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Prehospital teamwork life support service for traffic accident victims*

O TRABALHO EM EQUIPE NO ATENDIMENTO PRÉ-HOSPITALAR À VÍTIMA DE ACIDENTE DE TRÂNSITO

EL TRABAJO EN EQUIPO EN LA ATENCIÓN PREHOSPITALARIA A LAS VÍCTIMAS DE ACCIDENTE DE TRÁFICO

Waleska Antunes da Porciúncula Pereira¹, Maria Alice Dias da Silva Lima²

ABSTRACT

The objective of this study is to characterize prehospital teamwork service for traffic accident victims, identifying the actors' activities, the teamwork and the relations with actors from other areas. This is a qualitative study, in which data collection took place by observing the events that occurred at a public service in the city of Porto Alegre, in addition to interviews with each professional involved in the service. The results showed that prehospital care is founded on teamwork and that the understanding among professionals should go beyond the historical hierarchic relation existing in health organizations. There is a need to value the broad field of knowledge, which is associated with the core of care activities that meet most trauma victim needs.

KEY WORDS

Accidents, traffic.
Emergency relief.
Emergency medical services.
Patient care team.

RESUMO

O estudo tem por objetivo caracterizar o trabalho em equipe no atendimento pré-hospitalar às vítimas de acidente de trânsito, identificando as atividades dos atores, o trabalho em equipe e as relações com atores de outras áreas. Trata-se de uma pesquisa qualitativa, em que se utilizou, para coleta de dados, a observação das ocorrências atendidas por um serviço público de Porto Alegre, além de entrevistas com todos os profissionais envolvidos nessa assistência. Os resultados demonstram que o atendimento pré-hospitalar está alicerçado no trabalho em equipe, sendo fundamental um entendimento entre os profissionais que transcenda a relação hierárquica historicamente encontrada nas organizações de saúde. Evidencia-se a necessidade de valorização do campo de conhecimento ampliado, que está associado ao núcleo das atividades cuidadoras, e que responde à maior parte das necessidades apresentadas pelas vítimas de trauma.

DESCRIPTORES

Acidentes de trânsito.
Socorro de urgência.
Serviços médicos de emergência.
Equipe de assistência ao paciente.

RESUMEN

El estudio tuvo como objetivo caracterizar el trabajo en equipo durante la atención prehospitalaria a víctimas de accidente de tránsito, identificando las actividades de los actores, el trabajo en equipo y las relaciones con los actores de otras áreas. Se trata de una investigación cualitativa, en que se utilizó, para recolectar los datos, la observación de las ocurrencias atendidas por un servicio público de Porto Alegre y entrevistas con todos los profesionales que participan en esa asistencia. Los resultados demuestran que la atención prehospitalaria está basada en el trabajo en equipo, siendo fundamental el entendimiento entre los profesionales, lo que trasciende la relación de jerarquía, históricamente encontrada en las organizaciones de la salud. Se evidenció la necesidad de valorizar el campo de conocimiento ampliado, que está asociado al núcleo de las actividades del cuidado, y que responde por la mayor parte de las necesidades presentadas por las víctimas de trauma.

DESCRIPTORES

Acidentes de tránsito.
Socorro de urgencia.
Servicios médicos de urgencia.
Grupo de atención al paciente.

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INTRODUCTION

Mobile prehospital service (PHS) is a new health service in Brazil, and is part of the emergency service system. Its purpose is to provide care services to people in emergency situations at the place where the events occurred, so as to guarantee early and appropriate assistance, and the user's access to the Health System. These emergency events can be clinical, surgical, traumatic, or psychiatric, all of which cause suffering, temporary or permanent sequelae, and may possibly lead to the victim's death⁽¹⁾.

PHS can have a positive effect on trauma morbidity and mortality rates. Over the last two decades, traffic accidents have been one of the leading causes of death by external causes in the state of Rio Grande do Sul, representing 26.6% of these deaths in 2006⁽²⁾. In terms of the assistance given to traffic accident victims, mobile prehospital service helps reduce accident victim mortality and minimize the sequelae caused by a late or inappropriate first aid service⁽³⁾.

In everyday PHS practice, the work is structured based on technological devices and in establishing relationships between the team members, especially when assisting traffic accident victims, which implies there are several areas involved in the service. This work is collective and its outcome depends on the actions of each of these professionals, who work according to their specific knowledge and practices, and by their combined work. These actions are developed by several professionals, according to the specialties, competencies, and responsibilities of each team member.

In collective work there is always room for dialogue, for reflection, and for making decisions as a team, all for the purpose of achieving one objective: the quality of the care that is offered. Communication and interaction are essential tools in this job, through which the worker introduces changes to the existing power relationship, either between the involved professionals or between professionals and healthcare users⁽⁴⁾.

Teamwork is a modality of collective work that consists of a reciprocal relationship between the technical interventions and the agents' interaction. In the relationship between work and interaction, professionals build agreements that comprise a common service project that guides the whole integration of the work team⁽⁵⁻⁶⁾.

The purpose of the PHS in assisting traffic accident victims is to keep them alive until they can get to a hospital, where cure can be effected or fatal sequelae can be avoided, improving outcomes and saving lives⁽³⁾. Considering that the focus of the work is the traffic accident victim, and the time to complete this purpose is extremely short, there is a need to organize the team work in PHS.

The publications regarding mobile prehospital service are still incipient in Brazil, especially those focused on team-

work in situations involving traffic accidents. Therefore, since this study focuses on the interaction between the multiple professionals involved in this type of service and on the articulation of the actions performed, it can contribute to the organization of the work process.

In view of the questions that were raised, the purpose of this article is to characterize the teamwork of prehospital service to traumatized traffic accident victims, in the city of Porto Alegre, Rio Grande do Sul, identifying the professionals and the teamwork, as well as the relations with professionals from other areas.

METHOD

This is an exploratory descriptive study, using the qualitative approach as the methodological framework⁽⁷⁾. Data collection was performed through participant observation and semi-structured interviews at the Mobile Emergency Service (in Portuguese: *Serviço de Atendimento Móvel de Urgência - SAMU*), which is part of the Municipal Health Secretary in Porto Alegre. It is a public municipal service that provides care in clinical or traumatic emergency situations, in public or domestic environments, in addition to simple or medical patient transportation.

The publications regarding mobile prehospital service are still incipient in Brazil, especially those focused on teamwork in situations involving traffic accidents.

The study subjects were the Mobile Emergency Service professionals involved in service to victims: i.e., physicians, nurses, nursing auxiliaries or technicians, drivers, and also firemen, whenever they worked directly with the health team.

The observations were performed together with the teams that assisted at traffic accidents during times when there were a higher number of these events generated by the 192 phone system at the Porto Alegre Mobile Emergency Service Regulation Center. The observations were recorded in a field diary, as per the timetable established by the analysis of the information in the regulation files of 1310 traffic accidents assisted in the period from June to September, 2003⁽⁸⁾. A specific guide script was used, with the purpose of reporting the events and the involved teams, to describe the activities developed by those professionals, the aspects related to the work organization, and the relations between the team members and among the other teams involved in that service. Fifteen observation periods were carried out, corresponding to a total of 70 hours.

The people were chosen for the interviews based on the criteria for a qualitative approach, so as to benefit the social subjects who had the attributes that were being investigated and comprise a group of diversified informants. In this way it was possible to find similarities and differences⁽⁷⁾. The subjects were selected according to the number of events (included in the observation) in which they were involved. The interviews contained questions that addressed the professionals' opinions about the work they

performed in the PHS and the relationships that they established with others in this work process. The criteria used to determine the number of necessary interviews was that of data saturation, which was obtained with 12 interviews, involving three nurses, three nursing auxiliaries or technicians, two physicians, three drivers, and one fireman who was also a nursing auxiliary.

The study was approved by the Research Ethics Committee at the Porto Alegre Municipal Emergency Hospital, under document number 046/2003. The subjects signed the free and informed consent form, according to the ethical aspects contained in the National Health Council Resolution 196/96⁽⁹⁾.

Data analysis was performed following qualitative method guidelines: ordering, classification by relevance, synthesis, and interpretation⁽⁷⁾. The obtained data were classified and organized according to their relevance. The analysis categories that were used incorporated the contributions regarding team work typologies characterized as grouping team and integration team⁽⁶⁾ and the central concepts for caregiver, according to the professional and according to the problem, which coexist in the production of a health action⁽¹⁰⁻¹¹⁾.

RESULTS AND DISCUSSION

The organization of prehospital care service

Prehospital care is a recent organization as a health service, supported by normalizations from 1998. Before this period, prehospital care worked by means of a partnership between the Fire Department and the Municipal or State Health Secretaries, in an articulation between firemen and physicians. The Health Ministry normalizations strengthened the civil aspects of the constitution, which characterizes PHS as a responsibility of the health arena, under the coordination of a physician, according to the clinical health care mode, characterized by the implementation of health care protocols.

This reorganization of the PHS caused a rupture in which the health team, represented by physicians, became the leader in the process, while firemen, who once had the main role, now play a secondary part, together with other professionals that are not from the health arena.

The Fire Department played an important historical role in the prehospital system, before the policy represented by the Mobile Emergency Service (SAMU). In 1990, when the National Program for Facing Emergencies and Traumas was implemented, the prehospital care services linked to the Fire Departments in the cities of Rio de Janeiro, Curitiba, São Paulo, and in the Federal District not only provided the care services but were also responsible for training programs. There was a large investment in training instructors and standardizing the educational content, so as to train each fireman in each state of the country. This initiated the

process to implement and improve the Mobile PHS provided by the Military Fire Department across the country⁽¹²⁾.

In Rio Grande do Sul, PHS was initiated in 1989 through the service organized by the Fire Department. Nine years later, the first ordinance published in 1998 by the Health Ministry brought the responsibility for prehospital care to the health sector. Before this, prehospital care was developed exclusively by the Fire Department, as in the state of Rio de Janeiro, or through a partnership with the Health Secretary, as in São Paulo and Paraná.

In the state of Rio Grande do Sul, the Health Secretary took the place of the Fire Department in providing PHS. This became evident through the interviews and by the number of calls answered by both services, considering every traffic accident with victims registered in Porto Alegre in the period from July to September, 2003. At one moment, the PHS was responsible for 81% of the accident calls, while the rest were answered by firemen, the military squad, the city's Public Collective Transportation Company, private companies; some victims were transported by their own means⁽⁸⁾.

There has been unequal communication and cooperation between the Mobile Emergency Service (SAMU) and Firemen models of prehospital care in Brazilian cities. Administrators and professionals see the Mobile Emergency Service (SAMU) as a valuable initiative because it is capable of adding more resources and guaranteeing a broader coverage. However, it is also considered a loss of political space and financial support by the Fire Department, an institution that, over decades, has added much experience to PHS. This new reality demands the creation of new arrangements and articulations that involve both collaborative and conflicting aspects⁽¹²⁾.

In terms of traffic accident assistance, other actors are involved besides the PHS team, including agents of the Public Collective Transportation Company, the military police, firemen, and, in some cases, even the population. To ensure that the service is successful, everyone involved must be well prepared or there can be irreversible outcomes⁽¹³⁾.

In PHS there are techniques that should be known by the rescuers involved in assisting the trauma victim. These techniques include: opening the victim's airway, immobilizing their cervical spine, using the KED, immobilizing the standing or lying victim on a board, immobilizing victims with fractures, controlling bleeding, and others. All of these are not the exclusive domain of health professionals, but comprise basic life support service, which can be performed not only by firemen but also by the military squad and even agents from the Public Collective Transportation Company.

Assisting traffic accident victims

The basic support teams consist of the nursing technician and auxiliary and the driver, though during the observation periods there was a nurse who filled in for a nursing auxiliary who was on vacation.

The service activities are performed by the nursing technician or auxiliary based on their evaluation, and the physician is asked for instructions only when there is any difficulty in choosing the most indicated procedure, or if the situation is too severe and demands medical evaluation and intervention.

[...] When they (nursing auxiliaries) are alone, that's what they do: they puncture the patient, they just don't intubate, of course, they don't aspirate, they do everything they have to do, ... before the nurse is there (E1).

This situation, in which the nursing auxiliary performs all the necessary care, completing his or her tasks regardless of them being ordered or supervised by the nurse, has already been observed in studies regarding the organization of the nursing team's work⁽¹⁴⁾. Although the logic of work organization is to divide work equally, a complete expropriation of the work conception is not observed, which was also seen in the PHS, since there is an expectation of autonomy so rescuers can make decisions in each specific situation.

This work organization model is similar to that found in Intensive Care Units (ICU), where workers perform integral care, presenting a more global view of the patients' needs, which favors a more creative work style. These services, as with PHS, are for people in a risk-of-death situation, who need the care from professionals capable of continuously evaluating their evolution and making the necessary adjustments, which is something that is not possible with an equal work division. In integral care, tasks are performed in the health care context and not as stand-alone tasks. This allows for a more cooperative and comprehensive care, in which the gap between knowing and doing is smaller, leading to a possibility of changing the work division in nursing⁽¹⁴⁻¹⁵⁾.

By observing nurse auxiliaries' work in PHS it was identified that they have considerable autonomy when deciding which procedures are necessary in each situation. The protocols and guidelines for this service that support the professional when evaluating the patient's situation are important tools, together with the permanent contact with the regulating physician. The nursing auxiliaries develop actions and thus take over a certain space in the work process, being autonomous in their contact with the patient. This permits the existence of several ways to provide technical-healthcare interventions, confirming previous analyses⁽¹⁰⁾.

The drivers are present in both the basic support teams and in advanced support teams. Their job is to drive the rescue vehicle (ambulance or a fast vehicle), besides working as rescuers.

[...] that is how we work, we help the auxiliary, or the nurse, or the physician, we help according to the conditions (DO2).

[...] when there is only one person, it's just the rescuer and the driver... the driver always helps. So the rescuer will do the first evaluation, ... to check on the victims and the driver opens the ambulance door and takes the material out [...] (B1).

Although some reports show that there is little difference in the work done by professionals in the teams, it was clear that the drivers have an assistant position in assisting the nurses and physicians, including in the Fire Department's PHS team. It was apparent that there is a need to prepare all the professionals that comprise the prehospital team, especially the drivers, because although they did not receive any education in the health area, they are indispensable in the service provided by the basic support teams with only one nursing auxiliary or technician and the driver.

In addition to the theoretical basis for this service, there is a need for practical training so as to know the techniques and equipment used in this type of activity, because when the rescuers are not adapted or sufficiently prepared, the service is below standard. Furthermore, another consequence is that the service might take longer and rescuers who are more prepared can face a work overload, since they end up handling the service basically alone.

The team providing the service is reassured and supported by the guarantee that there is always a physician on standby to help, who can be contacted at the Regulation Central via radio or mobile phone. In some situations there can be communication problems, such as equipment failures or locations where conversation is difficult, and this requires the rescue team to take on more responsibility, since they are alone to make the necessary decisions in each specific situation.

The nurse's role in the prehospital service is to coordinate, integrate the team, and collaborate with the interrelations between the multiple actors involved, besides being recognized as the nursing team coordinator. He or she becomes a link between administration and health service, between medical regulation and the rescuer team, and between the service coordination and the team, since she moves about in every area, working with the basic team and with the physician in advanced support. He or she administers the service, supervises the team, and provides permanent education to the teams of nursing technicians and auxiliaries, drivers, and other professionals, such as the agents from the Public Collective Transportation Company. This role that nurses play, of working in multiple roles and sectors, is also present in other areas of the health system, such as Emergency Systems⁽⁴⁾ where they coordinate the nursing activities, articulate, supervise, and control the work dynamics, select patients with greater risk as per the determined priorities, and establish a connection between the medical work and all other workers, sectors, and services.

In more severe situations of prehospital service, the physician is always consulted, either at the location, when present, or via radio. The nurse, when at the location with the basic support team, assumes the role of coordination and communication with the regulating physician, but if the nurse is busy with a procedure, the nursing auxiliary can be asked to communicate with the Regulation Central.

When assisting at the events, the physician works only on cases which the regulator considers being of greater severity, determining the need to send an advanced support ambulance with the respective team or a fast vehicle to help the basic support team from a decentralized base:

[...] So the physician will make a difference in cases that are more severe. [...] Those are... procedures that are exclusively of the physician's domain (ME2).

In the advanced support service, the team works according to the knowledge hierarchy, in which the physician responsible for the diagnosis and for prescribing the treatment assumes the coordination of the process. The physician evaluates the patient's condition and the nursing team performs the actions that are considered necessary. This often occurs in the ambulance which is parked at the location or is moving, and the driver assumes the most peripheral position, helping the team or driving the vehicle.

There are situations that do not require invasive procedures that would be the exclusive responsibility of the physician; in these cases the physician works like the other professionals, performing the same actions. Since the priority is to save the life of the victim, the severity of the situation is what determines when the physician assumes the coordination of the service.

In the service, there is always a rescuer who coordinates the team's actions. This coordination is established when the event occurs and may not follow the hierarchy criteria, but takes into consideration not only the technical knowledge but also the experience and the position that the rescuer assumes the minute the service was initiated. This coordination position is generally assumed by the first to reach the victim or by the one who assumes immobilization of the victim's neck.

So, whoever reaches the scene first, whoever gets out of the ambulance first, either the nurse or the technician, one of them goes next to the patient's head. Usually there is a nurse and an auxiliary, so the nurse is the one who takes care of the head, the airway and immobilizes the neck. But there is no rule about it, considering it is team work... it is a job ... where everyone knows how to do everything and we don't feel limited for this reason ...this allows for giving a standardized service in every case, regardless of who does what [...] (E2)

Coordination is recognized as a function that can be performed by anyone on the team, but since there is a historical hierarchy, the physician commonly takes on the leadership role. When the team does not have a physician, according to the same hierarchy, the nurse would be the leader, or the most prepared technician.

In summary, all team members should know what to do and know the sequence of the service, because the team is organized according to the different situations that are presented and it is necessary to be prepared to assume any position during the provision of service.

Teamwork in prehospital service

PHS is founded on teamwork, in which each rescuer should be skilled and prepared to perform a number of necessary actions to provide basic support to traffic accident victims. Service quality is closely related to how the team operates. Their harmony and integration during service are often so in tune that communication takes on a background position.

The procedures are often performed simultaneously, and one person performs more than one task, making the service agile. This type of integration has been described in emergency situations when it is necessary to perform articulated actions, in which professionals work in cooperation, in harmony and with precision under the coordination of a physician. These interventions form a collective work that, due to the severity of the situation, involves the cooperation, complicity, and solidarity of the professionals involved.

The PHS performs emergency interventions, as in cases of traffic accidents, which always demand an integrated, articulated action as shown in the following statements by the interviewed professionals:

Especially in traffic accidents, when you provide care in the street, you need many people. Not just one or two. So everyone participates, helps to immobilize, or remove, sometimes, from the vehicle [...]. There are things... many things that have to be done at the same time. While one person immobilizes the victim, another punctures the vein, another checks the medication, another gives the oxygen. So, like, I think there's a lot of integration (ME1).

Some ICU studies have found that teamwork is easier because of the limited physical area and the reduced number of professionals, and because the proximity allows for observing the other's work and interactions whenever necessary. In more restricted sectors, the hierarchy of the competencies is not so evident in the service and, due to the characteristics of the clientele and the service, there is a need to establish cross-professional relationships^(5,15-16). In these situations, despite the differences of the specialized jobs, there are no hierarchical differences because the professionals are equally necessary. Therefore, the collective nature of health care becomes evident, which often appears shaded by the professionals' technical autonomy and by the isolation of the actions.

In PHS, teamwork takes place following the modality described as integration, where there is an articulation of the actions and an interaction between the agents⁽⁵⁾. Integrated teamwork results from the communicative work, in which all the agents are in harmony with the action plan, and the technical interventions of the group of professionals need to be articulated so the project can be effectively implemented. The factor contributing to this integration in PHS is experience. In agreement with other studies⁽⁶⁾, it was observed that in situations with less difference between the jobs and respective agents, there is a greater integration in the team.

In teamwork, the emphasis is on the flexibility of how the work can be divided, according to the specificity of each professional, making an effective integration possible. Teamwork is only possible when the workers build this integration among themselves, exchanging knowledge and articulating the production of care, which is common to most workers. This care, besides the interaction, permits each professional to use their creative power relating to the patient to, together, produce high quality care⁽¹⁷⁾.

There are several central aspects coexisting in the production of a health action, described as caregiver, professional-specific, and problem-specific. Every health professional provides clinical care and provides sanitary practices regardless of their professional group, which allows for thinking about alternative forms of work in health care⁽¹⁰⁻¹¹⁾.

It was identified that prehospital service has an area common to all the professionals, which is the basic support of the lives of trauma victims, in which every professional, regardless of their technical preparation, performs the same activities and organizes according to the patient, a traffic accident victim, and according to the situation per se, without considering a hierarchical structure based on specific knowledge, built historically and reproduced in the health systems, in either the hospital or basic care environments.

The basic support interventions, which involve immobilization and transportation, without the need to perform nursing procedures, belong to the caregiver position, which are common to all the professionals, health professionals or not. Situations that require activities pertaining to a specific professional area, such as nursing techniques or invasive procedures exclusive to physicians, or rescue actions developed by firemen, characterize the central aspect regarding each professional's specialized knowledge.

Even when each professional's differences are recognized due to their educational preparation, and recognizing the hierarchy due to their knowledge, these elements are not determinants in defining each one's space in PHS. In addition, there is a need for a specific type of knowledge, which does not pertain to a particular area and is not acquired at university, which is the experience gained in this field. The professional must know how to apply this knowledge to everyday situations, be able to evaluate and make decisions, have the competence to perform the necessary procedures according to the situation, and know how to work in a team environment, which is the essence of prehospital service.

In this way, it becomes evident that there is a need to value a wider field of knowledge, which is associated with the central aspects of the caregiving activities, and answers most of the needs presented by the patients seen at PHS, especially victims of traumas due to traffic accidents.

Working with professionals from other areas

There is often a need for teams that are not directly involved in health care to participate in the care service to

traffic accident victims because, in some situations, the SAMU team is not able to do the work alone.

[...] integration has already begun with the regulation board, because you are already asking: central, we need a fast vehicle here; we'll need one more ambulance; central, we need the Public Collective Transportation Company to isolate the area for a safe service; central, there are many drunk people here, we need the Military Squad; we need the Firemen for the extrication; we need the Power Company here because the car crashed into a power pole. [...] So there is integration everywhere: SAMU, the Power Company; firemen; the Public Collective Transportation Company, the Military Squad. The SAMU is unable to work alone, it couldn't work alone (A1).

The integration between the multiple professionals involved in the service represents teamwork, which occurs through the grouping of agents and the juxtaposition of the actions, characterizing the team as a grouping team⁽⁵⁻⁶⁾. Each of the professionals has specific knowledge and develops a specific job that complements the job developed by the health team, which is central and hegemonic. The support teams do not interfere in the work developed by the health team, neither do they interfere in the specific jobs of each professional; the team simply awaits information about the conditions, so they can start working.

In agreement with a study regarding multiprofessional teamwork in several health services⁽⁶⁾, the work of the many professionals involved in PHS showed that the objective complementarity of the specialized jobs happens along with the independence of the health care project of each professional area, or even each agent, suggesting that the agents have complete technical autonomy.

The relations between the Municipal Health Secretary's Mobile Emergency Service and the Fire Department's Emergency Service Group have not always been harmonic. At first, as reported by one of the nursing auxiliaries, there was a period of difficulty between the two groups because of a competition for space, which apparently was quickly overcome:

I remember when the SAMU started, the mobile service was done by the firemen. So there was a certain animosity, it was like one person wanted to take another person's place [...] Actually, we wanted to join forces, work together, but there was this one problem in the beginning. [...] Nowadays, there's no such thing any more. [...] it has improved a lot, now there's a strong integration between the SAMU, Firemen, Military Squad, and the Public Collective Transportation Company (A1).

It was an accommodation rather than an overcoming because, without legal support, funding, material or equipment, the Fire Department was unable to maintain their initial space, as when it was the only one providing this type of service, and it was impossible to establish a partnership between these two institutions. In some states, the administrators connected with the Fire Department argue that the institution has over 25 years of experience and

well-prepared teams, but they have not been supplied with resources, and have suffered a *scapping process*. In addition, the way that attributions are passed on or adjusted between the two institutions – Fire Department and SAMU – has caused discontinuity and poor information exchange between the two teams⁽¹²⁾.

This study has shown the existence of two public PHS in the municipality, one connected with the Municipal Health Secretary and the other with the Fire Department. These services work independently, with very little integration, since there is no partnership between their administrators. In this sense, there is a lack of approximation in the management aspect, which would optimize the service and take advantage of the firemen's preparation and experience.

FINAL CONSIDERATIONS

This study identified the dynamics between the professionals involved in delivering prehospital service to victims of trauma due to traffic accidents. It was found that physicians hold the central position in the organization of the service, through the medical regulation practice. However, in the organization of the service, which is made effective by answering the calls, nursing is present in every event, and thus represents a fundamental element in delivering the service, especially in situations in which the nurse takes responsibility for the direction of the process, and in basic support, as in cases when their job in the team is to offer support in the medical assistance.

The PHS team establishes relations that favor working in an integrated manner, assuring agility in the care provided to traffic accident victims. There is an understanding among the team members that transcends the hierarchical

relation historically defined in health organizations. This harmony permits the performance of group actions that favor a fast and adequate service.

The relationship with professionals from other areas shows that a collective work is being done, in which the health team takes a central position and the others perform the specific activities supporting health care. All professionals are essential, but there is a hierarchy in which the health team assumes the leading role in the actions, leaving the secondary roles to the rest. These relations are harmonic when everyone accepts their own role and there is respect for each one's specific professional work. When establishing relations with other areas it is necessary to improve the dialogue, seeking an integration that breaks the barriers established by the difficulties of working with a logic founded on horizontal relations, with pacts and commitment to the society.

Prehospital service presupposes dominion of teamwork, downplaying the technical or academic preparation of each professional. The relevance of the service to traffic accident victims and the involvement of the basic support team in this work process was shown, indicating the structure of interdisciplinary-based work. It is necessary to search for a form to organize the service, to manage this system, to respect the national and regional specificities, and to value the caregiver aspect inherent to every worker.

It is suggested that prehospital service benefits integration teamwork, by valuing the caregiver aspect, and is characterized as an interdisciplinary health action. Nursing, or the nurse in particular, has an essential role as an articulator, a facilitator of teamwork. This action has often promoted changes, advancements, and conquests in the process of forming interdisciplinary teams.

REFERENCES

1. Brasil. Ministério da Saúde. Política Nacional de Atenção às Urgências. 3ª ed. ampl. Brasília; 2006.
2. Rio Grande do Sul. Secretaria de Estado da Saúde. Estatísticas de saúde: mortalidade 2006. Porto Alegre: Núcleo de Informações em Saúde; 2007.
3. Pereira WAP, Lima MADS. A organização tecnológica do trabalho no atendimento pré-hospitalar à vítima de acidente de trânsito. *Ciênc Cuidado Saúde*. 2006;5(2):127-34.
4. Marques GQ, Lima MADS. Organização tecnológica do trabalho em um pronto atendimento e a autonomia do trabalhador de enfermagem. *Rev Esc Enferm USP*. 2008; 42(1):41-7.
5. Peduzzi M. Equipe multiprofissional de saúde: a interface entre trabalho e interação [tese]. Campinas: Faculdade de Ciências Médicas, Universidade Estadual de Campinas; 1998.
6. Peduzzi M. Equipe multiprofissional de saúde: conceito e tipologia. *Rev Saúde Pública*. 2001;35(1):103-9.
7. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 7ª ed. São Paulo: Hucitec; 2000.
8. Pereira WAP, Lima MADS. Atendimento pré-hospitalar: caracterização das ocorrências de acidente de trânsito. *Acta Paul Enferm*. 2006;19(3):279-83.
9. Conselho Nacional de Saúde. Resolução n. 196, de 10 de outubro de 1996. Dispõe sobre diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos. *Bioética*. 1996;4(2 Supl):15-25.
10. Merhy EE. Saúde: cartografia do trabalho vivo. São Paulo: Hucitec; 2002.

11. Merhy EE. O ato de cuidar: a alma dos serviços de saúde. São Paulo: CINAEM; 1999. (Coletânea da CINAEM – Oficina A Gestão de Escolas Médicas).
12. Minayo MCS, Deslandes SF, organizadoras. Análise diagnóstica da política nacional de saúde para redução de acidentes e violências. Rio de Janeiro: FIOCRUZ; 2007.
13. Deslandes SF, Souza ER, Minayo MCS, Costa CRBSFF, Krempel M, Cavalcanti ML, et al. Caracterização diagnóstica dos serviços que atendem vítimas de acidentes e violências em cinco capitais brasileiras. *Ciênc Saúde Coletiva*. 2006;11 Supl:1279-90.
14. Pires D. Novas formas de organização do trabalho em saúde e enfermagem. *Rev Baiana Enferm*. 2000;13(1/2):83-92.
15. Lunardi Filho WD. O mito da subalternidade do trabalho da enfermagem à medicina. Pelotas: Universitária-UFPEL; 2000.
16. Gaíva MAM, Scochi CGS. Processo de trabalho em saúde e enfermagem em uti neonatal. *Rev Lat Am Enferm*. 2004;12(3):469-76.
17. Franco TB, Merhy EE. O uso de ferramentas analisadoras para apoio ao planejamento dos serviços de saúde: o caso do serviço social do hospital das clínicas da unicamp. In: Mrehy EE, Magalhães Júnior HM, Rimoli J, Franco TB, Bueno WS. O trabalho em saúde: olhando e experienciando o SUS no cotidiano. São Paulo: Hucitec; 2003. p.135-60.