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Existential Damage in the Work of Nurses

Tricia Bogossian

Specialist, Santa Úrsula University in Rio de Janeiro-RJ, Brazil

ABSTRACT

The present study aims to discuss the existential damage in the work of nurses. Therefore, as a methodology, it uses the literature review carried out in legislation, books and scientific articles that are dedicated to the regulation and study of the subject under analysis. It was seen that the occupational environment of nursing presents a series of risks to the worker's health, which in most cases are relegated to the background; however, they can cause changes in the worker's emotional well-being, leading him to seek ways to adapt to the reality of work. It was concluded at the end of the study that in primary care, nurses are exposed to all types of risks: physical, chemical, biological, ergonomic and psychosocial, with physical and ergonomic risks being more prevalent, which leads to the understanding that they are trained professionals are needed in sufficient numbers to meet the demands of the area, in addition to being important to prioritize the use of PPE and good ergonomic conditions for workers, under penalty of the health institution being able to incur in moral damages cumulated with existential damages.

***Corresponding author**

Tricia Bogossian, Specialist, Santa Úrsula University in Rio deJaneiro-RJ, Brazil. E-mail: tricia.bogossian@hotmail.com

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Introduction

In modernity, in which social relationships are seen to be more vulnerable, it is known that people are more subject to injury to their rights and more difficult to prove, especially in labor relations, in which the employee's hypo sufficiency is recognized [1].

It is directed to these cases that recent research aimed at understanding the existential damage integrates a thorough search for alternatives that can make up for the lack of legal instruments.

Currently, nursing is inserted in the most diverse contexts of care, primary, secondary or tertiary health care, having its field of action in assistance, teaching, research, among others [2].

The work process in nursing is interdependent and collective and organized by the division of work into hierarchical actions according to the complexity and technical execution, requiring skills to handle the various instruments and methods used to achieve care effectiveness. This care is developed by nursing assistants and technicians under the leadership of the nurse [3]. It should be emphasized that the nurse is responsible for managing the team and must be able to handle, plan and implement patient care, establish priorities, goals and assess whether the results have been achieved [4]. This professional must still master IT and the new technologies implemented in institutions, be communicative, have a leader profile to coordinate and act in the most diverse situations that arise in the occupational daily life [5].

The health care offered in the work environment is basically focused on work-related diseases and injuries, including their treatment, monitoring and referral to special emergency care [6].

Nurses still face other situations in their daily work, such as: the complexity of pathologies, dealing with pain and death, work overload, long working hours, low wages, insufficient number of human resources and of materials, unhealthy environment, among other factors, which provide feelings of suffering, dissatisfaction, wear and tear and, in turn, can lead to stress [3].

The occupational environment of nursing presents a series of risks to the worker's health, ranging from the physical, physiological, ergonomic, chemical and psychological, which most of the time are relegated to the background; however, they can cause changes in the worker's emotional well-being, leading him to seek ways to adapt to the work reality [3].

Having made these initial considerations, the present study aims to discuss the existential damage in the work of nurses.

The study proves to be relevant, because when existential damage actually occurs, the employee suffers from major changes in his routine, abandoning the plans he had drawn for himself, being limited to socializing, and thus projecting his future. In moral damage, what harms you are your intrinsic attributes, in the body of personality rights.

Methodology

The criteria established for searching the literature included articles indexed in the LILACS, ScieELO, BDENF and VHL databases, published between 2008 and 2021, using the following

DECS/MSH descriptors and their corresponding words in English: Occupational Health; Nursing professional (nursing professionals); and Existential damage in a single or combo quest.

The categorization adopted was as follows: "existential damage", which covered the results of the descriptors "occupational health" and "nursing professionals".

Contextualization of worker health in brazil

There is no pretension to establish, here, a rigorous historical chronology for workers' health. The idea is to highlight some facts with the purpose of favoring the understanding of the emergence of workers' health in Brazil.

Dejours highlights that workers' health emerged in a context of democratic transition in the 1980s, whose characteristics demonstrated new thinking about the role played by work in its determination and with a new look at the health-disease process [6].

As a basic characteristic of this new practice, it is highlighted that it is a field under construction in the public health space, having as its object the health-disease process of human groups, in their relationship with work [7].

For Mendes and Dias, the social initiatives of the time that were expressed in the discussions of the VIII National Health Conference and in the holding of the First National Conference on Workers' Health were decisive for the establishment of worker health in the Federal Constitution of 1988. , and later incorporated into the Organic Health Law (Federal Law 8080/90) – (BRAZIL, 1990), which establishes the competencies of the Unified Health System in this field [8].

However, Worker's Health was only defined in 1998, through the Operational Norm of Worker's Health in the Unified Health System (NOST/SUS) – (BRAZIL, 1998).

In order to support diagnostic and treatment actions, establish the relationship between the disease and work and comply with article 6, §3, inc. VII of Law 8.080/90, the Ministry of Health, with the clinical and epidemiological objective, prepared a List of work-related pathologies, which was adopted by Social Security with the aim of characterizing occupational accidents and resulting procedures in accordance with Decree No. 3048/1999, which deals with the regulation of Social Security (BRASIL, 2009).

In 2002, the construction process of the National Network of Integral Attention to Workers' Health (RENAST) began, based on the Ministry of Health Ordinance nº 1679/02 (BRASIL, 2002), with the objective of strengthening the health of the worker within the scope of the Unified Health System – SUS, representing the deepening of institutionalization, consolidating the means and conditions for the establishment of a state policy (BRASIL, 2009).

In this way, the conception of a national network was articulated, whose integrating axis is the regionalized network of Occupational Health Reference Centers (CRSTs), located in each of the capitals, metropolitan regions and municipalities where care centers, health regions and micro-regions, with the attribution of providing technical and scientific support to SUS interventions in the field of workers' health, enabling a strategy for disseminating workers' health actions throughout the SUS service network (BRASIL, 2009).

The disarticulation and overlapping of the actions developed by the Ministries of Labor, Social Security, Health and Environment became a major challenge for workers' health to be fully guaranteed in their rights (BRASIL, 2009).

As a proposal to overcome the fragmented actions implemented by the Labor, Social Security, Health and Environment sectors, taking into account the constitutional dictates of the right to health, social security and work and the need to articulate safety and health issues 153/2004, the Interministerial Working Group Ministry of Social Security (MPS) / Ministry of Health (MS) / Ministry of Labor and Employment (MTE) was created (BRAZIL, 2009).

Among other attributions, the group should reassess the role and composition of the Interministerial Executive Group on Workers' Health established by the Interministerial Ordinance MPS/MS/MTE No. (PNSST), paying attention to the existing interfaces and common actions between the various government sectors (BRASIL, 2009).

Having as legal bases the Federal Constitution of 1988, the Consolidation of Labor Laws of 1975 and the Organic Health Law of 1980 (BRASIL, 2009), the National Policy on Safety and Health at Work (PNSST) came into force through the Decree-Law 7,602/2011, with the principles of universality; of prevention; the precedence of actions of promotion, protection and prevention over those of assistance, rehabilitation and repair; social dialogue; and integrality (BRASIL, 2011).

The PNSST aims to promote health and improve the worker's quality of life, enabling the prevention of accidents and other damage to health that are related to work or that occur in the course of it, through the elimination or mitigation of risks in the environments. labor (BRAZIL, 2009).

Specific ministerial measures are launched to improve working conditions in Brazil each year, as recommended by the ILO (BRASIL, 2009).

A major advance in this regard was the Regulatory Norm nº 32 (BRASIL, 2005) which is a legislation of the Ministry of Labor and Employment that establishes measures to protect the safety and health of health workers in any health service.

The objective of NR-32 is to prevent accidents and illness caused by work in health professionals, eliminating or controlling the risk conditions present in Health Services (BRASIL, 2005).

Changes in workers' morbidity patterns have justified the change and/or implementation of new legislation in several areas. Proof of this was the modification by the ILO of the new List of Occupational Diseases in 2010 to replace the 2002 list, which describes a series of physical illnesses and cites post-traumatic stress disorder as a mental disorder.

The list of the Ministry of Health (BRASIL, 1999) is more comprehensive and encompasses disorders from organic causes such as those resulting from intoxication by mercury, lead and manganese as well as those of psychological origin such as depression, post-traumatic stress, sleep disorder in workers. shifts and night shifts and burnout syndrome.

As a result, the Worker's Health Field has been the focus in Brazil and in the world, requiring more and more policies that permeate

the needs in this area. This awakens in researchers the need to advance in studies on various topics related to workers' health.

Occupational damages to which the nursing professional is exposed

The nursing professional performs a series of discontinuous activities and tasks that involve some factors such as responsibility according to the function performed in addition to the overload of dealing with life and death [9].

The nursing team consists of the following categories: nurses who are responsible for management, coordination or supervision; technicians and nursing assistants who perform the technical and routine activities of this type of service, which are the most arduous and repetitive tasks. Also, the nursing team, due to the types of tasks they usually perform in their daily lives, is a category that is exposed, over the length of service, to the wear and tear of their vital capacities, whether physical, psychological or biological [10].

According to Santana et al. a risk is defined as 'any environmental factor that can cause injury, illness or disability or affect the well-being of workers'. These risks can be of different natures and are often hidden in the work environment [11].

Un healthiness is evident in places that have nursing care, as these types of professionals are exposed to risk situations all the time due to the routine of their own activities [12].

Exposure to risks in nursing is directly associated with work overload, stress, work "addictions", "forgetting" to use personal protective equipment (PPE), and especially to the working conditions to which they are subjected. Exposed professionals [11]. Nursing workers are exposed to infectious diseases and other dangerous agents for these professionals. According to Souza et al. exposure to occupational hazards can lead to adverse effects that cause damage to the worker's health, such as serious injuries, illness, and even death [5].

Occupational risks are classified in accordance with the Regulatory Standard (NR) 9 by the Ministry of Labor and Employment and are characterized as chemical, physical and biological risks. In the area of nursing, these types of risks are classified as physical, chemical, biological, ergonomic and psychosocial [10].

Chemical risks are those related to the handling of drugs due to routine work activities such as medicines in general, antibiotics, cytostatic drugs, anesthetic vapors, among others that can cause hypersensitivity, mutagenic effects, sterility and resistance of the organism to antibiotics [13].

Chemical risk factors are characterized as: gases, vapors, chemical substances or products in general and medicines. The authors also mention that the physical risks to which nursing professionals are exposed are characterized by noise, extreme temperatures, ionizing radiation or not, humidity, vibrations, inadequate lighting, among others [14].

Regardless of the activity performed, all professionals are exposed to occupational risks due to their activities, some more others less depending on their occupation, what most differentiates nursing workers are biological risks, which are those that cause damage to the health of the worker. by virtue of their function. They are characterized by viruses, bacteria, fungi, HIV viruses and Hepatitis B and C are the ones that most concern health professionals [15].

Exposure to biological agents can cause diseases, such as tuberculosis, HIV, scabies, hepatitis A, B or C, influenzae, meningitis, among other diseases. Exposure to this type of risk is common due to the large number and variety of diseases that are described in a hospital environment [16].

Health professionals acquire "work addictions" throughout their workday, which often contributes to greater risk of accidents in this environment. The most common accidents in the nursing field are the biological ones caused by perforating-cutting materials and the ergonomic ones caused by poor posture when handling patients [17].

Health professionals are also constantly exposed to psychosocial risks, which are associated with the development of depression, stress, anxiety, among others. It is believed that this is associated with the fact that these professionals are directly in contact with the suffering and pain of patients and their families, and must also know how to deal with death [9].

Ergonomic risks are those that include the inappropriate place for work, shift work, excessive lifting and transport of weights and inadequate posture and furniture and are the risks that most affect the nursing professional [11].

According to Forte et al. ergonomic risks are characterized as physical and psychological stress, inadequate postures, intense physical effort [18]. In addition, these ergonomic factors influence work-worker behavior according to the way activities are performed, the insalubrity, lighting and temperature of the environment.

Therefore, it can be said that exposure to ergonomic risks by nursing professionals leads to withdrawal from their activities, affecting their quality of life and the organization of work in institutions and in the service and care of individuals who depend on certain services provided. in primary care [19].

The work process is characterized by the activities carried out by the individual for the transformation of the object through instruments subordinated to an end. Therefore, the components of this process are considered by: object, agents, instruments, purposes, methods, and products [12].

In nursing, the work process is characterized not only by caring, but also by organizing, coordinating and managing its activities, since care is not performed if these components do not work together, as Sanna says [20].

In the nursing team, each professional has their role according to their level of training. The nurse is responsible for planning, coordinating, and supervising the care activities provided by the team to individuals; while the nursing technician is responsible for participating and developing activities that can help in the prevention, promotion, recovery and rehabilitation of health [19].

Nursing workers usually deal with patients who are often temporarily unable or not to move alone, requiring the help of these professionals to mobilize these patients. Often, when these movements are performed inappropriately, they harm the health of professionals [21].

Thus, it can be said that working conditions are interdependent factors that directly or indirectly interfere with the quality of

life of professionals as a result of carrying out their own work activities [16].

It is believed that numerous factors interfere in the ergonomic risks of nursing workers, among them we can mention the professional's relationship with their work, age, sex, weight, height, resistance to fatigue [22].

Also, currently, hospitals have implemented many modernities as well as new norms and worker requirements, increasing charges for the provision of a better quality of care to patients. This type of demand can generate stress that interfere with the quality of work [22].

Furthermore, nursing workers often perform functions that end up generating mechanical overloads that influence their osteomyoarticular structures that occur due to inadequate occupational or functional postures that, according to Bezerra et.al. when performed for a long time it causes tension, pain and even muscle injury, in addition, the professional is also vulnerable to developing metabolic and circulatory disorders [15].

Thus, it is understood that ergonomic risks expose nursing professionals who work in all areas, from those who perform more bureaucratic activities to those professionals who perform more 'heavy' activities such as those who work in intensive care units, medical clinics and services. primary care [24].

Existential damage in the work of nurses

Currently, there is a great concern about the quality of work offered to health professionals, since it directly interferes in the care of patients, that is, it is necessary to take care of one's own health to take care of the health of others. According to Almeida, Torres and Santos , this type of issue has been widely mobilized by workers and researchers who are concerned with the effects related to health and work [10]. With this, it is possible to affirm that the ergonomic risks are those that affect the physical and/or psychological integrity of the nursing worker and that can lead to the development of diseases or discomforts.

In nursing, work activity significantly influences the physical and psychological exhaustion of professionals who work in primary care, mainly because they are often exposed to unhealthy situations in their workplace [10].

The accumulation of functions and tasks, the stress due to the 'pressure' to provide quality care, the great load, are some of the reasons that cause problems to the worker's health. It is worth noting that the exposure of health professionals to risks in their work environment also involves aspects such as the environment, the organization of work and even the patient [25].

It is important for the occupational nurse to know the conditions and risks to which workers are exposed, so that it is possible to take measures to reduce the consequences for these professionals who are part of the nursing team. To properly implement actions aimed at the well-being of the nursing team, the occupational nurse needs to know the routine of the entire team in depth, understand what their needs are, the greatest occupational risks to which they are exposed and thus define their actions for each situation [12].

If there is no action to prevent these risks and the worker suffers damage to his physical and/or mental health, it is possible for the nursing professional to file a labor lawsuit and be compensated for the existential damages suffered.

In addition to moral damage, which is also substantiated through sexual harassment, moral harassment (in its interpersonal and organizational modalities) and occupational accidents, other damages can be considered as threats to the health and well-being of the worker and to the worker himself. work environment.

According to Mikos, the number of possibilities for labor damage is immeasurable, either because the individual spends a large part of their time at work, thereby accentuating their participation in the relationships that derive from it, or because the market itself faces disparate situations and, above all, translate into conflicts of interest [26].

The causes for interpersonal conflicts have multiple aspects, especially in labor relations, which may be based on the individual's personality, dreams and expectations, competitive dynamics, salary issues and the dominant organizational culture model [27] .

With the enactment of the Federal Constitution of 1988 in Brazil, reparation for moral damages started to reach the status of a fundamental right, considering that this right was included in items V and X of its article 5, located in the chapter that is intended to specifically address the fundamental rights and guarantees.

Soon after the enactment of the Federal Constitution of 1988, the Civil Code of 2002 emerged with the purpose of regulating compensation for moral damages in the country. In its core, he established a dualist system, contemplating the existence of two types of civil liability: the subjective, which requires the presence of the guilt element for its characterization; and the objective one, when the agent's guilt is waived to determine the existence of a duty, on his part, to repair the damage or loss caused by him [28]. Moral damage is an expression often used to define the injury caused to non-patrimonial – or extra-patrimonial or immaterial – property protected by the legal system, which gives rise to pecuniary compensation [29].

Bittar after carrying out a detailed explanation on the subject, conceptualizes moral damages as those that "translate into disturbances of mind, into unpleasant, uncomfortable, or embarrassing reactions, or others of that level, produced in the sphere of the injured" [30].

This is also how Coelho understands, when defending the need to be configured as moral damage, thus having the possibility of indemnification, only that which arises from situations of intense shock, great suffering - that is, that escape the normality established in life. Daily [31].

Like moral damage, existential damage can be classified as non-pecuniary damage, and its contours (as well as its proof) have been demanding from Labor Law operators a high exercise of interpretation and adjustment to the Brazilian reality. Its origins were in the Italian doctrine, which sought an alternative for the composition of damages that did not conform to the conceptual criteria of moral damage, but that went beyond them in relation to the effects derived from it [26].

Lora recognizes existential damage as any "injury to the set of relationships that provide the normal development of the human personality, reaching the personal and social scope" [32].

In these relationships, all those that allow the individual to compose their identity, their recognition as a social being, must be inserted.

In this set, there are activities such as personal, intellectual, social and leisure, spiritual development, and even leisure, rest itself, for the benefit of their physical and psychological well-being [26].

Almeida Neto explains in even more detail, stating that existential damage violates the right that every individual has to plan and program their life, to have ideals and aspirations, to have projects and:[...] to start a family, study and acquire technical training, obtain their livelihood and leisure, have physical and mental health, read, practice sports, have fun, socialize with friends, practice their beliefs, their worship, resting in old age, in short, enjoying life with dignity [33]. This is the agenda of human beings: to walk with tranquility, in the environment in which their life is manifested towards their life project [33].

Although it may seem a highly subjective concept, the elements that constitute it are fully feasible and adequate to reality, especially if the understanding is made in the light of constitutional ideals [1]. It was the Italian doctrine, therefore, that provided the support for the understanding of this new type of damage. Lora teaches that its emergence arose from the need to, in expanding the institute of civil liability, cover other indemnifiable damages, not only moral damage and property damage [32].

The interpretation that is made is mainly based on the need not to adjust the existential damage to a sub-category of moral damage, but that it must be in line with the indistinct protection of the dignity of the human person, whose content does not portray an elaborate list with finite possibilities. On the contrary, it is a command that must be understood in its broadest and most complex extension, immersed in social reality, adjusted to the understanding of the legal system as a whole [34].

In Brazil, this interpretation can also take place within the scope of the principle of integral reparability, enshrined in civil-constitutional legislation, since not only material damages (which include loss of profits and emerging damages), immaterial damages (herein included moral damages)), but any type of damage must be repaired, even allowing for cumulative damages even if the damage has the same offense of origin [26].

And reparatory integrality has as its scope the protection of all the person's patrimony, since the damage caused can affect not only the economically appreciable patrimony, but also other intrinsic attributes, which, together, make up the personal collection, worthy of protection and legislative shield [35].

In this vein, by consecrating full reparability to any type of damage caused, the legislator sought to protect offenses that were already consecrated in social daily life, but also allowed the inference of the emergence of new types of damage, in the face of relational dynamics. In the work environment, likewise, the construction of recognition of new models of offense is incessant [36].

Often, as Garcia explains, the work environment suffers from disorders of different natures whose motivation can be explained by the dynamics of the relationships that are part of it, by the different personalities of each protagonist, by the use of harmful management techniques (instead of stimulating ones) [35]. competition, fear of unemployment, among others.

Thus, it would not be reasonable for the individual protection network to be limited to an exhaustive list of possible damages to be generated in human relationships. On the contrary, the intention must be interpreted as a protection system integral, even if unmeasured possibilities arise daily [1].

The monitoring of this network, which involves the employment relationship as a whole, is a mission that has been taken by doctrine and jurisprudence with absolute priority, although with regard to legislative developments, it is not the same way [36].

In this line, existential damage has been adopted as a parameter of the offense, whose contours are presented to, in a way, differentiate it from moral damage, however, in an attempt to conceive the existential damage as another threat to the health of workers and carry out its classification as an offense capable of being investigated, prevented and punished by the Internal Accident Prevention Commission.

Conclusion

Faced with limited budgets, managers of health institutions often resort to the quantitative/qualitative reduction of nursing staff, which implies work overload, impairs the organization and delivery of patient care and compromises the implementation of strategies to improve quality. of attendance.

The main occupational risks found in the literature were: risks of developing stress, burnout or depression; insufficient number of employees to carry out the necessary activities, implying a greater workload for professionals working in primary care; exposure to risks and injuries related to ergonomic and biological factors due to repetitive tasks that can trigger health problems; risks of contamination with sharp objects; high sound pressure level; insufficient or inadequate work tools; excessive maintenance of an equal posture at work; need to adopt uncomfortable forced postures; excessive repeatability of movements; cargo handling; danger of external contamination; and insufficient ergonomic knowledge; inadequate cleaning and shortage of human and material resources, in addition to the lack of appreciation of professionals.

Primary care professionals work at high speed, with physical and mental demands, exposed to chemical, physical and biological risks. All these factors cause tension, anxiety and fear, compromising not only your health, but the quality of service as well.

In addition, it is not uncommon for companies in which, for the sake of their productivity and profitability, they disrespect these legal precepts and prevent workers from enjoying their rest, thus keeping them away from their personal projects or preventing them from having them. This disrespect can occur in a punctual way, for exceptional attendance of excess work, lack of personnel or project deadlines; but it can also happen in a persistent way.

Existential labor damage must be recognized as any type of offense that involves material or moral damages to the employee and that frustrates their life plans. As such, it must deserve shelter and protection, like other threat models.

Both moral damage and existential damage are the result of violence and affront to the principle of human dignity of the worker. Both derive from an offensive act on the initiative of the employer, which does not prioritize the health and well-being of the employee. However, with regard to its categorization, the existential damage receives contours of immaterial damage (just like the moral damage), however the final object of the offense is different, since in the moral damage the result is due to the offense to values intrinsic to the individual's personality and in the existential damage, the offense is materialized while there is

an impediment in the realization of a life plan.

Another difference can be established with respect to indemnity. In moral damage (as represented here), the indemnity value has the power to compensate for the damage suffered, acting as a true relief, since it is not possible to restore the status quo ante. In compensation for existential damage, the objective is to reprogram the employee's life project.

From what was exposed in the reviewed literature, it can be concluded that in primary care, nurses are exposed to all types of risks: physical, chemical, biological, ergonomic and psychosocial, with physical and ergonomic risks being more prevalent, which leads to the understanding that trained professionals are needed in sufficient numbers to meet the demands of the area, in addition to being important to emphasize the use of PPE and good ergonomic conditions for workers, otherwise there will be existential damage to the nursing professional [37- 45].

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