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The intangible in the production of care: the exercise of practical intelligence in an oncology ward

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Abstract *This article brings the results of a research of which main goal was to investigate the use of practical intelligence by an oncology nurse team in an oncological ward, in a hospital in the city of Rio de Janeiro, Brazil. We assume that, in spite of the suffering inherent to health care work, it can have a creative and potent dimension in the exercise of care, even in the presence of the challenges faced by the precarious working conditions, the growing demand of patients and the demands of productivity. Participant observation, in-depth interviews and group interviews were carried out with a selected nursing staff. We observed two main forms of practical intelligence manifestations. The first is the exercise of speaking and listening. The second, as an exercise in the production of comfort. Such forms of practical intelligence interpenetrate and cannot be captured by numbers, indicators, and methods of performance evaluation. They are invisible to instruments that do not go through the word of the workers. We conclude that it is necessary to create collective spaces in health organizations where managers and workers can express and dialogue on such issues, socially validating this know-how and those workers'experiences.*

Key words *Work, Work psychodynamics, Oncology nursing, Work phycology, Nursing care*

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Introduction

This article originates in part from the results of a survey carried out in an oncology ward in a hospital in the city of Rio de Janeiro, Brazil[1]. The research aimed to use practical intelligence[2,3], the know-how of nursing workers, considering their strategies to cope with suffering at work, including their relationship with cancer patients and their families. Its theoretical basis consists mainly of the Psychodynamics of Work (PDW).

We work with the hypothesis that, despite the huge challenge of health care work and its pathogenic dimension, there is also a creative and potent dimension in the exercise of care, in spite of the challenges of daily work. The know-how of care, called, in one of its dimensions, as discrete know-how by Pascale Molinier[4], has an invisible dimension. If, on the one hand, it is necessary to be discreet in order to make care effective in the relationship and bond between health worker and patient – in small but fundamental everyday gestures and attitudes in the care relationship – on the other hand, such characteristic makes it impossible to be captured by traditional management methods.

The invisibility of this kind of knowledge becomes a question of the transition from suffering to pleasure at work, according to the Psychodynamics of Work – the theoretical framework of this study.

For the Psychodynamics of Work, it is precisely the dynamics of recognition that operates the transition from suffering to pleasure at work. This happens when a symbolic reward is offered to the worker's unique contribution. This retribution is recognition. Therefore, the invisible dimension of care work makes it necessary to take a different look at this type of work, since what is the most valuable – in the worker/patient relationship – is what is least seen[4].

This also means that, despite possible forms of potentially incapacitating work institutions– because they do not allow the worker to contribute with adjustments to the way the work is performed – there is also the exercise of creativity and adequate ways of operating the nursing know-how when meeting the user. This know -how is called by Christophe Dejours as "Practical Intelligence" or "Cunning Intelligence" or "Creative Intelligence"[2,3].

Dejours, based on the Greek concept of Mettis– from which the words métier and meticulous derive – called this intelligence "Practical Intelligence". For Dejours, practical intelligence is produced during the exercise of work. It is the exercise of work and the confrontation with reality that mobilize the formation of this intelligence, at both the individual and collective levels: *It is work that produces intelligence (practice) and not intelligence that produces work*[3].

One of the main sources of suffering at work is the obstacle to the use of this intelligence, from which one can conclude that a possible source of pleasure would be the opposite, the free exercise of this intelligence as a way of contributing to the organization of work:

On the opposite side, pleasure is in the finding of work, when it is discovered that it is precisely when the use of this intelligence is not contradicted or opposed, but also when one recognizes the fundamental contribution it makes to the organization of work. And this pleasure is of great importance for full health, because it inscribes the work relationship as a mediator of self-realization and identity construction. It is the necessary condition to validate the aphorism that "work is health"[3].

The possibility of having their singular contribution recognized within the work institution, whether by peers – what Dejours called *aesthetic recognition* – or by the hierarchies – what Dejours called "utility recognition"– produces what the author called the *dynamics of recognition*.

Practical intelligence is not equivalent to cognitive requirements and one of its first characteristics is being rooted in the body. However, when Dejours makes this statement, he is referring to a specific conception of the body. The author does not refer to the same body of biologists, but to a second body, the one that experiences the world affectively, the body that is inhabited, the body devoted to the relationship with the other[3].

Dejours also affirms the subjective experience of suffering as something that is registered in the body:

[...] *There is no suffering without a body to experience it. In fact, intelligence at work is never reducible to a subjectivity that surpasses the subject. Subjectivity is experienced only in the irreducible uniqueness of an incarnation, of a particular body and of an absolutely unique corporeality*[3].

Therefore, *metis* or *Practical Intelligence* are also an essential part of health care work and, mainly, of the nursing work, since in this profession there is usually a big hiatus between the prescribed and the actual work. This hiatus is a huge gap, through which the worker can contribute, but which can also be a source of suffering, as their education guarantees primarily the technical, theoretical and scientific aspects. The rela-

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tional dimensions, highly required in the daily work activities of this category, are generally not a source of priority investment in their training.

Therefore, we work with the hypothesis, in this research, that, in addition to the suffering arising from the relationship with cancer patients, considering the pains and challenges of oncologic care, there is also a dimension of tacit knowledge construction, crucial for the exercise of the nursing profession, which occurs in the relationship between workers, as subjects, and the exercise of their work.

Search strategies

In addition to the theoretical framework of psychodynamics of work, the research was methodologically based on the clinical psychosociological approach, which focuses on the question of the relationship between research and action or between theory and practice, not only as knowledge production.

This approach somehow breaks with the principles of scientific positivism, as it considers that the research and the act of intervention are inseparable when dealing with groups of subjects, communities or organizations that carry, albeit implicitly, some demand related to their states of suffering. It is an approach that gives centrality to the production of meaning and suffering of the subjects in the groups and organizations[5].

The strategies used in the research were participant observation, in-depth interviews and two group interviews, carried out with workers from the same oncology ward, selected for being considered by hospital managers as the sector where the workers suffered the most.

Participant observations were carried out between September of 2012 and December of the same year, twice a week. There were three daytime shift teams, working a 12-hour-on, 36-hour -off schedule, with additions. During this period of little more than three months, it was possible to observe and establish a relationship with the three daytime shift teams. The night shift was not included because it brought elements such as shift work, the diversity of employment bonds and other issues that the research work would not be able to cover.

The elements that were the object of the participant observations were as follows: relationship of the nursing staff with the work institution, such as division of labor, prescribed tasks, organization of time; relationship with other professional categories; relationship with patients and their families and reactions to unplanned events during daily work.

All technicians working the dayshift were invited for the in-depth individual interviews, which totaled fifteen, plus one day nurse and three day-shift nurses. Of this total of nineteen workers, fourteen provided in-depth interviews. The others just talked at informal settings.

To conduct such interviews, elements and themes that emerged during the participant observations were used, which were included as the worker answered the first question;that was a request to speak freely about the work itself.

In all, fourteen in-depth interviews were carried out, four with nurses, nine with female nursing technicians and one with a male nursing technician. The process of conducting the interviews lasted two months, starting in January of 2013 and ending in March of the same year. The long period devoted to conducting the individual interviews was due to the concern regarding the need to wait for the most appropriate moment, so that each worker could give the interview, at the time and with the duration that they deemed appropriate and comfortable.

For Giust[6], the interview, within the clinical approach of research: (...) *is a privileged device for individuals and groups to learn concretely the way they live, submit to or transform the organizations in which they inscribe their act, whether professional or not*.

The central topics that guided the individual in-depth interviews were the following: routines, tasks, assignments; the daily work; coping with the difficulties; feelings about the staff, patients and family members; feelings about the hospital and the sector.

The group interviews aimed at providing a collective creation about the emerging questions that had arisen during the participant observation and during the individual interviews. Such questions were part of the daily work of the nursing staff and their feelings about work. Thus, through group interviews, the research proposed to favor the construction of the meaning related to the experiences of daily work.

For Giust[5], the interviews allow the exploration and construction of attitudes, as well as the possibilities for listening and analyzing situations. The author observed that, from the perspective of the psychosociological clinical approach to research, the interview is also an intervention moment:

(...) the interview, for the psychosociologist, is not limited to conducting the clinical interview

[...] *The psychosociological interview is a device intended to listen to a social request (formulated or non-formulated) so there is an approach to the complaint, the disease, the crisis situations*[6].

The group interviews were organized according to the emerging categories that appeared in the previous stages of the research. The entire nursing team was divided into two groups to discuss the topics that emerged during the fieldwork.

The research project was submitted to evaluation of the Research Ethics Committee of ENSP /FIOCRUZ and to the Ethics Committee of the co-participating institution through Plataforma Brasil. It was ultimately approved, after minor corrections in the terms of consent, on 08/16/2012.

After completion, the survey was presented to the workers in the year 2014, despite the logistical difficulties in assembling an inpatient team.

The exercise of Practical Intelligence in an oncology ward

In the assessed ward, we highlighted two main forms of manifestation of what Dejours called *Practical Intelligence* or *Cunning Intelligence*. The first of them was in the exercise of speaking and listening, the second in the exercise of producing comfort, not only physical, for patients and family members.

To understand these results, we considered it important to highlight, initially, the context of major managerial changes that have been implemented in public administration in Brazil, especially since the 1990s. In the health sector, such changes start in hospitals, having been extended, more recently, into primary care. Currently, public health services are dominated by the logic of productivity, indicators and numbers. The need for goals, numbers and indicators is justifiable and justified, considering the needs of the users of the Brazilian Unified Health System (Sistema Único de Saúde - SUS) and the necessity of ensuring universal and equal access to health services, together with quality and efficient use of public resources. However, one must consider, as mentioned above, that health work has characteristics that make it barely visible, if not totally invisible, to traditional management methods[7]. Therefore, such processes, although central to the quality of care, are not amenable to direct apprehension or measurement. This poses an increasingly relevant management problem that is the relationship of health workers with their institutions and the many management methods that are currently being implemented, in the context that Gaulejac[8] calls "acute quantophrenia".

The demand for productivity is increasing and it is presented to all hierarchies of public health organizations, involving directors, managers and workers. The demand for numbers, indicators and goals almost never show a counterpart in guaranteeing the material and personnel resources that are necessary to attain them. We know that one cannot do management without evaluation, without goals and indicators. The point is that the productivist logic is increasingly taking the place of qualitative assessments of work processes, disregarding the place of human interaction in health care management and production processes.

In this context, the research[1] detected a certain degree of work discouragement from the relationship of workers with management. Such discouragement was expressed in speeches, such as *I don't say anything anymore*; *I no longer speak*, *I don't give my opinion anymore*, and even – perhaps as a defensive strategy against their suffering, it manifested itself in the workers' apathy, carelessness, neglect, or indifference towards those they should take care of.

In relation to this situation, the research indicated, mainly, a perception, by the workers, of the invisibility of the effort made by them related to the task of providing care to patients in material, technical and time circumstances that they considered not adequate for the exercise of care.

In addition to the many demands of technical expertise and scientific knowledge that are required for the exercise of professional nursing practice, these workers are submitted to heavy demands in the exercise of their professions, as during their work in the health area, they meet other bodies, other lives, other stories, at a moment of deep fragility, which is the moment of illness and, in this case, the moment of hospitalization. Moreover, there is the fact that the nursing professional is responsible for the continuity of care. Faced with these often dramatic situations, they are required to demonstrate skills that are not a priority in their training trajectories, such as dealing with the fear of death, the loss of a family member, and other deeply sensitive situations, especially in our culture, which keeps us away from idea of finitude, based mainly on power, success and youth[9].

Dealing with these issues is something that is demanded daily from all health professionals, but these issues are more intensely focused on

the nursing staff, because it is this category that ends up having a more intimate contact with patients, handling their bodies, witnessing their daily suffering and, more often than not, having to "prepare" their bodies after death. Thus, nursing professionals end up establishing a close relationship with these subjects and family members, giving room for the manifestation or production of affections inherent to such an intimate relationship.

These bonds and situations, with patients and family members, are often perceived as frightening, distressing, as events that require workers to exercise a type of knowledge that goes far beyond their technical and scientific knowledge.

Dejours states that it is in the meeting of the worker with their work that *Practical Intelligence* emerges and that this, the work, is not only a *task*, but that it colonizes the subjectivity: *Finding solutions, inventing new ways, this goes through a transformation of oneself, a deep one. Work does not stop at the studio, factory or hospital. It colonizes all subjectivity*[3].

Thus, we will describe the main ways *Practical Intelligence* manifested itself in the way the nursing staff performs their work in the assessed ward. Faced with the challenges of this context, it was through words and gestures that the nursing staff working in that sector expressed their ways to overcome obstacles. The team did not stop creating, despite a work organizing manner that made it difficult to debate these everyday micro-creations, which resisted not only obstacles, but the adverse context.

In Medicine, as well as in nursing, students are taught only knowledge, one cannot teach the work itself. [...] *It happens with the health professional's learning process, the same thing that happens with the child: you do not teach a child to walk, you can hold them by their hands, but we do not explain how to contract the muscles, move the joints, chain the movements. It is necessary for them to find out for themselves and, like us, to experience the reality... there are countless falls, bruises until they find or devise solutions to regain their balance when they stumble*[2].

Thus, the exercise of care production is an exercise of creation, of letting the *practical intelligence*, or *metis*, emerge, which is a nonrational intelligence that passes through reason only *a posteriori*. Letting this cunning intelligence emerge from the prolonged contact with the user:

The knowledge I acquire in everyday life, on a case-by-case basis, is an enriching one. It is like a grain of sand. It goes and adds up, do you get it? Inside of me. Most of what I am today, I learned by dealing with it face to face. (Nurse during the individual interview).

Practical intelligence as the exercise of speaking and listening

One of the frequent elements in the observations was the way nursing technicians and nurses not only communicated with patients, but also how they established a connection with them by speaking as they performed – and conceived in their own way – the prescribed procedures. We realized that the act of "listening and speaking" could be both a welcoming gesture between staff and patients, but sometimes represented the function of producing meanings, contributing for the patients to reflect or observe their disease and conditions from other possible angles.

There was a general understanding that it was necessary to listen, and that listening is part of the job, that the patients and family members who do not have their words heard tend to cause problems later. One nurse said in the individual interview:

I try every possible alternative to decrease the complaints, the suffering, because a patient and a family member who do not have anyone to listen to them… it means… almost means trouble for me. Because that gets bigger. Understood? There's no way I can escape it.

During the exercise of care, the nursing staff used to fill in the gaps that remained in the relationship between doctors and patients, helping in the construction of meanings about the moment lived by those patients, appeasing anxieties:

And the attributions we have is what we do with patients, right? Bathing, feeding, punctures, even conversational work, because sometimes it is just what the patient needs. Just the conversation. Sometimes they can be rebellious, we go there, talk to them, explain. Sometimes it is a procedure that was not explained to them. They know they are going to have surgery, but nobody goes to them and explain what the surgery will be like [...]. (Nurse in the individual interview).

Similarly, a nursing technician refers to the role of speaking, the mediation exercised by her during moments of care, in the relationship between doctor and patient, and in the production of meaning about the disease:

I try to show, I don't know, the good things of the moment. Talking, trying to relax. They talk to me, they start talking: 'ah, I don't know why I'm here, why this problem'. Then I say: How did you

start observing it? Then they start telling me: 'It started with a pain, so and so. [...] *I usually advise: 'talk to your doctor, try to know more about it, try to understand what is going on'.* (Nursing technician in the individual interview).

The technician exerts this mediation – within some limitations due to their place in the hospital hierarchy – as she says, *there are so many humble people, many humble people who go through this, who are going through this* and this *humility* of patients often require a mediator between the doctor and them, a role often played by nursing technicians or nurses. Perhaps because of their intermediate position in the hospital hierarchy and in the technical and social division of health care work, they can identify more easily with patients and be more open, more available to exercise such mediation, more available to hear and embrace the meaning[10] of the encounter with this other, the patients, who approaches them in their position of least power in care relations.

The nursing staff, in this case, has the role of mediation between the medical category, whose power and professional prestige are at the top of the hospital structure, and the *humble* patient: one who does not understand their illness and the reasons that lead them to be there, but also those for whom the medical language is unintelligible, the one who really needs to be stimulated by the nursing technician to ask the doctor questions:

I don't know if they feel more comfortable with us. They see that doctor figure, which may cause some fear. [...] *And there are many* [doctors] *who do not give the patient the opportunity to talk. So* [...] *I always talk a lot and I want to know how everything is going there. Then they open up more to me.* [...] *they tell me things that they don't tell the doctor and then I have to end up directing it, understand?* [...] (Technician in the individual interview).

The above transcript also demonstrates how the nursing technician adapts her working rhythm to the patient's rhythm and how this adjustment leads to a possibility of bonding between the patient and her, so that the patient can feel comfortable when speaking.

In addition to *explaining*, *clarifying* what the doctor could not clarify or communicate to the patient, there is also the dimension of embracing:

Sometimes I go to the bed to give the patient some type of medication, then the patient starts talking, and I try to listen. Because sometimes just by listening to that person, you are helping them, letting them vent. [...] *I try not to give my opinion, to make decisions, understand? I just really listen. I keep listening.* [...]. (Nursing technician in the individual interview).

Another technician, when performing her acts of care, tries to explain all procedures to patients in order to minimize their distress.

Another nursing technician mentions: [...] *I will give you the medication* [...] *I tell them the name of the medication, what it is, I explain* [...].

A nursing technician discloses how her *conversation work* helps her with the performance of the "evolution" itself, that is, recording the patient's condition and well-being throughout the day:

But I try, at the bath time, and then I talk, I ask them ... [...]. *How did you spend the night, are you eating...?Then ... starting from this conversation I'm already performing my evolution....* [...] *I, I try to give them some freedom, do you understand?* [...] *Let them talk a little, while I'm caring for them, I'm doing it, I'm doing it ...* [...]. (Nursing technician in the individual interview).

A nurse on duty speaks about how she understands her work and tells us, as in her words, she *deconstructs myths*. She begins by talking about the deleterious effects of the small fantasies in the form of *growing doubts* in patients:

Then I try to decrease [...] *the suffering. I try to encourage them to leave that state of sadness they find themselves in. And insecurities. The more doubts I can clarify, I know it is better. Because sometimes they get ... It's a small thing, but in their minds, a doubt grows and grows and sometimes it was not all that.* (Nurse in the individual interview).

The strategy of being silent to care or not speaking so as not to hurt seems also to be a form of manifestation of practical intelligence and is verified not only in the discourses that refer directly to death, but also to the life conditions in general.

A nursing technician, who has an adolescent daughter reveals how – in a situation where she was caring for a seventeen-year-old amputee – she was able to swerve, by not saying everything, but hide it in the name of the patient's well-being. The sick girl and her mother asked her if she had children, and she felt like she couldn't talk much about her daughter, who was a healthy girl, while the user whom she was treating had many limitations:

You know ... I avoided answering when she, or her mother asked, 'Oh ... do you have a child?' I said: 'I do, I have a daughter too'. She said, "Ah ... how old is she?" I only told her my daughter's age. Then she would look at me ... But, you know, when you try to avoid talking about your daughter, be-

cause you know that your daughter is a healthy girl [...]*? A girl who dances, who studies, goes to school. And you look at that girl over there, and you can see that she doesn't do any of that ... Because she can't.* [...].

However, the technician is able to find a way to have access to the girl through humor, being able to promote some identification between the patient and her daughter, at the start so different in their situations of illness and health. Moreover, humor also allowed her, as a nursing technician, to deal with the affections that the identification process with the mother-sick daughter pair mobilized, since they referred her to the relationship with her own adolescent daughter.

Then, there was one day I went to take her to the bath [...]*, then her mother said: 'Hey, look, the nurse will be able to see your little things' and such. I said: 'Oh, never mind, because my daughter also says that it is the Atlantic Forest'. Girl, she just grinned (makes the gesture on her face, showing a wide smile* (Technician at the collective interview).

Thus, the exercise of care presents itself not only as speaking, but as being silent, as retreating, as withdrawing, as hiding, and in this case, in addition to being silent, being able to joke afterwards, in the midst of the drama.

Practical intelligence as giving comfort

Faced with their powerlessness over healing and death, nursing technicians and nurses mentioned the possibility of *providing comfort* to patients, comfort in the face of death, comfort in their last moments of life, comfort by doing what it is possible within their powerlessness in relation to topics of such intensity of affection:

I know I can't change the patient's health status, I don't have the power of healing, it's beyond my reach. [...] *but what I am able to do to bring them comfort, help... There was a patient the other day who asked me for a lemon ice pop. By then it was past lunch time and everything. Then I called the dietitian, and I told her: Josefa, try to get a lemon ice pop for this patient because she is not eating, she cannot eat anything anymore and she said she was feeling like a lemon ice pop. Such a simple thing, one that if I, as I am healthy and feeling like it, can go out and buy it. She simply can't do that* [...]. (Nursing technician in the individual interview).

We have observed some scenes in which nursing technicians and nurses negotiate with dietitians some foods that are not prescribed or even not recommended for end-of-life users, some very young ones. In one scene, a nurse firmly negotiated with the nutritionist also a nice pop for a twenty-three-year-old female patient with respiratory distress. The dietitian argued that it would only be possible to provide the popsicle if the nurse remained next to the patient helping her, until she finished the ice pop, so there would be no aspiration into the lung.

This episode showed not only the understanding that the ice pop was more than a physical food, but that it represented a life wish for the patient, who was close to death, but also that the patients' demands – even though they may go through something that is initially apparently physical – go well beyond the biological aspect; that negotiations with other professionals are appropriate to meet these demands – when the time of care allows it, considering so many different demands – and that it is relevant to make the moments close to death something that is *positive* for the user.

One day a family member approached a technician, claiming that the patient was uncomfortable. The technician went to the patient's bed, asked what she was feeling, to which the patient replied: "(...) *something bad*..." He changed the patient's position a few times, asked her to sit up, to change the position, offered her some water, and kept asking how she felt until the patient replied that she was much better. Upon returning to the nursing station, the field researcher asked what he had done and how he had understood that episode, to which he replied: *We know that the discomfort they are feeling is not only physical, but we go there, try to give them some comfort, some attention and then perhaps they might feel a little better....*

Thus, knowing about the expressions of discomfort is something much more refined than what is contained in technical nursing training and it goes through this hand-to-hand meeting with work.

The ways how nursing technicians and nurses provide comfort are diversified, as in the following statements, which presents the issue of listening, of moving forward and withdrawing, according to the users' need, which refers to the production of care as a *discreet savoir-faire*, as described by Pascale Molinier[4]:

An attentive work, when done well, is not seen! Your success depends largely on your discretion, that is, on the suppression of your tracks. [...] *The beneficiary does not know how much that cost to the person who performed the service, especially since this person anticipated their needs even before they were expressed.*

A technician mentions how to deal with the user's excrements, mentioning care and comfort also related to this *dirty work*, which no one does and how she deals with the user, with this intimacy, this contact with moods and excrements, in order to avoid embarrassing and violating the user:

Because I know that patient is not that, that… not those excrements. That all that is a natural thing. That it is in me. So, I always put myself, I try to put myself in that patient's shoes. How would I like to be handled if I were in that situation? [...] *So, as far as possible, I always try to respect their body.* [...] *You have preserved yourself, protected yourself for so many years and suddenly you have to be exposed all the time to a person you have never seen before* [...] *because you need it. Thus, I try to handle them with my touch. At the time of cleaning, of handling these residues, these excrements and such, as naturally as possible, because I keep imagining my expression seeing someone collecting what I have eliminated with a certain disgust, right?* [...] *We record the odors; it is impossible not to record them. But I try to be as natural as possible.* (Technician in the individual interview).

In this excerpt from the technician's speech – which condenses the speech of many nursing workers interviewed in the research –the care appears in its five dimensions enunciated by Pascale Molinier[4]: care as *gentleness*, as *discrete savoir-faire*, as *dirty work*, as *invaluable work* and as *ethical narrative*.

The technician understands the user's fragility, not only because of the disease itself and its consequences for the physical body, but also due to their lack of autonomy, because they have to undergo having their excrements cleaned by a stranger. From this interpretation of the user's condition, the technician uses her abilities, including her body, facial expression and emotions, to maintain the user's sense of dignity as much as possible.

The care also appears in this excerpt of speech as *discrete savoir-faire*, as she is careful with her expressions and tries to be as natural as possible, despite recording the odors (through her olfactory sense), when cleaning the user's excrements. It is a discreet attitude, not perceived by the outsider and one that anticipates the expression of the user's need.

This attitude of care also appears in its dimension of *dirty work*, as cleaning up another person's excrements is, according to the common sense, considered repugnant, which one avoids doing and is delegated to a person in socio-professional positions considered to be hierarchically inferior.

In this excerpt from the technician's speech, the care also appears as *invaluable work*, as it is indispensable, not subject to prescription and, at the same time, not measurable:

Invaluable work is not measurable, especially through management methods: how can one measure a smile or a presence? Its value is priceless, which makes the question of its remuneration a highly complex one: why does that which has the most value receives the least pay?[4].

Finally, we can also state that care appears here as an *ethical narrative*, as it goes from the stereotypes of kindness or idealization of care to something that occurs in the concreteness of the relationship, which appears as an ethical attitude between the caregiver and the one who receives care, beyond any kindness, pity or benevolence.

Final considerations

We observed that the exercise of practical intelligence by nursing workers in the assessed oncology ward are expressed as ways of speaking, listening, silencing and producing comfort by the nursing staff. Such forms of practical intelligence interpenetrate each other and cannot be captured by numbers, indicators and performance evaluation methods. They are invisible to instruments that do not go through the word of the workers.

When this know-how of care workers tends to be invisible, important damages to the quality of care are posed. One is the widening gap between care workers and management workers. Another is the increased suffering of the worker and their discouragement towards work.

The recognition that human work is not reduced to its immediate material or quantifiable results, comprising a much broader and intangible dimension, hardly visible or apprehensible by traditional assessment methods, is a shared comprehension between Work Psychodynamics[11,12] and the other approaches that are considered "work clinics"[13,14], such as the Activity Clinic[15,16] and Ergology[17].For these perspectives, work will always require the unique and collective contribution of workers. More than a reunion and exchange with others, it will require working with others, on a common object, a know-how that lies between repetition and creation, between deed and creation[14] and, thus, a privileged field of mediation between the uniqueness of the worker and the social.

From this viewpoint, it is imperative to create collective spaces in health institutions in which managers and workers can express and dialogue about such issues, socially validating this know-how and these workers' experiences and, thus, converting practical intelligence into practical wisdom, the latter with a collective characteristic. Finally, it is noteworthy that taking these intangible dimensions of care out of invisibility can represent an important opportunity to review the way work is organized, its routines and practices, strengthening their care production potential.

Collaborations

MLG Fonseca participated in the study design, research, data analysis, writing and critical review of the manuscript. MC Sá participated in the study design, data analysis, writing and critical review of the manuscript.

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