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Clinical practice as an arborescent and rhizomorphic practice in surgical nursing work

A CLÍNICA COMO PRÁTICA ARBORÍFICA E RIZOMÓRFICA DO TRABALHO EM ENFERMAGEM CIRÚRGICA

LA CLÍNICA COMO UNA PRÁCTICA ARBORÍFICA Y RIZOMÓRFICA DE TRABAJO EN ENFERMERÍA QUIRÚRGICA

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ABSTRACT

A qualitative and exploratory case study was conducted in a surgery unit of a university hospital. The study aimed to analyze the nurses' work from the perspective of health care production and clinical practice. The subjects of the study were six nurses. Non-participant observations, documentary research and in-depth interviews were carried out, followed by discursive textual analysis. Nursing work is organized according to two interconnected and interdependent perspectives: a clinical model, which forms the central structure of its practice, and a structure formed by multiple and heterogeneous elements. in this way, the clinical model of health care is organized as a centered structure that enables the fulfillment of biological needs and acts as a basis for connecting disparate knowledge and practices that expand practice through interconnections with the work environment.

DESCRIPTORS

Nursing
Operating room nursing
Clinical competence
Work

RESUMO

Foi realizada uma pesquisa qualitativa e exploratória, na forma de um estudo de caso, em uma unidade de internação cirúrgica de um hospital universitário, que objetivou analisar o trabalho do enfermeiro sob a ótica da produção de cuidados em saúde e do exercício da clínica. Os sujeitos do estudo foram seis enfermeiros e foram realizadas observações não participantes, pesquisa documental e entrevistas em profundidade com posterior análise textual discursiva. Verificou-se que o trabalho da enfermagem é organizado segundo duas perspectivas interconectadas e interdependentes: a do modelo clínico, que compõe a estrutura-mestre de sua prática, e uma estrutura composta por elementos múltiplos e heterogêneos. O modelo clínico de assistência organiza-se como uma estrutura centrada que possibilita a resolutividade das necessidades biológicas e atua como base para a conexão de outros saberes e práticas que expandem o fazer do enfermeiro por meio de interligações com o ambiente.

DESCRITORES

Enfermagem
Enfermagem de centro cirúrgico
Competência clínica
Trabalho

RESUMEN

Se realizó una investigación cualitativa y exploratoria en forma de estudio de caso, en una unidad de hospitalización quirúrgica de un hospital universitario. Tuvo como objetivo analizar el trabajo de los enfermeros en base de la producción de los cuidados y la práctica clínica. Los sujetos de estudio fueron seis enfermeros y se hicieron observaciones no participantes, investigación documental y entrevistas en profundidad con posterior análisis textual discursiva. El trabajo de enfermería se organiza según dos perspectivas interconectadas e interdependientes: la perspectiva del modelo clínico, que constituye la estructura principal y una estructura de la práctica compuesta de múltiples y heterogéneos elementos. Así, el modelo clínico de la asistencia está organizado como una estructura centrada que permite la resolución de las necesidades biológicas y sirve como base para la conexión de otros conocimientos y prácticas que se expanden a través de las interconexiones con el medio ambiente.

DESCRIPTORES

Enfermería
Enfermería de quirófano
Competencia clínica
Trabajo

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INTRODUCTION

Considering clinical practice in medicine and nursing demands a reconstruction of the scenarios and flows of assistance. The pathological phenomena should be in the background, while the individual should be the protagonist in healthcare production. In this manner, it is possible to envision a clinical practice that produces diversions, gives new meanings to relationships and establishes itself in the process of care.[1].

Conceptually, clinical practice is polysemic, comprising not only the perspective of interpreting the signs and symptoms of illnesses but also an appreciation of the relationships established by individuals[1]. Thus, the clinical/biomedical model of healthcare is arranged as a stable, biologistic way of organizing work, one that adopts an interpretative perspective of illness. However, the work of nursing needs to implicate clinical practice in conceptual frameworks that go beyond hegemonic health care models. If achieved, these novel frameworks would allow nurses to be better employed for work that highlights the adoption of knowledge, integrated with diversity and the very environment into which patients and nurses are themselves inserted.

Nursing knowledge has been built over time to conform to a scientific *corpus* with logistical, pedagogical, technical and ethical fundamentals[2]. In the 1970s, nursing moved closer to the social and human sciences and to several contemporary philosophical currents. At this point, nursing work was transformed by these spheres of activity, escaping the reductionist sphere of technicality and broadening to include the social subject as an object of care[3].

Still, health care services demand a tense routine that conflicts with this transformation, instead favoring traditional methods of work[4]. Thus, the clinical model of healthcare has ended up dominating many health production environments.

Clinical practice and the working process must have a mutual relationship because the concrete conditions of the working process determine the possibilities of clinical practice.[3]. When clinical practice is conceived under a broader perspective, it acts as a tool, enabling user-centered health care production and including not only the illness but also the subject, in his or her own context, in cohesive, collective goals[5]. Therefore, clinical practice, as a field of knowledge, can be an important instrument for the proper practice of nursing work.

This study defines clinical practice as a field in which knowledge and practice, both biomedical and non-biomedical, interact to promote new compositions and strategies of action in healthcare[6]. Despite the predominantly hegemonic clinical/biomedical model in which nurses operate on a daily basis, the interconnectivity of these bodies of knowledge and practice is no less apparent. Reaching a diverse, integrated and flexible conception of medical practice is not only still possible, but it is even integral to the future of patient care.

After an integrated literature review, it became evident that clinical practice, conceived of as a field of knowledge for producing health and care, is not central to the scientific conception of Brazilian nursing. Instead, this vital topic seems to be a secondary object in relevant studies[7]. The present lack of attention notwithstanding, clinical practice, conceived of as an instrument to construct links between research and care in nursing, must promote a permanent movement toward the construction and deconstruction of these current knowledge and practices, even if such movement occurs secretly or unconsciously.

Based on these preliminary findings, this study aimed at analyzing the work of nurses from the perspective of health care production and clinical practice. Therefore, we adopted the philosophical framework of Deleuze and Guattari, who are advocates of a multiple and interconnected thinking style, to comprehend the phenomenon at hand[8]. We selected these authors primarily for their evocation of two important reflective structures: the arborescent structure – tree – and the rhizomatic structure – rhizome.

Our study argues that nursing demonstrates its work through a clinical practice with rhizomatic characteristics, while the clinical/biomedical model of health care may be better represented by the tree of interconnected knowledge that is necessary for action in the health care setting.

According to Deleuze and Guattari, the tree represents a centered, hierarchical structure, the characteristics of which articulate and hierarchize details. This structure inspires an image of thought that describes a multiplicity emanating from a superior, centralized unit. In this way, arborescent models receive information from a superior unit and proceed through the subjective attribution of pre-established connections. Conversely, the rhizome is characterized by the principles of connection, heterogeneity, multiplicity, asignifying rupture, cartography, and decalcomania. It represents a structure that has acentered, horizontalized relationships[8]. Importantly, even if the rhizome is considered an adequate structure, the tree is not necessarily rejected. Our study argues that nursing demonstrates its work through a clinical practice with rhizomatic characteristics, while the clinical/biomedical model of health care may be better represented by the tree of interconnected knowledge that is necessary for action in the health care setting.

METHOD

This is a qualitative and exploratory investigation that takes the form of a case study. The case study, as a form, is employed to contribute *to knowledge about individual, organizational, social, political and group phenomena, besides other related phenomena*[9]. To increase its reliability,

the present study used a protocol with an overview of the project, field procedures, case study questions, and a guide for the report.

This study was conducted in a surgery unit of a university hospital located in the south of Brazil, and six nurses from this unit comprised the complete sample of the study. The data collection methods included non-participant observations, together with documentary research. Later, in-depth interviews were performed on a one-on-one basis, investigating topics that emerged from the analysis of the data obtained through the other two data collection methods previously used. The duration of the observations totaled 200 hours, and the observations were performed over all three work shifts (morning, afternoon and night) from October 2012 to January 2013, with the acknowledgement of the subjects observed. The documentary research used patients' records and the book of nursing records. The study considered all of the records compiled by the group of nurses (unit of analysis) during the shift of the observation to be data.

The data were reviewed according to a mode of discursive textual analysis. This method of analysis enabled the researcher to identify and isolate enunciations from the contents submitted to analysis, categorize them and produce texts to integrate description and interpretation[10]. The texts collected were thoroughly read, and a concomitant deployment of description and interpretation from the researcher's perspective was undertaken based on the theoretical-philosophical framework proposed for the study. The units of analysis were then identified, and the most similar units were synthesized, reintegrating them into categories based on the establishment of relationships.

The aims of this research were developed according to Resolution 196/96 of the National Health Council; they were submitted to the Health Research Ethics Committee and approved by decision n. 87/2012. To avoid identifying the nurses who participated in the research, they are called T1P1, T1P2, T2P1, T2P2 and so on. The letter T stands for the shift, and the letter P, for the professional [in Portuguese, *turno* and *profissional*, respectively].

RESULTS

A total of 520 written records about inpatients of the Surgery Unit were found in the book of nursing records. This number corresponds to 38 periods of observation. Among these records, both complete and complementary notes had been added to the notes written by the nurses who had worked the previous shift. To clarify the records found, only those results with complete notes are presented.

Finally, the research considered 372 notes, corresponding to 28 periods of observation. In all 28 periods of observation, the book of nursing records presented the following: date, shift, worker's schedule of the nursing team, signature and COREN number (registration number in the Regional Nursing Council) of the nurses in charge.

The notes corresponding to the 28 periods of observation were categorized according to the higher frequency of records found. They were organized in the following manner: patient's name and bed, surgery and/or reason for admission, biological aspects and/or changes, invasive devices, diet and/or diet acceptance, perioperative period (preoperative or postoperative), tests (done and/or to be done), patient in/to go to the surgical block, discharged patient, change in medical approach, psychosocial aspects, and comorbidities. Chart 1 shows the percentages of each of the categories verified in the 28 periods of observation.

Table 1 – Categories and percentages about the notes in the book of nursing records.

Categories	Frequency of records
Name/bed	100%
Surgery/reason for admission	100%
Biological aspects/changes	93%
Perioperative period	89%
Tests (done/to be done)	89%
Invasive devices	79%
Procedures performed	79%
Diet/diet acceptance	50%
Patient in/to go to Surgical Block	36%
Discharged Patient	32%
Comorbidities	32%
Change in medical approach	29%
Psychosocial aspects	18%

Throughout data collection, four nursing progress notes were found in the patients' records; one of these notes was made by T2P1, and the rest were made by T2P2. They are identified here by the Roman numerals I, II, III and IV. From these notes, the aspects that reflect the patients' records were identified according to the nurse's evaluations and approaches, as shown in Chart 1.

Chart 1 – Aspects evaluated and recorded in the nursing progress notes present in the patients' records.

Assessed and registered aspects	I	II	III	IV
Pain	x	x	x	
Wound	x	x	x	x
Characteristics	x	x	x	x
Drainage	x	x	x	x
Dressing	x	x	x	x
Products used	x	x	x	
Food acceptance	x	x		x
Locomotion/mobility	x	x	x	x
Eliminations (urinary/bowel)	x			

When nurses receive a patient in the surgery unit, they organize the health care based on the reason for admission (pathology and/or type of surgery to be performed) and the routine of the unit itself. Nursing care in the surgery unit studied is organized, first and foremost, according to the clinical aspects of the clientele, the routines of the service and the specificities of the surgical intervention itself.

> Investigating the history of illnesses, the illness that is going to be treated here, the reason why they are being admitted [...] This is not a unit that usually has critical patients demanding a lot of care. Then, I carry on with the routine of visits, I check the problems and try to solve them. (T2P2) - [interview]

> At the moment the patient is admitted, he is weighed and measured, and we talk about change in health. [...] We follow the rules of the institution [...] That is, the routines. (T1P1) - [interview]

One of the peculiarities of the surgical unit is the relatively short visits of the surgical inpatients. This aspect may have an effect on the organization of health care and direct the focus towards aspects of the surgical process itself. Therefore, the type of surgery that the patient is going to be put through and the pathology linked to the necessity of that surgery are factors that favor biologistic actions in the nurse's work.

> We focus, and I think we have to focus, on the surgical issue, on the surgical pathology. [...] Will I detect all the clinical problems and will I be able to solve them? No, it's not here, at this moment, that they'll be solved. So, I can try to set some things off. (T2P1) - [interview]

The clinical practice of nursing work in the surgery unit studied may not continually manifest itself. It may be more emphatically expressed in the actions that are performed during intercurrent events or, better still, to anticipate clinical changes in patients. Communication among nurses is valued and expressed during the shift handover periods.

> I've worked in a surgery unit, and the nurse's action in the clinical area, was bigger. There's no doubt about that. Here, I think it's bigger during intercurrent events. (T3P1) - [interview]

During the shift handover period, T1P1 talks about a patient who is going through bowel preparation with mannitol and has not been prescribed fluid therapy. T1P1 calls attention to this patient, who may dehydrate due to bowel preparation. [observation]

At first, there is a focus on the aspects of the pathology and the surgical process, but later, the nurse observes and evaluates the psychosocial aspects. In this way, there is initially a biological focus on care, although the other emerging necessities of the inpatient are not denied.

> I talk to the patient, detect necessities, perform a physical examination, check socioeconomic situation, and evaluate receptivity conditions. I also do all this so that I can know how to talk to the patient. [...] We have to talk to them according to their culture, their beliefs. (T1P2) - [interview]

Nursing's clinical practice is not limited to the clinical/biomedical model of health care. It goes beyond the biological aspects of the human being. The nurse's work incorporates psychosocial and environmental aspects. In this light, we can also note that the nurse can serve as a reference for other professionals who share the same conception of care.

> I think social conditions and economic conditions are a fundamental issue. (T1P2) - [interview]

The psychology resident comes to talk to T2P1 to give information about a patient having family troubles and insalubrious housing conditions. They talk about the necessity of improving home environment conditions to receive the patient after discharge. [observation]

A 14-year-old patient with pilonidal cyst is admitted; T2P2 chooses to admit her to a two-room ward, which in that moment does have any patients.

> I can't admit this girl to the available wards... In ward x, there are some elderly ladies who are disoriented and in critical general conditions. In ward y, there's also no way to... So I prefer to let the girl stay alone in a two-bed ward because she's not only very young but will also go through a surgery that may be quite delicate for her. [observation]

During the period of hospitalization, the nurses sometimes prioritize biological aspects and, other times, non-biological ones, according to their clinical evaluation and the patient's demands.

> Many patients come for surgery, but their emotional health is even worse than the physical condition demanding surgery. I know that this emotional state will have an influence, during surgery and the postoperative period. So I have to work on this, because otherwise... Sometimes patients get here with something so important from outside... from their own lives. (T1P2) - [interview]

During shift handover, T2P1 talks about a mammaplasty postoperative patient who complains about a lot of pain:

> She's also a bit whiny, but I praise her a lot during the afternoon to improve her self-esteem and I noticed that she started to report less pain. [observation]

The nurses mention some instruments and work conditions that are necessary for clinical practice. They note that the central element is the clinical knowledge that is used as a work instrument. In addition, they mention health care protocols, multiple professional interaction, service management/organization, equipment and facilities.

> Knowledge is certainly an instrument. One can't work without knowledge. And it's not only knowledge. It's also taking action. [...] Having a notion of what is normal, of what is expected in each case, knowing how to act. If you know, more or less, what is expected in the immediate postoperative period, you have a good background for giving the best assistance, and this is really important. (T1P1) - [interview]

> If the patient's sad, depressed, it's good that he or she is visited by the psychologist, or if it's not depression, he or she may be depressed due to the adverse effect of the medicines. Interaction with the psychologist... Clinical knowledge is always good, even in the relationship with the heath care team. (T2P1) - [interview]

DISCUSSION

The connections drawn from Deleuze and Guattari's philosophical framework allowed us to unpretentiously bring the nurse's work in the surgery unit closer into certain understandable formats, such as arborescent structure, rhizomorphic structure, lines of flight, intermediations and war machines. The tree represents a centered hierarchical structure, while the rhizome represents an acentered structure with horizontalized relationships. Lines of flight form connections between points and positions that permit variation, expansion and conquest. The war machine does not correspond to a war per se but is instead projected from abstract knowledge and formed by the lines of flight that question a hierarchical model[8]. Thus, this study attempts to demonstrate the connections, diversions, contradictions and elements that form the nurse's work, which is complex and, at times, interdependent.

Thus, a clinical practice that emerges from an arborescent science may be rooted in biological knowledge; therefore, the clinical model draws upon a tree-like structure that has one main root system with branches representing the knowledge of anatomy, physiology, biology, pathology, and pharmacology. In the clinical/biological model of health care, professional action may span all of those branches, reaching as deep into this *soil* as necessary to respond to the needs that come from the components forming this tree. However, this action is limited to the space of the tree.

In the biologistic perspective, clinical practice is materialized during the approach of pathological phenomena that are located and specialized within the body; clinical practice lacks any relationship to the contexts in which the subjects operate, thereby excluding other fields of knowledge and other health care practices[1]. However, this conception is opposed by the clinical practice view of care-taking, which encompasses the hearing of the individual patient's particularities and is not limited to the formal structure aimed at the ill individual[4].

In the clinical practice of nursing, necessities other than biocentered demands emerge and require actions that go beyond the arborescent structure. Therefore, a rhizomorphic structure might be a more appropriate format to depict the manner in which nurses can meet this requirement of their work. Nevertheless, professionals may respond to the demands of a nurse's work by searching to integrate a fragmented and decontextualized image of clinical practice that minimizes the very elements that distinguish its action.

The entries made by the nurses in the book of nursing records or the patients' records indicate that their work is centered around aspects related to the clinical/biomedical model of care. A close relationship with a biologistic conception of care is reflected by the notes, which in turn barely hint at the true work performed by the nurses.

As reflected by the nursing records, a predominantly clinical/biomedical model of care guides the organization of nursing care in the surgery unit. Care is structured in such a way that it fulfills the clientele's biological necessities and the necessities of the service itself.

The nurses organize their actions according to an arborescent structure. They absorb the necessary knowledge to deliver care from the tree's roots and branches. In this structure, which constitutes the clinical/biomedical model of care, nurses underpin their work in a generalizing and limited way. Individual patients viewed through this structure must be treated according to the content materialized in their bodies, and nurses adopt this view in healthcare settings.

When a surgical client is admitted, he or she has an urgent need motivating the surgery. At that moment, regardless of whether this need is due to a pathological cause, the patient expects a specific action: the surgical procedure and everything that it involves. This is what prompted the hospitalization, and regardless of how the terms of his or her treatment may broaden later, there is a concrete sense of the clientele's needs at this exact moment.

The satisfaction of patients in a surgery unit can be connected to the nurse's ability to properly identify the symptoms and establish pertinent care[11]. After all, clinical practice is known to focus on subjects who are in search of answers to their health needs[1].

During their stays in the surgery unit, patients intrinsically seek specialized assistance and professional care, and many have previous knowledge about their needs. The nurses initially guide their actions through the clinical/biomedical model of care, searching for a preceding connection between the solution expected by the patient and the solution arrived at by the professionals themselves.

Thus, the arborescent structure is not a decontextualized choice. Rather, it is a visible and emergent necessity. The nurse turns to this arborescent structure as a projected image of patients because this is how the nurse perceives them. The reason for the surgical hospitalization is contained in the tree, and the pathology and biological changes arising from this reason establish how the service is organized. Consequently, the nurse's process of work may be understood within an ethics of intervention, in the sense that the clinical practice is developed to focus on the individual. Thus, the illness is not forgotten or disdained but is considered a part of the individual's experiences[3].

Based on his or her knowledge, the nurse recalls the necessary procedures pertaining to each type of surgery and to the treatment of all potential side effects. At first glance, the nurse's work may be characterized as actions reproducing the clinical/biomedical model of care, including an action that is hierarchized and fragmented or an action that is arborescent.

This organization of the nurse's work tends to have predictable actions and may more or less well describe the actual demands of caregiving in clinical practice. Nonetheless, nurses seem to explore clinical practice more intensely when patients develop complications while not contradicting practices that stay close to the changing demands of the emerging contexts.

Perceiving the patient within an arborescent structure does not necessarily mean that this structure will be explored. When a nurse understands that the structure shows a certain diversion, concern for the diversion's repair arises. As a result, despite having clinical knowledge, nurses do not always apply it in the strict sense of referring to the totality of the tree. The nurse who has mastered his or her clinical knowledge can, based on this knowledge, predict the right moment to explore clinical practice as a way to rationalize the time spent and undertake solutions within his or her work.

When analyzed more thoroughly, the nurse's clinical practice in a surgery unit does not correspond to what is observed in the nursing records or upon fast, superficial observation. Research into nursing records in surgical and clinical inpatient care units found that these records do not always indicate the professionals' participation, the treatments received by the clients or their responses[12]. However, the present study shows that although the clinical/biomedical model of care prevails, connections are made in an attempt to include other aspects of patient care, e.g., psychosocial and environmental, that involve the human being.

Some patients who are admitted to a surgery unit have feelings of concern about their families' economic subsistence. Such anxieties may be connected to a fear of not being able to afford the medicines or even food, among other issues that involve life in society. Thus, these external concerns strengthen the idea that the nurse's performance requires an approach that can comprehend the bio-psychosocial and spiritual dimensions of the patient's experience[13].

Though it is inserted in a biologistic model, the work of nurses is not necessarily unconnected with broader clinical practice. By creating lines of flight, the nurse seeks mechanisms that fulfill the patient's needs, both individually and in a way that is integrated with the environment. In this way, the lines of flight promote intermediations and ways of providing health care that are singular and coherent within the working reality of these professionals.

The search for an integrated care remains difficult to notice because the scarce nursing records barely indicate its existence. Nevertheless, it was found that of the multiprofessional healthcare team, the nurse acts as an element of reference for these lines of flight. The creation of lines of flight occurs *from* and *towards* the nurse because the other health care professionals can collaborate within this acentral relationship, combining realms of knowledge and replacing the current hegemonic clinical/biomedical model of care.

The nurse's role is perceived to fall under the purvey of an ethics of intervention in the sense that it develops a clinical practice focused on the individual; pathology is not dismissed but is instead considered part of the individual's experience[3]. Based on this role, the nurse broadens the tree and creates rhizomes that extend from this same tree. These rhizomatic structures, which result from the very necessities of clinical practice, can reach points that the clinical/biomedical model of care cannot; thus, the rhizome reflects the nurse's capacity to overcome this centralizing model. The individual needs of the patient change the established model of nursing care, thereby refuting the initial idea of an essentially arborescent organization of the nurse's provision of health care.

To accomplish the tasks demanded, the nurse uses clinical knowledge as an instrument that strengthens his or her actions. Knowing becomes doing, and this transfer fuels a war machine that offers solutions and the capacity to transform in health care, creating lines of flight and intermediations along the way. The present study also demonstrates that both the work based on the arborescent structure and the work based on the rhizome are individual activities.

The development of the nurse's clinical practice is indicated by the many constructions and deconstructions in other fields of health care and by the complexity of its integration into society. As a result, the processes of the nurse's work have singular characteristics[3]. The nurse's clinical work occurs within the routine as a response to the health needs of the population. Therefore, the nurse needs to understand that this process of construction depends on his or her gain of space and on the consolidation of his or her practice[4].

No perfectly structured trees or rhizomes exist among the daily realities of a nurse's work. Any particular, customized action in health care is actually achieved by the individualized work of a single nurse. That is, a clinical/biomedical model of health care is established, but each nurse works according to his or her own personal conduct. The nurse does not *intend* to create lines of flight; however, they organically emerge from the patient's needs. A professional must be able to perceive these connections and act because knowledge supports action. Knowing how to act is the element that guides every action within these structures, regardless of whether they are arborescent or rhizomatic.

CONCLUSION

Clinical practice deriving from an arborescent organization can be visualized as rooted in biologic knowledge; therefore, the clinical model reflects a tree-like structure that has a single main root and many branches. Nurses organize and base their work on this structure, seeking the knowledge necessary to provide care in the roots and branches. Upon first glance, the nurse's work may be characterized as actions that reproduce the clinical/biomedical model of health care: hierarchized, fragmented, and arborescent.

A nurse's work, however, cannot escape connections reaching towards other aspects – psychosocial and environmental – affecting a patient's life. Despite its seeming insertion into a biologistic model, nursing work is not necessarily unconnected with a broader clinical practice. By creating lines of flight, the nurse seeks mechanisms that fulfill the patient's needs, both individually and in a way that is integrated with the environment.

The nurse broadens the tree and creates rhizomes from within this same tree. These rhizomatic structures, which result from the practical necessities of clinical practice, can reach points that the clinical/biomedical model of care cannot; this reach indicates the nurse's capacity to overcome this model. Nurses use clinical knowledge as an instrument in their work; thus, knowing becomes doing, as if the process were a war machine possessing solutions and the capacity to transform health care.

The present study also shows that both the work based on the arborescent structure and the work based on the rhizome represent individual activities. The clinical/biomedical model of health care is formally present, but each nurse works according to his or her own mode of conduct. Thus, we return to the thesis that a nurse's work is established according to two interconnected and interdependent perspectives. First among these is the perspective of the clinical model, which forms the main structure of the nursing practice and can be represented by the arborescent structure of Deleuze and Guattari, which in turn represents all biological, physiological, pathological and pharmacological knowledge. The second perspective is characterized by a rhizomatic structure, which is formed by multiple and heterogeneous elements and represents aspects that interfere with patient's environment: social, family, work or other. According to these models, the clinical model of health care is organized as a centered structure, enabling the fulfillment of biological needs and acting as a basis for the linkage of other knowledge and practices that expand the nurse's practice through their interconnections with the working environment. As a result, clinical practice draws closer to what is considered, or at least called, integrality.

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