REFLECTION ARTICLE

OBJN
Online Brazilian Journal of Nursing
ISSN: 1676 - 4285 | www.objnursing.uff.br

Submission: 10-Aug-2025
Approved: 27-Aug-2025

REPERCUSSIONS OF THE TECHNICAL-SOCIAL DIVISION OF LABOR IN NURSING IN LATIN AMERICA: A THEORETICAL REFLECTIVE ESSAY*

REPERCUSSÕES DA DIVISÃO TÉCNICO-SOCIAL DO TRABALHO DA ENFERMAGEM NA AMÉRICA LATINA: ENSAIO TEÓRICO REFLEXIVO

Fabrícia Martins Sales[1] ORCID: 0000-0002-8693-874X
Rosimere Ferreira Santana[2] ORCID: 0000-0002-4593-3715

[1] Federal Fluminense Institute, Campos Guarus campus. Campos dos Goytacazes, Rio de Janeiro, Brazil
[2] Fluminense Federal University, Aurora de Afonso Costa Nursing School. Niterói, Rio de Janeiro, Brazil

How to cite: Sales FM, Santana RF. Repercussions of the technical-social division of labor in nursing in Latin America: a theoretical reflective essay. Online Braz J Nurs. 2025;24(Suppl 2):e20256890. https://doi.org/10.17665/1676-4285.20256890

RESUMO

Objetivo: analisar as repercussões da divisão técnico-social do trabalho da enfermagem na América Latina. **Método:** Estudo teórico reflexivo, orientado pelo referencial filosófico de Karl Marx, com base em análise documental conduzida segundo os pressupostos de Bardin. **Resultados:** A análise evidenciou que a força de trabalho em enfermagem na região é majoritariamente composta por profissionais de nível médio, submetidos à precarização laboral, baixa visibilidade social e atuação centrada em procedimentos técnicos. Essa configuração reforça relações hierárquicas, fragmenta o cuidado e limita a autonomia profissional, ao mesmo tempo em que expressa processos de alienação, reificação e fetichismo do trabalho. **Conclusão:** Constatou-se que a divisão técnico-social do trabalho reproduz desigualdades históricas e compromete a integralidade e a qualidade da assistência. Superar esse quadro demanda políticas públicas articuladas entre saúde e educação, revisão das propostas formativas, valorização do cuidado como saber e prática específica da enfermagem e melhoria das condições de trabalho, de modo a fortalecer a autonomia e a capacidade resolutiva dos profissionais de enfermagem que atuam na América Latina.

Descritores: América Latina; Enfermagem; Processo de Trabalho em Saúde; Capitalismo; Técnicos de Enfermagem; Relações Médico-Enfermeiro.

ABSTRACT

Objective: to analyze the repercussions of the technical-social division of labor in nursing in Latin America. **Method:** A theoretical reflective study, guided by the philosophical framework of Karl Marx, based on a documentary analysis conducted according to Bardin's assumptions. **Results:** The analysis showed that the nursing workforce in the region is mostly composed of mid-level professionals, subjected to job precarity, low social visibility, and practice centered on technical procedures. This configuration reinforces hierarchical relationships, fragments care, and limits professional autonomy, while also expressing processes of alienation, reification, and work fetishism. **Conclusion:** It was found that the technical-social division of labor reproduces historical inequalities and compromises the comprehensiveness and quality of care. Overcoming this situation demands articulated public policies between health and education, a review of training proposals, the valorization of care as nursing's specific knowledge and practice, and improvement in working conditions, in order to strengthen the autonomy and problem-solving capacity of nursing professionals working in Latin America.

Descriptors: Latin America; Nursing; Health Work Process; Capitalism; Nursing Technicians; Physician-Nurse Relations.

Corresponding author:
Fabrícia Martins Sales
Email: fabricia.martins.sales@gmail.com

Publisher:
Escola de Enfermagem Aurora de Afonso Costa – UFF
Rua Dr. Celestino, 74 – Centro, CEP: 24020-091 – Niterói, RJ, Brazil
Journal email: objn.cme@id.uff.br

What is already known:

- The shortage of nursing professionals in Latin America is exacerbated, above all, by the migration of nurses to other countries.
- In Latin America, the workforce is predominantly composed of mid-level professionals, who are frequently subjected to precarious working conditions.
- There is a scarcity of studies that articulate Marxist concepts to understand and transform the configuration of nursing in the Latin American context.

What this article adds:

- It shows how the technical-social division of labor in Latin American nursing reinforces historical inequalities.
- It articulates Marxist concepts to explain the processes of alienation, reification, and fetishism present in nursing work relations.
- It indicates that overcoming this scenario requires integrated public policies, curricular review, and the valorization of care as nursing's own knowledge.

INTRODUCTION

Nursing care work consists of care between human beings, carried out through interpersonal relationships within the context of health services[1]. When incorporated into the capitalist mode of production, work ceases to represent an organic interaction between people and instead plays a role in the generation, conservation, and expansion of economic value[2]. Similar to other professions, nursing work has been appropriated by productive rationality, transforming into an activity that surpasses its exclusively humanitarian dimension to also become inscribed in the dynamics of capital[3].

The incorporation of nursing work into capitalism consolidated a productive organization based on the fragmentation of tasks and the hierarchization of knowledge, which materialized in the technical-social division[4]. The rationalization of care activities, guided by criteria of efficiency and control, reduced care to a set of operational actions, emptying it of its relational and subjective dimension, and subordinating it to the logic of productivity[5].

Nursing work in Latin America presents unique characteristics, resulting from the coexistence of fragmented health systems, influenced by colonial legacies, cultural heterogeneities, and profound socioeconomic inequalities. These particularities generate specific labor dynamics, molded by historical and social factors unique to the region, which demands an analysis that goes beyond the models adopted in other contexts[6]. In this sense, it becomes relevant to investigate the technical-social division of labor in nursing in the Latin American scenario.

Latin America is among the most unequal regions in the world, where millions of individuals face difficulties in accessing health services. About 29% of the Latin American population lives below the poverty line, and the poorest 40% receive less than 15% of the total income[7].

The literature review on the technical-social division of labor in nursing reveals a predominance of studies that discuss working conditions and the quality of care, as well as their impacts on the health of nursing team professionals[8-11].

Studies conducted in Brazil show the precarity of the nursing team's working conditions, marked by temporary contracts, high turnover, excessive working hours, and multiple jobs. These factors are associated with low remuneration, work overload, and a shortage of professionals, negatively impacting both the health of the professionals and the organization of the work process[8-9].

Research conducted in Finland revealed that excessive workloads, low wages, and job instability compromise the health and well-being of nurses[10]. Similarly, in Sweden, a study linked precarious labor conditions to the physical and mental suffering of the nursing team[11].

The presence of this problem in developed countries, such as Finland and Sweden, reinforces that the precarious working conditions in nursing are not limited to contexts of greater social inequality but constitute a structural phenomenon of the capitalist mode of production. However, in Latin America, such conditions take on more critical contours, due to the fragmentation of health systems, historical inequalities, and the region's structural limitations, which justifies the scope adopted in this study.

Considering Sustainable Development Goal No. 3 of the United Nations (UN) 2030 Agenda, which aims to ensure quality and accessible health for all[12], the importance of promoting research on nursing in Latin America is highlighted as a strategy for strengthening regional health systems and promoting equity in access to care[7].

Reflections have sought to understand the current stage of nursing as a discipline, as well as to identify strategies for its expansion and strengthening in the labor market[11,13]. It is essential to analyze the professional development of nursing within the context of the world's predominant economic system, capitalism[3]. The objective of the present study is to analyze the repercussions of the technical-social division of labor in nursing in Latin America.

METHOD

Study type

This is a theoretical reflective study. The philosophical framework of Karl Marx[2] was used to support the analysis. The choice of this design is justified by the relevance of developing a conceptual and historical analysis of the transformations in nursing work in Latin America, from a critical perspective that goes beyond mere empirical and normative description.

Data collection

Data collection was carried out between February and April 2025 and consisted of an exploratory search for scientific articles and documents available in digital format regarding the technical-social division of labor in nursing in Latin America. The websites of the Pan American Health Organization (PAHO) and the World Health Organization (WHO) were consulted, in addition to the databases: Latin American Literature in Health Sciences (LILACS), Google Scholar, Scopus, PubMed, and Web of Science.

The articles from the databases and the documents from PAHO and WHO were selected according to thematic relevance and alignment with the study's objective.

In the databases, the article search was conducted using the descriptors: Latin America, nursing, health work process, and capitalism, which were combined with the Boolean operator "AND", according to the specificities of each plat-

form. The combinations used were: "Latin America" AND "nursing"; "nursing" AND "capitalism"; "health work process" AND "capitalism"; "health work process" AND "Latin America". Language restrictions were applied (Portuguese, English, and Spanish) and document type (articles published in scientific journals). The language restriction was justified as it includes the most used languages in scientific production on the topic, especially in the Latin American context, in addition to ensuring greater fidelity in the interpretation of the texts, avoiding possible biases arising from automatic translation. The time-period filter was not applied.

For the material selection, the titles and abstracts of the articles were read. The selected materials were organized into thematic folders on the researchers' computers and subsequently subjected to exhaustive reading.

Data analysis

The material was processed using the thematic content analysis technique according to Bardin[14], used as a methodological resource to identify meaning nuclei relevant to the object of study. The meaning nuclei were grouped into three axes that guided the construction of the theoretical reflection: Axis 1: Origins and historical foundations of the technical-social division of labor in nursing; Axis 2: Expressions and contradictions of the technical division of labor in nursing in Latin America; Axis 3: Alienation, reification, and fetishism of nursing work in Latin America.

RESULTS AND DISCUSSION

Axis 1: Origins and historical foundations of the technical-social division of labor in nursing

The technical-social division in nursing results from historical, social, and economic factors that reflect the capitalist system. This system segments functions, defines hierarchies, and shapes professional practice according to production demands[3].

From Christianity to feudalism, nursing was guided by a religious model, practiced autonomously, and recognized as an art. In that period, nursing and medicine acted with distinct purposes and maintained little relation to each other[15].

At the end of the 18th century, with the consolidation of capitalism as the economic system in Western society, medicalization and the hospital-centric model of health care were strengthened, marking the decline of the religious and autonomous paradigm that had characterized nursing until then[16]. According to capitalist interests, physicians were responsible for decisions about treatments and therapeutic plans, as well as leadership positions. Nursing was assigned responsibilities related to the environment. The nurse, through servile activities, acted as a facilitator for the physician's work and occupied a position of total subservience to him[15].

In 1860, Florence Nightingale founded the first school of nursing in England. The training of nurses was structured based on social distinctions: the lady-nurses, from upper classes, who supervised and taught, and the nurses, from humble origins, who provided direct care to patients[17].

Nightingale legitimized hierarchy and discipline as foundations of nursing work, incorporating traits of her aristocratic origin into the profession, as well as religious and military organizational models. This configuration strengthened relations of domination and subordination in nursing practice, perpetuating within the profession the class inequalities typical of the capitalist system[16].

Nursing developed in line with the advancement of industrialization, which accentuated the separation between manual and intellectual labor based on social class criteria. With industrial expansion, hospitals grew, and there was a significant increase in the number of nursing schools[17].

In the school environment, ideological practices were established with a view to standardizing nursing work within the hierarchy of a fragmented system dominated by physicians. The teaching consisted of procedures without emphasis on the "why", or without the delineation of scientific principles, and the main objective of nursing was to assist the medical work[16].

The separation between manual and intellectual labor, highlighted by Marx, widened the distance between teaching and practice[2]. In the capitalist context, the valorization of intellectual knowledge over manual work legitimizes the hierarchy in nursing, subordinating the technical team to the domain of the nurse[18].

The incorporation of nursing care work into the capitalist order intensified, especially after the 1929 crisis, when the expansion of private health insurance deepened the exploitation of the labor force. The introduction of models such as Taylorism and Fordism standardized and controlled nursing activities, prioritizing productivity and cost reduction to the detriment of care quality and working conditions. Among the most visible effects are the increase in working hours, the intensification of the technical-social division, and the loss of workers' autonomy over the production process—repercussions that rapidly consolidated in the daily life of nursing[3].

From the end of the 19th century, the first nursing schools emerged in Latin America, established alongside hospitals and with the support of international organizations[16]. In the 1950s, the Rockefeller Foundation boosted nursing education in the region through financing, scholarships, and curricular proposals based on the Anglo-American training model[19]. Therefore, there was a reduction in the influence of traditional practices and religious approaches that had predominated in Latin American countries until then[20]. Concurrently, PAHO contributed to the standardization of nursing training in Latin America, especially in countries like Argentina and Colombia[21].

The transformations in health services drove changes in nursing training schools, which began to reflect the capitalist dynamic of fragmenting the productive process, distancing the professional from their central object: healthcare.

In this context, the division of labor in nursing in Latin America was consolidated with the creation of courses for assistants, aimed at training a workforce for manual tasks, legitimizing the separation between intellectual and operational work. In the 1960s, this separation deepened with the introduction of the nursing technician category, created to fill gaps left by assistants, due to their limited training, and by nurses, given their numerical scarcity. The technician was responsible, among other duties, for supervising small units and assisting critically ill patients[22].

Since its origins, mid-level professional education in nursing has historically been associated with a lower social status, reflecting the so-called structural dualism[23].

In the first decades of the 20th century, nursing meth-

ods and techniques were centered on procedures and not on patients[15]. This practice contributed to the deepening of the technical division of labor, as different stages of the same activity began to be performed by various professionals[2].

The fragmented care dynamic imposes risks on assistance by reducing care to an operational rationality, prioritizing task execution and compromising the comprehensive approach to the patient[24].

When nursing care is understood only as a set of technical procedures, its relational, ethical, and reflective dimensions are lost. In this sense, the resumption of care as the specific object of nursing is advocated, supported by its own knowledge that articulates theory, practice, and subjectivity, in opposition to the productivist logic that depersonalizes the patient and disqualifies the act of caring[23].

In this configuration, the fragmentation of functions and the historical subordination of nursing to medicine contributed to the construction of an identity crisis in the profession, still perceptible in hierarchical relationships, in the symbolic devaluation of care, and in the difficulty of affirming its own body of knowledge[24]. These factors have repercussions on the self-esteem of nursing students, especially among students in technical courses, who face greater barriers to professional recognition[25].

Axis 2: Expressions and contradictions of the technical division of labor in nursing in Latin America

Nursing constitutes the main professional category in the health sector, corresponding to approximately 59% of the workforce in this area. Paradoxically, nursing professionals account for half of the global shortage of health workers, currently estimated at about 4 million people[12]. This unequal distribution in the number of and population access to nursing professionals is especially evident in Latin America. In the region, only Cuba, Chile, Brazil, and Uruguay reach the recommended density of 40 nursing professionals per 10,000 inhabitants. In the Region of the Americas, 87% of nurses are concentrated in just three countries: Brazil, Canada, and the United States[7]. The shortage of nursing professionals evident in Latin America is explained by factors related to the lack of investment in the profession, scarcity of nursing schools, the career's low attractiveness to young students, and the emigration of professionals to countries with higher levels of economic development[12]. In this scenario, Mexico ranks first among countries sending qualified migrants, mainly to Canada and the USA[26].

Nursing professionals working in Latin America are subject to precarious working conditions imposed by the region's health systems, coupled with low wages and the team's limited autonomy to define their means of practice. In this context, strengthening regulatory mechanisms is configured as a fundamental strategy for the advancement of nursing in the region[27].

Throughout history, successive crises in the capitalist system have caused transformations in labor relations. Among the main effects observed are the reconfiguration of productive processes, the suppression of social rights, the increase in labor precarity, and the weakening of the working class, with a consequent reduction in its capacity for mobilization and demand[3].

About 70% of the nursing workforce in Latin America is composed of mid-level professionals. In contrast, in the United States, 64% of the nursing workforce has higher-level education. Educational training for mid-level positions ranges from 12 to 18 months of formal training to three years of technical or vocational training. Higher education training is 5 years in most countries[7].

The configuration of nursing with a majority composed of mid-level professionals is observed not only in Latin America but also in other developing countries, where the quantity of professionals with higher education is still limited[28].

Mid-level professionals are designated as technologists, technicians, or nursing auxiliaries and work in providing basic care to patients[7]. Nurses work in roles ranging from direct patient care to leadership functions, research, and the development of public health policies[12].

Chart 1 presents the technical-social division of nursing according to the professional categories existing in Latin American countries.

Diversity in the organization of professional nursing categories in Latin American countries is evident. Variations exist in nomenclature and team structure, although a common pattern of segmentation between higher-level and mid-level professionals is observed, which reinforces hierarchies internal to the profession itself.

In Latin America, Brazil stands out for presenting the most complex structure of technical-social division, with four distinct professional categories. In countries such as Argentina, Bolivia, El Salvador, Ecuador, Paraguay, and the Dominican Republic, nursing is organized into three categories. In the others, the structure is limited to two professional categories[29].

The composition of nursing categories in each country results from its own historical, political, and educational trajectories, which shape different forms of organization and technical-social division of labor.

Nursing schools in Latin America face challenges, such as a lack of administrative infrastructure, ineffective teaching methodologies, a shortage of qualified faculty, and insufficient government investments, factors that compromise the training of prepared professionals[30].

Technical training in nursing coexists with limitations such as reduced visibility in social and academic circles, the persistence of an educational model centered on hospital-based and biomedical logic, and the reproduction of historically established hierarchical and dichotomous relationships. Teaching in technical nursing courses has been structured around technocratic practices, centered on the execution of procedures focused on cure, which ends up reproducing the logic of the social division of labor in the health field[23].

Governments of Latin American countries must expand access to higher education in nursing, especially in vulnerable regions, through the interiorization of bachelor's programs, the provision of scholarships, and the creation of policies that favor the inclusion of historically marginalized populations. The institution of career plans is an alternative for the valorization of mid-level professionals[31].

It is fundamental to strengthen mechanisms for the regulation and accreditation of course quality, invest in faculty training, and foster academic-care partnerships that guarantee practice settings aligned with the health system's needs. These measures, articulated with a policy of valorizing the profession, have the potential to reduce technical-social segmentation and promote greater equity in the training and practice of nursing professionals in Latin America[7].

Chart 1 - Classification of professional nursing categories adopted by countries in Latin America. Niterói, RJ, Brazil, 2025

Countries	Higher-level nursing categories	Mid-level nursing categories
Argentina	Registered nurse	Nurse Nursing assistant
Bolivia	Nurse Obstetric nurse	Nursing assistant
Brazil	Nurse	Nursing technician Nursing assistant Midwife
Chile	Nurse	Nursing assistant
Colombia	Nurses	Nursing assistant
Costa Rica	Nurse	Nursing assistant
Cuba	Registered nurse	Nurse
El Salvador	Registered nurse	Technician Nursing technician
Ecuador	Registered nurse	Technician Nursing assistant
Guatemala	Professional nurse	Nursing assistant
Haiti	Professional nurse	Nursing assistant
Honduras	Professional nurse	Nursing technician
Mexico	Registered nurse	Nursing technician
Nicaragua	Professional nurse	Nursing assistant
Panama	Professional nurse	Nursing assistant
Paraguay	Professional nurse	Technician Nursing assistant
Peru	Nurse	Nursing technician
Dominican Republic	Professional nurse	Technician Nursing assistant
Uruguai	Registered nurse	Technician Nursing assistant
Venezuela	Registered nurse	Technician Nursing assistant

Source: prepared by the authors, 2025.

Regarding technical training in nursing, the low visibility of the courses before society and the academic community constitutes a challenge to be overcome. This scenario is aggravated by the growing commodification of education and the lack of updated databases, which hinders the understanding and qualified dissemination of information about this training modality[23].

From a Marxist perspective, the dynamics of the technical-social division of labor in Latin American nursing reveal themselves as a concrete expression of class struggle and the exploitation of the labor force. The lack of investment in training and in the valorization of the profession contributes to the reproduction of an unskilled workforce subjected to precarious conditions, favoring the structure of domination present in the capitalist mode of production.

The current configuration of the division of labor in nursing not only reproduces but also accentuates the inequalities present in Latin American society. To transform this scenario, it is necessary to adopt structuring strategies that articulate investment, public policies, and integration between the health and education sectors[27].

Axis 3: Alienation, reification, and fetishism of nursing work in Latin America

Nursing work in Latin American countries expresses the Marxist precepts related to alienation, reification, and commodity fetishism.

Alienation occurs when the worker is separated from the product of their labor, loses control over what they produce to the point of not recognizing themselves in the productive process, and begins to serve only the interests of capital[2].

In Latin American nursing, alienation manifests itself through the technical-social division of labor, which fragments functions, restricts professional autonomy, and reduces care to standardized and hierarchical activities. This process distances the worker from the patient and nullifies the integral meaning of caring.

Reification is the process by which ideas are transformed into objects. When this happens to people, they begin to identify with the commodities they produce, losing comprehension of the whole[2].

Reification is evidenced in nursing work in Latin American countries, where specialization and the fragmentation of functions transform the worker into an instrumentalized object within the health system. In this context, the nurse and the technician are reduced to executors of tasks and not to complete subjects in a process of integral care. Both professionals lose connection with the total meaning of the work they perform.

Reification in nursing within Latin American health systems negatively impacts the care offered to patients and harms both the quality of care and the professionals' relationship with their work. Lacking the autonomy to act holistically, professionals find it difficult to adapt and personalize

care, which results in standardized and mechanized service that ignores the particularities of each case. This aggravates the distance between the professional and the patient, dehumanizes care, and weakens the bond necessary for quality care. For the population, this means a less responsive health system, in which comprehensive support is rarely achieved. This process demotivates professionals, generates high turnover and loss of experience, which deepens the challenges of a sector already marked by resource scarcity and worker overload.

Commodity fetishism corresponds to the illusory perception that products have intrinsic value, as if they existed independently of the human relationships that created them. This phenomenon conceals the collective labor and invisibilizes the relations of exploitation between workers and employers, causing subjects to become subordinate to the objects they produce, as if these objects had power over their lives[2].

This dynamic manifests in the health field, especially in nursing, through the technical-social division of labor, which reinforces the biomedical model by centralizing disease as the main focus of intervention. In this scenario, fetishism is expressed in the exaltation of medical knowledge to an autonomous and superior status, dissociated from the collective effort, which contributes to the devaluation of the knowledge and practices of other professionals[18].

The physician comes to be recognized as the sole legitimate producer of health, accumulating prestige, authority, and higher financial income. Thus, the figure of the physician as the "owner" of the cure is consolidated, obscuring the role of other members of the health team, whose actions only gain prominence when there is no possibility of cure and continuous care becomes indispensable. This care, however, because it is linked to chronicity and practical knowledge, is frequently devalued and distanced from the hegemonic scientific field.

The hegemony of the biomedical paradigm in society fuels a disciplinary devaluation of nursing. Professionals trained under the primacy of medical knowledge and distanced from the specific theoretical foundations of the profession find it difficult to develop a sense of belonging[25]. The lack of insertion into the field of care's own references weakens the social and scientific recognition of nursing, compromising the consolidation of professional identity and its transformative potential[24].

Nurses operate under the supervision of employers, and their activities tend to benefit the interests of the latter, which characterizes a paradoxical situation: on one hand, they are salaried workers exploited by capitalist employers, and on the other, they assume a pseudo-antagonism by exercising control over the labor force of other nursing professionals, who are also salaried and exploited. Nurses represent the interests of employers, even if they do not own the means of production; they work towards maintaining capital accumulation and implementing policies favorable to the market and elites, all while they maintain the fetish that they are caring for the collective well-being[5].

CONCLUSION

The analysis of the repercussions of the technical-social division of labor in nursing in Latin America, based on a Marxist framework, identified the fragmentation of functions, the hierarchization of knowledge, and the technification of training and practice as the dominant pattern. The configuration of nursing, with most of the workforce composed of mid-level professionals subjected to precarious labor conditions, reinforces social inequalities. Practice focused on technical procedures compromises the comprehensiveness and quality of care. The processes of alienation, reification, and fetishism manifest in labor relations, which devalues nursing's own knowledge and naturalizes the primacy of medical knowledge. To confront this scenario, it is essential to strengthen integrated public policies between health and education, with structuring investments in critical training, the valorization of work, and the construction of an emancipatory project for nursing in the region. It is necessary to build a new rationality in health, one that recognizes care as the central axis of health practices and values nursing knowledge in its ethical, scientific, and social dimensions. Through structural transformations and the political engagement of nursing professionals, it will be possible to overcome historical inequalities and guarantee a care practice centered on human dignity, professional autonomy, and social justice.

This study contributes to the critical understanding of the organization of nursing work in Latin America by highlighting structural inequalities and their effects on training and professional practice. The research provides theoretical support for strengthening public policies capable of promoting greater equity in the division of labor and the valorization of all nursing categories. Furthermore, it broadens the knowledge base for international comparative research and guides training institutions in revising their curricula, with a view to qualifying care and strengthening professional autonomy.

*Article extracted from the Doctoral Thesis titled “Teaching the nursing process in technical nursing courses at the Federal Institutes of Brazil”, to be presented to the Academic Program in Health Care Sciences (PACCS) at the Fluminense Federal University (UFF), Niterói, Rio de Janeiro, Brazil, in 2026.

CONFLICT OF INTERESTS

One of the authors of the article serves as the Editor-in-Chief of the Online Brazilian Journal of Nursing (OBJN). However, she declares that she will not participate in any stage of the editorial or review process for this manuscript, in order to ensure impartiality in the evaluation.

REFERENCES

1. Al Anazi SDB, Al Anazi KDB, Al Anazi ADB, Al Anazi AA, Al Harthi AF, Al Arjani MN, et al. The dual pillars of healing: how nursing care and health services work InTandem for patient recovery. EPH-International Journal of Biological & Pharmaceutical Science. 2022;8(1):9-14. https://doi.org/10.53555/eijbps.v8i1.42
2. Marx K. Capital: a critique of political economy. 3rd ed. São Paulo: Abril Cultural; 1983. Book I, Volume 1.

3. Silva RN da, Ferreira M de A. Nursing and society: Evolution of Nursing and of capitalism in the 200 years of Florence Nightingale. Rev Lat Am Enfermagem. 2021;29:e3425. https://doi.org/10.1590/1518-8345.4482.3425
4. Dillard-Wright J, Jenkins D. Nursing as total institution. Nurs Philos. 2024;25(1):e12460. https://doi.org/10.1111/nup.12460
5. Adhikari R, Smith P. Global nursing workforce challenges: Time for a paradigm shift. Nurse Educ Pract. 2023;69:103627. https://doi.org/10.1016/j.nepr.2023.103627
6. Ruano AL, Rodríguez D, Rossi PG, Maceira D. Understanding inequities in health and health systems in Latin America and the Caribbean: a thematic series. Int J Equity Health. 2021;20(1):94. https://doi.org/10.1186/s12939-021-01426-1
7. Pan American Health Organization. The strategic importance of national investment in nursing professionals in the Region of the Americas [Internet]. Washington (DC): PAHO; 2022 [cited 2025 Mar 12]. Available from: https://iris.paho.org/handle/10665.2/55957
8. Batista KC, Sousa KHJF, Ruas CA da S, Zeitoune RCG. Knowledge about antineoplastic drugs: implications for the health of nursing workers in a general hospital. Rev Bras Enferm. 2021;75(3):e20210025. https://doi.org/10.1590/0034-7167-2021-0025
9. Magalhães APN de, Souza D de O, Macêdo FP de, Silva Cruz SÂF da, Pereira-Abagaro C, Rosales-Flores RA. Working conditions in nursing in the face of Covid-19 from the perspective of precariousness. Rev Bras Enferm. 2023;76(Suppl 1):e20220679. https://doi.org/10.1590/0034-7167-2022-0679
10. Hult M, Halminen O, Mattila-Holappa P, Kangasniemi M. Health and work well-being associated with employment precariousness among permanent and temporary nurses: A cross-sectional survey. Nord J Nurs Res. 2022;42(3):140-146. https://doi.org/10.1177/20571585211070376
11. Jonsson J, Matilla-Santander N, Kreshpaj B, Johansson G, Kjellberg K, Burström B, et al. Precarious employment and general, mental and physical health in Stockholm, Sweden: a cross-sectional study. Scand J Public Health. 2021;49(2):228-236. https://doi.org/10.1177/1403494820956451
12. World Health Organization. State of the world's nursing report 2025 [Internet]. Geneva: WHO; 2025 [cited 2025 Apr 3]. Available from: https://www.who.int/publications/i/item/9789240110236
13. Bellaguarda MLDR, Queirós PJP. Nurse autonomy expressed in Portuguese and Brazilian professional legislation: a documentary study (1986-2022). Rev Esc Enferm USP. 2024;57:e20230199. https://doi.org/10.1590/1980-220x-reeusp-2023-0199en
14. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2016.
15. Geatti S, Lorenzon M. When nurses would have been called dispensatores. Nursing Philosophy. 2010;11(3):204-208. https://doi.org/10.1111/j.1466-769X.2010.00441.x
16. Nyborg VN, Hvalvik S. Revealing historical perspectives on the professionalization of nursing education in Norway-Dilemmas in the past and the present. Nurs Inq. 2022;29(4):e12490. https://doi.org/10.1111/nin.12490
17. McDonald L. Florence Nightingale's Nursing and Health Care: The Worldwide Legacy, As Seen on the Bicentenary of Her Birth. SciMed J. 2021;3(1):51-58. https://doi.org/10.28991/SCIMEDJ-2021-0301-7
18. Cavalcanti FMS, Amaral MVB. Fetichismo da técnica e geração de valor no trabalho do profissional em saúde. R. Katálysis (Online). 2020;23(3):658-666. https://doi.org/10.1590/1982-02592020v23n3p658
19. Korndörfer AP, Ramacciotti KI. Uma proposta, duas experiências: a Fundação Rockefeller e a formação de enfermeiras no Brasil e na Argentina (primeira metade do século XX). Descentrada. 2021;5(1):e131. https://doi.org/10.24215/25457284e131
20. Magalhães RC da S. Nova história da Fundação Rockefeller: a odisseia da saúde global revisitada. Hist Cienc Saude Manguinhos. 2016;23:1245-1248. https://doi.org/10.1590/s0104-59702016000400013
21. Bacolla N, Allevi JI. La Escuela de Nurses de la Universidad Nacional del Litoral. Profesionalización del cuidado, circulación de saberes y polí-ticas estatales de salud en la provincia de Santa Fe, primera mitad del siglo XX. Trab. comun. (En línea). 2019;(49):e082–e082. https://doi.org/10.24215/23468971e082
22. Vargas GL, García JCR. Enfermería en Contexto de Trabajo en Salud Pública en América Latina. Revista Científica de Salud y Desarrollo Humano. 2021;2(1):51-66. https://doi.org/10.61368/r.s.d.h.v2i1.14
23. Adamy EK, Ramos FRS, Silva GTR, Jesus LA. Panorama Nacional da Formação em Enfermagem: Diretrizes Curriculares Nacionais da Formação Técnica e da Graduação. In: Adamy EK, Cubas MR. Os sentidos da inovação tecnológica no ensino e na prática do cuidado em enfermagem: reflexões do 18º SENADEN e 15º SINADEN. Brasilia (DF): Editora ABEn, 2023. p. 12-20. https://doi.org/10.51234/aben.23.e20c2
24. Brandão MAG, Barros ALBL de, Caniçali Primo C, Bispo GS, Lopes ROP. Nursing theories in the conceptual expansion of good practices in nursing. Rev Bras Enferm. 2019;72(2):577-581. https://doi.org/10.1590/0034-7167-2018-0395
25. Leal JAL, Melo CMM de. The nurses' work process in different countries: an integrative review. Rev Bras Enferm. 2018;71(2):413-423. https://doi.org/10.1590/0034-7167-2016-0468
26. Fernández-Sánchez H, Enríquez-Hernández CB, Vázquez M de los ÁZ, Horcasitas-Tovar AG. Emigración de profesionales de enfermería en México. Rev Cuid. 2021;12(1):e2008. https://doi.org/10.15649/cuidarte.2008
27. Cassiani SH, Dias BM, Durães MD, Almeida BG, Palha PF, Ventura CA, et al. Final Report of the Forum on Nursing Practice Regulation in the Region of the Americas: March 15-16, 2023. Enferm. foco (Brasília). 2023;14(Suppl 1):e-202301ESP12. https://doi.org/10.21675/2357-707X.2022.v14.e-202301ESP12
28. American Association of Colleges of Nursing. Baccalaureate Education. Washington (DC): AACN; 2023 [cited 2025 Apr 3]. Available from: https://ww

w.aacnnursing.org/students/nursing-education-pathways/baccalaureate-education
29. Pan American Health Organization. Regulación de la Enfermería en América Latina [Internet]. Washington (DC): PAHO; 2011 [cited 2025 Mar 12]. Available from: https://iris.paho.org/handle/10665.2/31332
30. World Bank Group. Population, total - Latin America & Caribbean [Internet]. Washington (DC): World Bank Group; 2022 [cited 2025 Apr 5]. Available from: https://data.worldbank.org/indicator/SP.POP.TOTL?locations=ZJ
31. World Health Organization. Orientaciones estratégicas mundiales sobre enfermería y partería 2021-2025 [Internet]. Geneva: WHO; 2021 [cited 2025 Apr 5]. Available from: https://apps.who.int/iris/handle/10665/351147

AUTHORSHIP CONTRIBUTIONS

Study conception: Sales FM, Santana RF.
Data acquisition: Sales FM, Santana RF.
Data analysis: Sales FM, Santana RF.
Data interpretation: Sales FM, Santana RF.
All authors are responsible for the textual drafting and critical review of the intellectual content, for the final published version, and for all ethical, legal, and scientific aspects related to the accuracy and integrity of the study.