intensive capital: as machines were incorporated, the number of workers was reduced. The efficiency and efficacy of work remained directly related to machines that, over time, grew increasingly sophisticated and hence encompassed more parts of the work process, to the point of dispensing with the laborer. In contrast, work in the healthcare field – as in other social areas – is intensive human capital; for it to be more efficient and effective it requires more workers and not more machines, because work is based on people not only as workforce, but also as intelligence, feelings, and emotion.²⁰ This has social relevance because few sectors of the economy require the generation of employment to be more effective and efficient, and this is of particular importance given the problem of employment currently faced by young adults.

The NHS was the entity that offered the greatest employment in Great Britain¹⁹ and, in Argentina, in 2012, 4.4% of the economically active population

worked in public health, private healthcare, and social security organizations.²¹ The talent of these workers, the ties they construct, the domain of the symbolic, the knowledge they have of the organization and its members is a value that tends to increase over time and makes the workers the organization's principal asset. These are virtues machines do not have and capital that cannot be entirely transferred and which is therefore lost when those workers leave the job or retire.

10. Alienation and elucidation

The health of health workers has not been vastly studied²¹ and this hinders discussing the process of alienation and elucidation that can be related to their work. The alienation process described by Hegel and further broadened by Marx²² indicates the process through which workers lose the meaning and sense of their work: although Marx also indicates that work is not only alienation and that as workers change reality with their work, that reality changes the workers.¹ Both situations can be found in health work. The alienation process is described through the silver screen, in distinct eras and films, from the already discussed *Modern Times* (1936), *The working class goes to heaven* (1971), or *Human resources* (1999). All these show the alienation of the worker as product of repetitive work that does not provide the subject sense or meaning. But it is wrong to reduce health workers to the role of victims – above all professionals – given that they have control over their work through the exercise of technical power.^{15,21}

That freedom, inasmuch as workers understand that doing is thinking, may be inscribed in the concept of *elucidation* formulated by Castoriadis (doing what one thinks and thinking what one does),²³ which places the worker on the antipodes of alienation and empowers the worker as a subject of change through his or her work process as micropolitics.²⁴ This means channeling the power in order to strengthen the institution in which the work takes place.

11. The influence of the general theory of management is not enough to annul the game

The influences of the trends of thought of management in the healthcare field are multiple and accompany its centennial history. Promoted by capital, these place production in the center and subordinate work process to it. Throughout the history of the general theory of management concepts were created, which were applied in the healthcare field. They make up a long list among which we may cite: Taylorism, Fordism, competitiveness, Toyotism, total quality, reengineering, marketing, empowerment, coaching, etc.²⁵ All are related to productive and/or organizational models that seek to introduce an industrial logic into the healthcare field, but do not always succeed in doing so, nor does evidence exist that they improve the health situation of the people.

Mission, vision, values, quality, organizational diagrams, norms, and regulations constitute dogmas of the general theory of management upon which industrial work is instituted with few or no deviations; when deviations do occur it is likely they will be easily detected. In the pyramid-type structure the bases report and bosses order in a clear division between doing (hands and feet) and thinking (head), which has been incorporated into socialization processes²⁶ and installed as something natural. In the factory, upper management may, if necessary, reformulate any of the norms, regulations, and organizational diagrams to increase efficiency, efficacy, and control over products and the work process, reformulations which will then be applied, not without resistance, but finally accepted as part of the rules of the game.

But if we look at a health institution, we will find a very different world. The mission is unknown by a vast majority of its members who work in isolated manner, which in common sense translates as something “full of feudal divisions”, “each playing his own game”. Perhaps at some point quality standards were drawn, promoted, and financed by an international organism, and

just as they were established they were forgotten. In the hospital organization, strange things occur from the industrial point of view, to the point that when hospital workers talk about their work with industrial workers and the latter realize the levels of autonomy and freedom hospital workers have, they state: “what you do is not work”. This is due not to the organization’s nature, but to the nature of the work that generates such an atypical placement of the pyramid (inverted). Hence, in general, the influences of the general theory of administration do not manage to affect the essence of the artisanal work that constitutes the core of well-done work among professionals of the healthcare field.

12. Nomadic and sedentary workers

Industrial workers must remain most of the time next to machines; that is the place that, in general, defines whether or not they are working. In the healthcare field, workers do not need to be next to the patient to work; they can be away from the patients and still be working, they may not see or touch them for several days and yet still may be working with these patients, because they are thinking of something that should be done, or because they speak to other professionals about indications to be administered. That possibility of working away from the “object” is a clear difference with respect to industrial workers and grants health workers a nomadic nature.

13. Specialized knowledge is acquired outside the organization

In the factory, in general, knowledge is acquired within and it is there where the forms and times of the work process are defined. If new skills are needed, upper management in the organization decides where and what will be learned and, if necessary, finances the learning. Little of this occurs in health organizations, where technical knowledge – above all – is acquired outside the organization, whether through university formation in graduate courses, scientific journals, specialist associations, and/or conferences. This opens the possibility of applying – without consulting the

organization's upper management, or mediating estimation of costs or viability of the expense – diagnosis and/or therapeutic processes. This is further complicated by the fact that within the same specialty and the same organization, procedures and/or contradictory therapies may coexist due to different economic interests, conceptions, and/or knowledge. Therein the multiplicity of models of care that coexist to address the same problems in the healthcare field. Imagine that situation in an industrial organization, for example, an automotive factory: would such a thing be possible?

14. The infinite task

Industrial work, because it is tangible, does not necessarily capture the subjectivity of the worker. This reality differs from that of healthcare workers who, upon engaging themselves in the relational process, discover that their task is almost infinite and that their heads, with relation to the problem, do not function with an on-off logic; on the contrary, at any moment and without them meaning for it to happen, memories return to their conscience that distract them, and they are reproached by their family group for their inability to keep work outside of the house. This situation is much easier for industrial workers, given that their inter-subjective interactions are fewer. All of this provokes anguish in health workers, who see that the more they do the more work they have, given that they do not interact with simple problems in which the logic of the solution functions but rather with complex problems where there are no solutions, just new situations that are good for some and bad for others and which do not always give them a sense of having completed the task.²⁷ For this reason, at times the worker chooses not to commit and to remain distant as a form of self-preservation; but this is a mistake, as the price paid is not small.

15. Error may not in fact be error but novelty

Industrial work manages to standardize its products and define them precisely, thus, control is effective, giving way to the role of the

supervisor and/or foreman who detect errors. Rather, in health work, we cannot always comply with this logic that, although existent, is not dominant. Such error, understood as a deviation from the standard, in healthcare many times it is not in fact an error but rather a new way of presenting the problem and/or disease, and thus there is no certainty that if identical algorithms are followed the same results will be obtained in different individuals. For this reason, error can be the motive for new learning, not only for the individual, but also for the institution. Singular processes are not strange as in the factory, they are more common; thus the saying “there are no sicknesses, only sick people”.

16. Tension between practical sense and university formation

Health workers are stressed by their work, given that they perform it one way, but think it should be done in another. This last thought corresponds to the socialization processes that had – or were perceived as – pyramidal or mechanized models of organization.²⁶ This should not be adjudicated to the university formation that, generally, omits problematizing the issue of organizations.

Few institutions have the quantity of university alumni that the healthcare field does, but these professionals, formed within a Cartesian conception of the subject and influenced by Enlightenment principles, suffer upon seeing the dynamics of the organization's work process and logic of functioning. In their rational model, they expect a certain way things “should be” to be fulfilled: a pyramid with an upper management that gives orders and that subject-patient that becomes an object, as well as a future that is predictable and planned. They seek in graduate courses tools to make up that machine they imagine. The subject of reason drags them toward dreams and illusions that are not fulfilled, but at the same time they realize that they themselves do not comply with what is expected, and that their practices are different from what their head dictates. That stress disorients them and they suffer, because what is not understood causes

suffering. Little is known of practical sense and of *habitus*.²⁸ But because they do not know that they do not know, workers continue waiting for what they desire and at the same doing something that they do not know how they learned but which serves them to solve problems, albeit not as they in a Cartesian manner desire. Stressed by that situation – which often makes them ill – they see how the institutional life continues without modifications in spite of the changes in the authorities and with an everlasting sense of being at the edge of a precipice. Sennett indicates that upon separating the head from the hand, science from technique, and art from trade, the head suffers and both comprehension and expression are damaged.¹⁹

17. Non-replicability of what is done

Industrial logic instilled the idea of the matrix: once the prototype is achieved, it is developed at industrial scale. This is a highly successful model limited to managing “objects”, but impossible to apply in the healthcare field where work is done with subjects. Nonetheless, we witness daily attempts and proposals to transfer successful experiences of a service, a care model, an organizational model of a health center or municipality, and/or nationalize experiences as if we were to find the same people, desires, passions, stories, and cultures. Often, international organisms bring proposals that force the entry of manufacturing logics obsessed with standardizing relational processes as if they were akin to assembling pieces of the same machine in different places.

The experiences of the healthcare field are quite difficult to extrapolate and, if they are extrapolated, they will have the place’s unique singularities, so that they will never be 100% equal, something which to industrial logic is a sign of error.

18. Work combines art and science

If we analyze the care process of a professional, we may see – in general – that, at first, the diagnosis is guided by intuitions based on knowledge and experiences, that generate “speculations” (up

to this point more art than science) and then, over time and with the help of the evolution of the process and/or of complementary studies a diagnosis may be affirmed (here, science dominates), although many times the affirmation will have to be reexamined and the process started anew. In synthesis, we may say that uncertainty dominates prospectively and science dominates retrospectively. How much art and how much science? It is defined in each connection established, in each situation, in each game, without failing to recognize that there is no art without theory behind it and vice versa.

19. The Tower of Babel

If we observe the work process in health, it is notable that its principal tool is language – verbal and non-verbal – unlike with the industrial worker who needs hands or feet and who Taylor silenced, ordering for words to circulate in written form to limit subjective dimensions and avoid distractions that affect productivity.³ On the contrary, health workers speak – and with words make things happen!²⁹⁻³³ The people who hear them may lay down or stand up; laugh or cry; become happy or sad; dress or undress until nude. And if we again look at the workers, they only pronounced words. This indicates the strong symbolic dimensions of work that go beyond the original conception of the artisanal and which permits understanding the organization as a network of conversations.³¹

Language creates links and relationships that impact both in the subjectivity of the worker and that of the patient, in a relationship that has the potential to transform the subject and grant meaning and sense to his/her work and thus constitute a reason for that work in that place.³⁴ Health work has a component of abstract work, strongly linked to the symbolic.¹⁵

Health work constructs a lexical field³⁵ with certain unique synonymous relationships that, outside that field, would be contradictory. For example, the use of concepts of health and disease that, although opposed, within the healthcare field tend to be used one in place of the other, provoking relations

of synonymy: they are called health institutions and health workers when they, in reality, work most of the time with disease. That the success of a work team, of a service, or of an institution depends more on the ties, on the narratives, and on the sense of belonging than on the scientific and academic background of its members reflects the profound symbolic dimensions this work has and which makes it pertinent to imagine it as a field of symbolic battles. For Hannah Arendt, it is speech and action that characterizes humans⁹ and health organizations are clearly human: people caring for people. That human nature is what industrial logics try to overshadow.

20. *Homo sapiens*, *homo faber*, and *homo ludens*

In health organizations, we find the *Homo sapiens*, the *Homo faber*, and the *Homo ludens*. Notwithstanding the efforts of functionalism to think of those organizations as systems that follow rational models, they are far from that. The ludic aspect, that is, play, runs through them and constitutes them. It is a complex game, of changing rules, of violation and production of rules, capable of producing joy, anger, and indifference, where the ability to play overshadows scientific knowledge in the effectiveness of the plays of many of the players. Playing should be encouraged; that is, the slogan should be “play, play, play”, given that it is an organization more permeable to game than to order and assigned roles. It is team work comprised of people, where machines are secondary in most of the work processes. The results of the game depend more on soft technologies (connections) than on hard technologies (machines).²⁴ In the game, as the work takes a central role, the group will become operational.³⁶

Health artisans: final reflections

At the beginning of this essay we asked: why is health work artisanal? We have mentioned aspects we consider predominant as responses, without precluding other visions as expressions of the possibilities that result from the interaction of the players of the field, their plays, and their

contexts; nor do we think that what we have described has rigid and inflexible boundaries. We consider health work artisanal due to diverse reasons: it is done at a reduced scale, using simple tools most of the time; the work is done individually or in small groups, independent of the size of the organization that contains them; there are apprentices to whom the work is taught; each patient is unique and unrepeatable; in the care process the hands, brain, and/or feelings are used and mediated by verbal and non-verbal language; and fundamentally because the work done in this way has yet to be bettered by any machine.

We continue recognizing that artisanal work takes more time than industrial work, but in the long run it is more effective because it works at the singular level and there is no planned obsolescence if it is well done.³⁷ Additionally, artisanal work consumes less renewable resources and does not contaminate, while industrial work is contaminating and consumes non-renewable resources. Although industry is a source of wealth, it is also a source of disease, while artisan work has the potentiality of being a source of wellbeing and employment. Growing for the sake of growth in a finite planet is not rational; hence, we postulate the model of artisanal health work, not from a place of nostalgia, but rather as a new ways of thinking about work in the healthcare field. And we highlight “new ways of thinking” because it is not about “new ways of doing” given that, by nature, health work is artisanal. What is important is that the worker-subjects at the individual or collective level may elucidate their work process so as to understand and accept themselves as artisanal workers.

Health organizations are quite complex and very different from other organizations of society, for the reasons already exposed. This is why we propose the need to think of work and denominate these workers “health artisans”, postulating a highly humanized and singular work marked by the meeting of – at least – two people: the health worker and the user who requires care. As indicated by Hannah Arendt: “we can only achieve a more human material life if we better

understand the production of things”.⁹ The craftsman’s mark of identity was that of doing good work, a definition given by the community in the traditional world.¹⁹ Control exerted by social groups over the trade union – making an allusion to the verdict the group of craftsmen received – is the very proposition we make: for social groups to again have the right to define whether the work conducted by health workers and their institutions is good work, and for this definition not to rest only in the hands of science, without ignoring what abstract work grants to the “shaman of the tribe” and the limits that places on the idea of social control.

We understand that no development or strengthening of public health services is possible without the active participation of its workers, the critical mass – in quantity and quality – without which it is impossible to think of transformations in the healthcare field.⁶ This does not imply simplifying the complexity of the field, or supposing they play alone and that there are no other players with different interests. It is necessary for these workers to understand the potential for the change they have in their hands given the singularity of their work process, hence, the centrality we recognize in the micropolitics²⁴ that understands workers as organizers not only of their work process, but of the relational processes they establish and the ties they construct with users, teams, the institution, and the community.³⁸

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