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Qualitative analysis of the Spanish Health System in the context of Covid-19 pandemic

María Jesús Gómez Camuñas[1]*

[1] Health Center, Primary Care, Madrid Health Service, Madrid, Spain; mariajesus.gomezcamunas@gmail.com

* Correspondence: María Jesús Gómez Camuñas; mariajesus.gomezcamunas@gmail.com

ABSTRACT

Objectives: The objective was to carry out a qualitative analysis of the Spanish health system in the context of Covid-19 pandemic, in order to detect inefficiencies and create a model capable of tackling them.

Methods: This research was carried out in five public Spanish hospitals, using the following qualitative perspectives: ethnography and the grounded theory. The data were collected through the techniques of information gathering, including 79 observation sessions in the hospitals with an average duration of 1:44:10, 410 documentary materials (official and unofficial records, photos and videos taken in the hospitals) and formal in-depth interviews about the quality of the Spanish health system (n=26), with an average duration of 47 minutes and 4 seconds.

Findings: The results provided answers not only to the research questions formulated throughout the work but also led to the determination of the contextual conditions of health organizations on the basis of a plausible explanation of the events that occurred during the COVID-19 pandemic.

Conclusions: The findings of this research, which analyzed some of the events that occurred in the COVID-19 pandemic in Spain, suggest that it is necessary to create a true organizational culture oriented to the common good, introducing into health organizations people truly responsible for the other.

KEYWORDS

Coronavirus; health organizations; cultural anthropology; grounded theory.

1. INTRODUCTION

This article attempts to answer the key question that Spanish citizens are asking about the coronavirus 2019 pandemic (SARS-CoV-2): How is it possible that the Spanish health system, which has been publicized as 'the best in the world' [1], has produced such high numbers of deaths and infections?

According to Jiménez [2], a journalist and contributor to the New York Times, our leaders have been making the mistake for years, whether deliberate or not, of equating the quality of the health system with life expectancy. This is a health myth for which a very high price has been paid, and which should lead to the construction of a model capable of meeting the needs of an ageing and vulnerable population, as well as reviewing and applying reforms to a public health system fragmented into seventeen regional models, for better coordination, and investigating the failures committed, following the creation of a parliamentary committee.

1.1. Contextualizing the topic of study

However, in order to resolve this pressing issue, it is convenient to go back, at least in a synthesized way, to the origin of the Spanish National Health System (known as SNS). The first legislature of the Socialist Government of Felipe González, following the project of state, implemented organizational and functional reforms aimed at configuring the public health service and consolidating the Welfare State (Law 14/1986, 25th April, for General Health) [3]. Some of the normative proposals related to the subject can be obtained from the aforesaid law. The means and actions of the health system are oriented to the promotion of health and prevention of diseases, guaranteeing health care in all cases of health loss, and to adapt its services according to the principles of efficiency, speed, economy and flexibility. Considering these as the fundamental activity of the SNS, the epidemiological studies should guide the prevention of health risks, through an organized system of health information, surveillance and epidemiological action.

This was a law that, since its inception, is considered from the economic perspective more as an expression of intentions for future reforms than as a plan of immediate actions [4]. It must be understood that the main cause of the decentralization process and the reason for its characteristics, as it has taken place in Spain, is the political and not the economic factor if we compare it with what has been carried out in companies [5].

In 1990, the Parliamentary Group Democratic and Social Centre (CDS) urged the government to propose a commission of experts for the analysis and review of the SNS due to 'current

environmental trends and their possible future projection', for instance: the growing economic tensions resulting from the unstoppable increase in health expenses, the progressive ageing of the population that produces thousands of vulnerable and dependent people every day, the increase in the number of people suffering from chronic diseases, the risky lifestyles prevalent in society and the incessant pressure of accelerated technical-medical progress costs, without improving productivity, to unbearable limits [6].

One year later, the April Report was published, in which the shortcomings of the SNS and recommendations for dealing with them were set out, recognizing 'the exhaustion of the health system'. However, due to the parliamentary rejection [7], the union opposition and the social pressure, this has gone into oblivion.

Abril Martorell, the key drafter of the document, explains these adverse reactions as 'a propensity to kill the messenger', alleging that nobody dares to face the problem of health care, while warning that the more years it takes to find a solution, the bigger and more perverted it will become [8].

Consequently, in accordance with the eternal call for health care reforms, we present this study carried out in Spanish public hospitals, as part of a thesis on health care culture [9], with the aim of finding a model that addresses the inefficiencies detected decades ago, and consequently provide society with an explanation of the events that occurred during the SARS-CoV-2 pandemic.

2. METHODS

2.1. Research design

The research design involved a qualitative design based on reflection with an a priori ethnographic focus to achieve the objective of the study, guided by significance of the research for the human group under study and for the scientific community, and, by extension, society in general to which the researcher directs the results [10].

2.2. Research scenario and ethical considerations

This research was carried out in five public Spanish hospitals. The hospitals were selected based on the criteria of convenience [11] and heterogeneity [12] and the sample of the study was chosen in accordance with the established criteria of intentional sampling, through the following two modalities: opinion sampling [12] and theoretical sampling. The participants volunteered for the study and the sample size was governed by the principle or strategy of theoretical saturation [13].

The research was authorized by the Research Ethics Committee of the Rey Juan Carlos University (ID number: 37/12). Access permissions to the participating hospitals were obtained from the responsible people in each hospital. The information concerning the study is guaranteed to be anonymous and confidential, respecting international data protection standards, such as the current Spanish legislation [14].

2.3. Data collection and participants

The data were collected through the techniques of information gathering, including 79 observation sessions in the hospitals with an average duration of 1:44:10, 410 documentary materials (official and unofficial records, photos and videos taken in the hospitals) and formal in-depth interviews about the quality of the Spanish health system (n=26), with an average duration of 47 minutes and 4 seconds. The demographics of the 26 participants who were interviewed are presented below (Table 1).

Table 1. Demographics of participants in formal interviews

Gender	**n**	**%**
Woman	19	(73)
Man	7	(27)
Age		
20-29	5	(19)
30-39	8	(31)
40-49	1	(4)
50-59	7	(27)
60-69	3	(12)
n/d	2	(8)
Categories		
Nurse	8	(31)
Supervisor	4	(15)
Sanitary	3	(12)
Pupil	3	(12)
Manager	2	(8)
Cleaner	1	(4)
Head of service	1	(4)
Nursing Director	1	(4)
Patient	1	(4)
Family member	1	(4)
Physiotherapist	1	(4)

Contract		
Permanent	11	(42)
Temporary	5	(19)
Occasional	2	(8)
Services commission	1	(4)
No contract or not working	5	(19)
n/d	2	(8)
Total	26	(100)

**n/d means that it has not been defined by the participants.*

2.4. Data analysis

During the fieldwork, the data were simultaneously analyzed with the Atlas.ti software (Table 2), obtaining categories, meta categories, themes and domains from the ethnographic perspective.

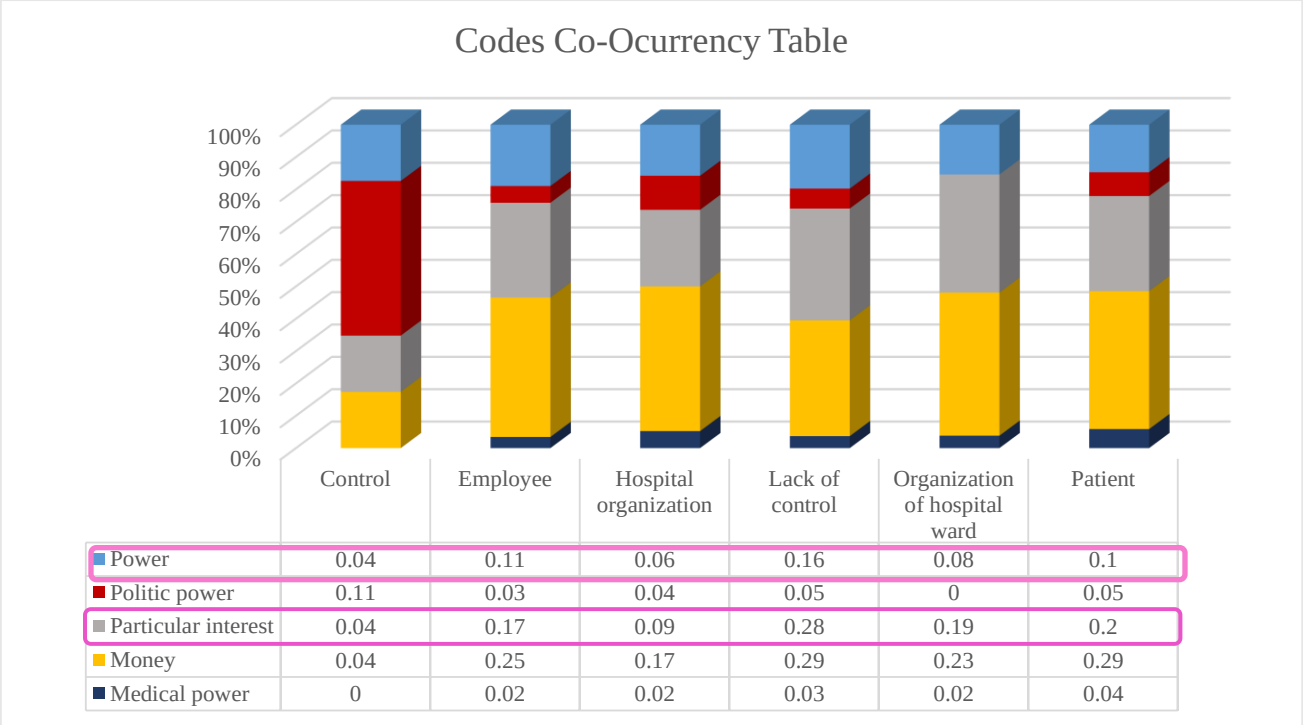
Table 2. Accounting of operations in Atlas.ti

Analytical data	**n**
Primary document families	16
Primary Documents	101
Quotes	5009
Hyperlinks (links between quotations)	1364
Code families	934
Codes	476
Codings	208126
Code-code links	4203
Memo families*	60
Memos	2579
Theoretical	604
Methodologies	169
Comments	1594
Observations	212
Semantic Networks	931
Total	226378

However, while reviewing the results something seemed to be missing, and a new analysis was considered appropriate. This time, it was through the grounded theory. In this way, the central category is discovered: the particular interest and the condition of the environment, fundamental to answer the research question.

A conceptual ascending analytical process was used, allowing to deepen and understand the studied reality, in addition to explaining new events when the contextual condition remain unchanged, as stated by Strauss and Corbin [13].

As a clarification, the codes with the highest grounding of each scenario were found using the statistical formula of frequencies, and the inductive finding of the central category was supported through the code co-occurrence table (Figure 1).



	Control	Employee	Hospital organization	Lack of control	Organization of hospital ward	Patient
Power	0.04	0.11	0.06	0.16	0.08	0.1
Politic power	0.11	0.03	0.04	0.05	0	0.05
Particular interest	0.04	0.17	0.09	0.28	0.19	0.2
Money	0.04	0.25	0.17	0.29	0.23	0.29
Medical power	0	0.02	0.02	0.03	0.02	0.04

Figure 1. Central category in Atlas.ti

3. RESULTS

The results of this study indicate that the contextual condition, the actions of the environment and the consequences in the subject are characterized by submission (Table 3). Table 3 shows the main concepts and results classified according to the grounded theory, and therefore the theoretical elements that are exposed throughout the article.

The results are presented in the article through two methodologies: the grounded theory with the concepts and the ethnography from the references, which speak for themselves. Some important concepts used in this research are: the others (different individuals), actors (all the people included in this research), power (institutions or people that have power).

In addition, the meanings are illustrated with words of the actors, in italics, adapting to the narrative; or inserted references before, during or after their presentation, showing their support in the data. At the same time, those terms that the participants emphasized with their tone of voice or those that bring meaning to the research are distinguished in bold.

Table 3. Characteristics of the concepts of basic social process (BSP): 'Power to survive'

Submission	**Property**	
The non-Organization Insecurity Defencelessness	**Theoretical code** Categories	Surrounding condition
Subjugation Learning in the subjugation Nullification of the profession Nullification of being	**Theoretical code** Categories	Surrounding actions
Being the object of power	**Theoretical code**	Consequence on the subject

3.1. The non-organization

[They have overlooked it" (P35 OBH1, 132).]

The structural PSB (basic social process) of 'Power to Survive' is defined as the use of the subject's own capacities to satisfy his/her need, through a self-centred action that rules out his/her responsibility towards others and produces disconnection from the environment.

This is exposed from the contextual condition resulting from the actions of a power that is not responsible towards the other. The contextual condition, in the case of political power, manages its objectives associated with money, while controlling information, time and image for its own particular interest.

[These days the emergency has been blocked and they had to open beds, 22 beds, until it has not come out on television, nothing...," (P62 OBH1, 017).]

A contextual condition is defined as non-organization, which is originated by the exercise of a power not responsible towards the other, obtaining submission and docility in individuals – a type of power that is inferred from the belief that the subject has of himself/herself, an object worthy of care, where the other is only a tool to satisfy his/her need. In this way, he/she chains himself/herself to submission establishing a type of subject specific to this environment.

Having said that, the organizational disorder is evidenced by not being attentive ["Marisa (nurse supervisor) looks at the blood transfusion request flyer and says, **'this was for 8th March, I have to tell the girls that they have missed it.** Today is 11th March' (P35 OBH1, 131:132)".] This compromises the safety of the patient and the worker; in an everyday reality that he/she internalizes by adjusting it to his/her particular interest, through understanding of subjectivity of the other and trying to solve this reality, hoping to obtain a favour from those who believe that he/she has a superior power: ["…now the beds we have are beds for…they're not for trauma patients, because the tractions are misplaced…**patients can't hold on to anything**, you have to lift them yourself…" (P83 EH1, 241)].

This is a daily situation, described by this nurse as 'unsustainable' (P84 EH1, 156), in which a way of working is established as 'you get by with what you have' (P81 EH1, 223), leading you to use damaged, unsuitable or out-of-stock material.

[Delia (assistant): "**Sometimes I steal** sheets from my colleagues to make beds for my patients, **because we don't have any**…" (P43 OBH1, 120).]

This is how the responsibility towards patients is ruptured and focus shifts to oneself ["There is less staff, it is evident that there is more ... more dirt and fewer resources for everything" (P85 EH1, 697)] and it is an experience of suffering in the institution that is supposed to resolve, subordinating its moral principles to its particular interest, keeping silent.

[…I've been working for many years and this has been happening. I saw an x-ray technician asking an 85-year-old woman to stand on the x-ray table. When she wasn´t able to, the technician didn't even bother to help her... **I'll never forget that. It is best to avoid coming to the hospital** unless you don't have any other choice. My father died in my house, thank God... **There is a lot of suffering here**. We will all be patients and **they don't realize that they will have to go through this** - when he says this he stares at me. I am breaking inside, I can see the pain in her eyes, in her soul, this is far too much. (P42 OBH1, 228:230)]

A context with two different conceptions of working: the old ones and the new ones. 'The old ones passed the round, we tried to work as a team' (P17 OBH1, 033), and the new ones, which impede due patient care, thus creating a flow value, as the data shows:

[Look, these young women have distributed the breakfasts, they have reached 420 (dummy room number), and there were only two more left, but since they are mine they have left them and gone to sit…' (P43 OBH1, 058).]

3.1.1. Insecurity

Insecurity emerges from an environment in which ["People don't give a damn" (P88 EH1, 385)] and whose irresponsible actions with others ["Stay up in the air" (P88 EH1, 341)] are a characteristic of the organization ["Those who work least, the laziest, benefit" (P84 EH1, 172)].

So, fear appears before the feeling of threat of loss of security ["In this hospital you feel very coerced, you can't say many things…if you want to keep working, I mean" (P84 EH1, 275)] and belongingness ["What happens if they kick you out! John (ex-director of nursing H3), because you're taking the risk ... saying this" (P99 EHCA1, 302)]. It's an emotion shown by permanent employees, temporary employees and managers, such as fear of going to prison, of losing your contract ["You are much more afraid and you don't talk as much, because ... the fact is that your contract depends on these people" (P84 EH1, 144)] or being ["kicked out" (P39 OBH1, 231)] in the case of a manager.

Insecurity is a feeling that leads to focus on particular interest and *to forget about those things* ["There are **no doctors physically** on the floor, they are in the operating room..., **they are** in ... the emergencies **... I don't know, somewhere around"** (P81 EH1, 347)], increasing the patient's vulnerability. Sometimes it is because of the architectural design ["I find a great **labor difficulty** in taking the patient to the bathroom with one step to put him in the shower, we have another step from the shower tray, some screens with an impressive narrowness that I have to get myself inside to be able to shower him..." (P78 EH1, 041)] and that shows an insensitive reality to the other ["Director of Nursing H1: [...] **the idea**, it was necessary to get single and double rooms with..., in the same structure than before" (P94 EH1, 127)].

3.1.2. Defencelessness

Defencelessness is another characteristic of this organization, which the data show through the distribution of space and aesthetics, modulating and conditioning the work activity, and which originates in the worker an emotional disturbance of incompetence.

[The faulty architectural design **creates a terrible stress**, because they have made some construction work that is a disaster. They should have leveled the bathroom floor to make room for the patient when they did the work not long ago, I do not know, maybe five or six years ago, I don't know who the hell they asked, frankly... (P78 EH1, 041:044).]

The badly designed processes ["They leave it to us to solve it" (P98 EH1, 286)] submit us to a continuous burning during the job ["Do I wear myself out? a lot" (P78 EH1, 414)], generating

impatience for not being able to control the threatening situations that the patients face even if you want to, an experience that leads the worker to exhaustion and defencelessness ["We do not solve it, because we do not! **I don't have the capacity to solve it**, I have the capacity to say this system that we have … this computing system does not work, **but I cannot change it"** (P98 EH1, 280:290)].

3.2. Subjugation

["P**ractically, it is not to think about things**" (P88 EH1, 105).]

An environment in which a power irresponsible for the other is exercised and actions of submission are carried out generates loss of identity of the individual when accepting them for interest [**"You do it and shut up"** (P91 EH1, 165)].

3.2.1. Learning in submission to power

From the moment a student or a health professional enter the health institution, they verbalize the way of working ["I was taught to work like this' (P88 EH1, 586)]. Although they manifest in this way their discrepancy if there is something that interests them, they reproduce it, becoming reflections of their models and the reason for their own submission.

["Alberto (physiotherapist)—in the end the way to work…is, practically not to think about things, you say walk, then walk, come on, tutututu... Have you walked? Come, sit, I'm going." (P88 EH1, 105)]

Evidently, it's a workplace that is focused on the task and not on the patient, where institutionalized routines and attitudes subdue the worker, the worker ends up resigning himself/herself to the organizational environment ["I do not like..., this is a routine, all the same, we distribute the medication, then … I like emergencies, it is more varied" (P20 OBH1, 048)], assuming that the leaders are those who think. It showcases an organization that subjugates you through inefficient relationships between departments and services ["T**o get something fixed here**... (P22 OBH1, 133)], relating physical resources ["**Now I wait** to collect them (thermometers) and I put them on those who are missing" (P22 OBH1, 138)] and human resources, determined and insufficient ["I have not had a summer like this, an auxiliary and **a nurse for sixteen (patients), one assistant for a whole floor**. This summer **the patients did not get up** on weekends" (P60 OBH1, 148)], with patients and relatives ["**who are always right**" (P43 OBH1, 037)], focused on their interest in *those little things* (for example a patient asking a very busy assistant for a glass of water when the patient has a family member next to him), not responsible with the other already affected by the workload.

Likewise, according to the results of this study, the client, with this attitude, is insensitive to the needs of the other and submits to an organization that he/she ignores ["**When** they really **must** denounce**, they don't know** what to denounce…" (P43 OBH1, 037)].

This experience causes in the worker a growing sensation of impotence, uselessness, depersonalization, indifference that generates indecision, errors, accidents and the acceptance of this reality as irremediable [**"Nothing will change here"** (P25 OBH1, 084)].

3.2.2. Cancelling a profession in favour of another

This section refers to hierarchical and compartmentalized organizations that protect their interest by avoiding interference in their action or in others, pushing the professional to focus on his/her interest and self-molding his/her profession to the institution.

In this way an organizational model is established, which favours certain professions ["The only country that has paediatricians in primary care is Spain" (P89 EO, 669:673)]. This is done by increasing the number of employees of professions aligned with power and also allowing them to permeate towards other disciplines, thus harming professions not aligned with the pre-established interest of power, producing in them a loss of identity until they ignore its value and transcendence [Soledad (nurse): "I'm a glutton for punishment. While she talks to me, she keeps working, signs medication, looks at the medical report ..." (P60 OBH1, 50)].

3.2.3. Self-Destruction

["I don't think any of us **value ourselves**" (P90 EH1, 687).]

In fact, the comments of the people who participated in this study suggest that an incapable organizational context controls the work environment ["**It doesn't matter how you work"** (P84 EH1, 105)], which brings guilt and shame ["**Bad, bad I'm very ashamed**" (P95 EH1, 255)], to which the worker has to get used to, becoming a mute spectator of a normalized reality ["You would be scandalized here by everything, for everything that has happened" (P83 EH1, 583)].

Indeed, an organization that causes defencelessness restrains the professionals and reduces them to delimit the responsibility ["**I do what I have to do and I assume what I have to assume, I am not going to assume what the others have to do**" (P88 EH1, 385)], exposing the patient.

Pepi (social worker): "What we have here is a mistreatment of the patient, yes, but this has been going on for years…but for some years now, above all, certain professionals, especially those who are only here for the money they receive at the end of the month... I have friends who are nurses who are

'broken', some have been able to set limits, because no one does anything, I do not know why so many supervisors, directors..., they look away, because when you are in a hospital, you are 'defenseless'...." (P42 OBH1, 224,226)]

3.3. Being an object of the power

["We **are little puppets** that **they manage**" (P78 EH1, 316).]

To be an object of power is the consequence that emerges from the data analysed in this study when power, for its interest, decides on the annulled individual.

The data show how the subdued worker and the client dependent on his need ["**They see you are up to your ears and keep asking you** to do…" (P60 OBH1, 157)] serve the goal of power, through practice, reorienting them.

Thus, the professional centred on himself/herself, objectified ["**You are like a bunch of chickpeas**" (P84 EH1, 105)], in an organization that makes him/her feel emotionally and laborally bad ["Here you are nobody, you **are a number**, and that is what I tell you…**that affects you at the labour level or…emotionally**" (P84 EH1, 172)], *is a number* ["We **are a number** for the management" (P39 OBH1, 241)], and as such dispensable ["T**here is a lot** and **that lot is left over**, left over for economic reasons **and that's it**" (P84 EH1, 172)], with a profession reduced to activity.

["The administration or the bosses are not interested in quality, or the feeling I have is that they are not interested in quality but in quantity." (P88 EH1, 093:101)]

In this way, the patient becomes a number that can be divided into parts ["Because … in the end they are numbers, they are not … John Doe, is not ... this shoulder, this ... knee, this ... foot, and number" (P88 EH1, 105)], not a person which implies entering into a relationship, placing him here or there as appropriate.

4. DISCUSSION

The discovery of the conditions that make possible the routinization of actions or interactions in spite of unanticipated events, especially in organizations, can be explained in the words of Strauss and Corbin [13] 'as an important contribution to the development of knowledge and as the study of a new and problematic action/interaction' (p.184).

Hence, the discussion is raised from the results of the contextual condition, through the literature used and other theories, which is the basis of the response to COVID-19.

4.1. The non-organization

"What is seen … and not seen …" [15, p. 336]

Non-organization is the environmental condition that uses the non-responsible power to control actors and actions, obtaining submission and docility from individuals. According to Dewey [16, p. 133, 102], the condition acts as a control factor, as well as the consequences of the facts, setting a 'rule' in the sense that one must fold into concrete future modes of action. Following this proposition, the results reveal that power establishes the condition by introducing, at any level of the health organization, a certain type of subjects centred on themselves and dependent on another to satisfy their basic needs.

A power that, for Foucault [17], acts within the same productive network, distributed in multiplicity and allowing actions to be executed mechanically to achieve the desired product. This is why it is possible to have working health personnel who have had 'close contact with probable/confirmed cases of COVID-19 without individual protection equipment', who are asymptomatic and for whom the collection of samples for diagnosis is not recommended [18].

This type of subjects in the institution contribute to the maintenance and expansion of the daily reality through the organizational disorder, affecting the patient, the other employees and the organization. They are objects, both near and far, which are their manipulative zone of interest, directly or indirectly, about which they think and act [19].

In this way, power, through the environmental condition, sets an order; therefore, a hidden control in the randomness of events causes disorder, such as through a technology which is not facilitated or the purchase of masks that do not meet minimum safety standards, exposing the worker/patient and consequently the society to the virus [20].

For Morin, order-disorder has a relationship of complementarity and complexity, what allows us to see the phenomenon from all perspectives, from a random aspect and one of determination. There is an order that has the need to self-produce by means of the organization and that order is quite particular since it tolerates an important part of disorder, even collaborating with the disorder also producing complexity. An association of two antagonistic and complementary terms, 'that allows us to maintain duality in unity' [21, 22].

Likewise, from this relationship of order and disorder, in this investigation, negative effects emerge in the others, which are ignored by the actors. This is a way of acting, as Taleb [23] explains, based on one's own benefit, which does not take into consideration other effects apart from the visible ones, not considering those 'silent tests', which, for Bastiat [15], 'explain the fatally painful evolution

of humanity' (p. 337). From this approach, one can understand the meaning given by power to the dead in this pandemic, a number in the statistics interpreted as one more indicator [24].

However, the effects on others, neglected according to this study, are revealed as part of the experience lived by the subject in this condition whose denominator is suffering. Focusing this finding on the professional, the literature explains that this type of pain finds its root in the non-acceptance of reality, producing memories and expectations of the ego when it enters into conflict with its value judgment for this environment [25]. It is a non-conformity that occurs in the person, in the work sphere, with changes in the culture of the organization, losing their identification with it and, therefore, having difficulty in committing to it [26].

In line with the above, two different conceptions of work are found in the results: some who end up adhering to this established 'order', subordinating their moral principles to their particular interest and remaining silent, and others placing limits on disorder, being faithful to the patient.

To understand this conclusion, another relationship of antagonistic and complementary meanings comes into play, i.e., program-strategy, which Morin [22] explains as follows: While the word program should be used for sequences that are situated in a stable environment, the word strategy is the action or actions aimed at taking the opponent's mistakes, reducing the randomness of events to achieve advantage. For Pérez-Carballo [27], these terms are central to the business management, if what is desired is to achieve the success of the company.

Thus, in the results, it is evident through the program-strategy relationship that with the growth of this type of organization grows order and disorder, as Morin [22] explains with hidden consequences. It is an experience that has become visible during the pandemic, when very serious patients come to the hospital with publicized symptoms [28]. While other clinical manifestations were already reflected in the scientific literature [29], there were no data yet on the hospitalized patients in Spain [30].

This argument is confirmed in this study, where the strategy emerges, not only because of the existence of a certain type of subjects focused on their needs but also through the characteristics of the environment: insecurity and defencelessness that constitutes a reality in which the products become producers.

According to Morin [22], this is a circular idea where what is produced enters again into what produces it, generating a recursive organizational process. Hence, these qualities of the environment favour the growth of such individuals in the institution through the product-producer relationship, with the aim of achieving the vision of power, at the micro level in the subject and at the macro level for the company. The finding is revealed through the knowledge of the parts to know the whole and the whole

that is in the parts, a principle exposed by Morin [22], which links with the previous relations exposed to understand the complexity of a health organization and the subject in it.

Thus, for the worker, insecurity emerges in a particular type of employee before any sense of threat of loss or damage to something, which he feels is vital to his existence and it generates fear. It is an emotion that leads the employee to focus on the need, exposing the patient to greater vulnerability and to submit to the one who is supposed to have some power to gratify his/her lack. In this way, it is possible to assume the rationalization that, as shown by studies carried out in China, the mortality rate of COVID-19 increases with age, being 3.6 per cent in the 60–69 year age group, 8 per cent in the 70–79 year age group and 14.8 per cent in the oldest age group. Thus, it is established that "as a general rule, all residents of nursing homes with acute respiratory symptoms should restrict their movements as much as possible and stay in a room with good ventilation and ideally use own bathroom" [31, p. 5]. The result interpreted the norm: confinement of the residents within their rooms.

Therefore, one of the hidden effects of this study is that reality leads the subject (patient or worker) to be executors of the plans of the political power. Therefore, we should not forget Foucault's words that politics gets hooked on the life of individuals to satisfy economic demands [32] such as through work activity, as revealed in this research as well. To do this, power establishes a modelling program, which the subject, without being aware of it, accepts or rejects, depending on his/her particular interest, locating himself/herself inside or outside the institution.

An adjustment is proposed by Huxley [33] in his utopia of *A Happy World*, which explains that the leaders assign each individual to his adequate place in production, thus achieving social stability. This will ensure that the round peg is not in the square hole, and it does not harbour dangerous thoughts about the social structure and spread its discontent (p. 9).

It is like a program that begins from the moment an individual enters the institution, even if the individual manifests discrepancies with the way of working. If there is some interest at stake, the program reproduces itself. If the individual satisfies his/her need, he/she becomes the reason for his/her own submission. An imitation of the model that Bandura [34] explains is made when evaluating its successful consequences.

Therefore, it is understood that, as in literature, in an organizational environment where the worker is focused on the task and not on the patient, actions and routines are repeated and maintained over time, institutionalizing the way of working, assuming that the leaders are the ones who think [27]. This reflects a way of enforcing power without being present physically [17], where ‘the machine turns, turns, and must continue turning’ [33, p. 37], as if it had inertia.

However, the acceptance of this organizational reality only for gaining interest, by limiting the required human and physical resources and undermining multitude of interests such as those little things of patients or relatives that hinder the process and increase the load, produces submission. This is a work reality that leads the worker to an emotional, physical and mental state of helplessness and uselessness, with a feeling of being trapped and a lack of enthusiasm for work and life in general. For Buendía and Ramos [35], the development of burnout syndrome in the worker appears before this imbalance between organizational demands and personal resources as evidenced in this research.

Therefore, continuing with the literature and, in accordance with it, this labor context exerts a repression on the worker and causes him/her pain, depersonalizes him/her and lives as something that affects him/her individually and punctually, settling for the elimination of his/her symptoms. For Marcuse, these are evils that he attributes to hyper socialization, where the self dissolves into the social mass and leads to reactions of frustration…and weakening of critical faculties [25, p. 443].

These findings reveal a lack of consideration for others by the institution by not taking them into account, which affects their self-esteem and security, generating feelings of inferiority, weakness and helplessness, which reduces their capabilities to the point of invalidating them as human beings. This is clearly a lack of respect, if you take Kant's [36] reasoning on the meaning of respect. For this author, respect is a sentiment that is externalised as a tribute to the merit of the other; therefore, it only applies to people, never to things, since it affects the sensitivity of rational entities and things are exempt from this attribute (p. 167–168).

Following such argumentation and according to the results, in accordance with Maslow [37], a subject frustrated in one of his/her basic needs poses a threat to his/her personality and can be considered sick or, at least, inferior to completely being human. It follows that, if the individual's frustration is due to external forces, his/her illness will ultimately come from a disease of society (p. 46). Even from a business perspective, the fact that 'the person is not considered a value in itself' undermines the success of the company's process management [26, p. 299].

In a context where the others are, in the words of Foucault [17], 'object of an information, never subject in a communication' (p. 204), when the power approaches the worker, it does that in an attractive way masking the worker's objective. This transforms him/her internally, as he/she keeps debating between what he/she is interested in believing and what his/her institutional experience is, and this relativizes and cushions the experience by transferring it to the past. In this way, a selection of patients can be made for transfer to the hospital, referring to criteria of distributive equality and rationalization, leaving others at home with a shortage of resources for their care [38].

For Favret-Saada [39], there is an inadequacy in this consent achieved by persuasion and seduction, which keeps the conscience locked between the alternative of coercion and consent as 'free acceptance' and 'explicit agreement' (p. 57). However, Bourdier [39] goes further by exposing that the dominated contributes, without knowing it or in spite of it, to his/her domination by tacitly accepting the limits imposed by power. Thus, according to his investigation, the acceptance is produced at the moment they give consent to this labour condition by particular interest. A relationship of domination, for this author 'only works through the complicity of the inclinations, sinking its roots for its perpetuation or transformation in the perpetuation or transformation of the structures that produce these inclinations' (p. 59).

This complicity leads the professional to a self-moulding of his/her profession to the institution, managing to establish an organizational model previously designed, and it favours or harms certain professionals depending on whether they are aligned with the interest of power. Specifically, the nursing profession, in the learning of submission, experiences a lack of authority through a distribution of work contrary to care, which separates and unlinks from the user's delegated power to care [40].

According to this study, the result of this organisation is a defenceless professional, who slows down and auto-limits his/her responsibility, exposing the patient to an environment that he/she is unable to control, and of which he/she is guilty and ashamed and to which he/she has to get used to because of his/her need, becoming a mute spectator of this normalised reality.

Piñuel and Zabala [41] relate the defencelessness learned through different studies on violence in the public administration and in the family environment where this syndrome leads the subjects to feel incapable of reacting to defend what they believe in 'with all their heart. The mechanisms that generate violence, some of them 'subtle', have been normalized and naturalized, favouring their concealment (p. 82) in the same way that the emotions of guilt and shame experienced by the maltreated person contribute to their social isolation [42]. Coinciding with the previous argumentation, in this investigation, a subject is found to manifest belief in some value but, nevertheless, surrenders to a context that centers him/her in his/her need and not in that of the other.

In this study, it is revealed that an individual, moved by his/her need but annulled by the elements of the environment, becomes the object of power – an equal and quantifiable product, which can be divided and located in the desired place. Thus, in the counting of COVID-19 deaths, the number can be frozen for more than 12 days in June 2020, a situation that 'already happened at the end of May 2020, when the ministry readjusted the historical figure of deaths, leaving it at 26,834 (about 2,000 less than the reported of the previous day),' justified 'by a change in the methodology introduced' [43].

Therefore, this study shows a form of standardization of the human product, which makes the task easier for the leaders [33, p. 9]. In this research, a constructed reality is revealed, in which the power decides on the other, including the deceased, for its particular interest.

5. CONCLUSIONS

Considering the results of this research, in which some of the events that occurred in the COVID-19 pandemic have been analysed, the conclusions of the author were:

5.1. In relation to finding an organizational model:

- The creation of a true organizational health culture, oriented towards the common good and not towards the particular interests of individuals, is a priority.

5.2. In relation to the organizational environment and its connection with the facts of the pandemic:

- The individual's particular interest in meeting his/her basic need in a health organization rather than in the good of the other leads to the annihilation of the human being and, consequently, of the society he/she is treating.
- When one is silent before a painful reality, one collaborates in spreading the painful reality for all.
- What you don't see doesn't exist in a non-responsible subject with the other.
- The exercise of non-responsible power is chained to submission.
- Information, image and time are actions that use power for social, organizational and subject control.
- Political power, without being present in clinical practice and against professional ethics, manages its objectives associated with money.
- Power can do whatever it wants in a self-centered subject.
- The domesticated worker and the self-centered patient fulfil the objective of power by establishing the condition of the environment.
- Power's control on the need and moral values of individuals is fundamental to organizing external reality.
- The subjects responsible for the other mitigate the contextual condition.

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CONFLICTS OF INTEREST

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