ORIGINAL ARTICLE

Social representations of caring and treating: the look of patients and professionals*

REPRESENTAÇÕES SOCIAIS SOBRE CUIDAR E TRATAR:
O OLHAR DE PACIENTES E PROFISSIONAIS

REPRESENTACIONES SOCIALES SOBRE CUIDAR Y TRATAR:
LA VISIÓN DE PACIENTES Y PROFESIONALES

Moema da Silva Borges[1], Lilian Silva Queiroz[2], Hellén Cristina Pereira da Silva[3]

ABSTRACT

The objective of this study was to learn about the central nucleus of the social representations of caring and treating for patients and nurses. This qualitative study was founded on the theoretical-methodological framework of the structural approach of social representations. Participants were 90 subjects, who answered a questionnaire using the free association technique. Data analysis was performed using Evoc software. Results show that the social representations that patients and professionals have of the concepts of caring express an ethical, sensitive, solidary, affective and committed relationship with a loving human life. However, the representations of treating point at different meanings and different expectations. In conclusion, the difference between these representations is rather concerning and deserves special attention. Such discrepancy denounces that the service that the professionals have delivered does not meat the demand and desires of patients.

DESCRIPTORS

Nursing care
Humanization of assistance
Interpersonal relations
Professional competence
Nurse-patient relations

RESUMO

A pesquisa teve por objetivo conhecer o núcleo central das representações sociais de pacientes e enfermeiras(os) acerca do significado de cuidar e tratar. Consiste em um estudo de natureza qualitativa, baseado na fundamentação teórico-metodológica da abordagem estrutural das representações sociais. Participaram do estudo 90 sujeitos. Aplicou-se um questionário utilizando-se a técnica de livre associação. Os dados foram analisados com o auxílio do software Evoc. Os resultados revelam que as representações sociais de pacientes e profissionais acerca dos conceitos de cuidar expressam uma relação ética, sensível, solidária, afetiva e compromissada com a vida humana amorosa. Entretanto, as representações sobre o tratar apontam para diferentes significados e distintas expectativas. Conclui-se que a discrepância entre essas representações é bastante preocupante e merece atenção especial da categoria. Tal discrepância denuncia que o serviço oferecido pelos profissionais não satisfaz à demanda e ao desejo dos pacientes.

DESCRITORES

Cuidados de enfermagem
Humanização da assistência
Relações interpessoais
Competência profissional
Relações enfermeiro-paciente

RESUMEN

La investigación objetivó conocer el núcleo central de representaciones sociales de pacientes y enfermeras/os acerca del significado de cuidar y tratar. Estudio de naturaleza cualitativa, basado en fundamento teórico-metodológico del abordaje estructural de las representaciones sociales. Participaron 90 sujetos. Se aplicó un cuestionario usando técnica de libre asociación. Los datos se analizaron con ayuda del software Evoc. Los mismos revelaron que las representaciones sociales de pacientes y profesionales acerca de los conceptos de cuidar expresan una relación ética, sensible, solidaria, afectiva y comprometida con la vida humana amorosa. Mientras tanto, las representaciones sociales sobre el tratar apuntan hacia diferentes significados y distintas expectativas. Se concluye en que la discrepancia entre las representaciones es bastante preocupante y merece atención de la categoría. Tal discrepancia expresa que el servicio ofrecido por los profesionales no satisface la demanda y el deseo de los pacientes.

DESCRIPTORES

Atención de enfermería
Humanización de la atención
Relaciones interpersonales
Competencia profesional
Relaciones enfermero-paciente

* Extracted from the study "O dilema da Enfermagem: cuidar ou tratar", Undergraduate Research Fellowship Program at the University of Brasília, 2008.

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INTRODUCTION

Every profession needs to justify its service delivery, delimit its field of competence and demonstrate its indispensability[1]. However, after more than one century of professionalization, the identity of nursing is still a goal to be achieved [1]. There is a lack of clarity concerning the meaning of nursing, which is influenced by many factors, among which the following stand out: gender issues that characterize the career as being female; a capitalist rationale that regulates and permeates the organization of health services; education that gives priority to technicality focused on the disease; hegemony of medical power and knowledge in the context of health care with an emphasis on healing to the detriment of caring[2].

In health facilities, especially in hospitals, a lack of distinction between the concepts *caring* and *treating* favored the meaning of the latter to insidiously invade the first, masquerading itself as it[1]. The values and the hierarchical organization of care roles imply to society that nursing care is only required in the presence of disease.

The establishment of the equation *nurse=disease* creates obstacles for the acknowledgment of the nursing profession, which compromises the social value of nursing work. A lack of knowledge that *caring* is different from *treating* deviates the focus of nursing practice, dislocating its role from assisting patients to assisting physicians[1,3].

A lack of knowledge that caring is different from treating deviates the focus of nursing practice, dislocating its role from assisting patients to assisting physicians.

The result of this set of factors is translated by a feeling of exclusion that propagates the (dis)value of work among the professionals themselves. And even though this aspect does not exclude the nurse from her/his space of work, it leaves her/him in a vulnerable condition. As an aggravating factor, patients and family members claim not to know *what the real role and value of the nursing work is*[3-4].

The value of nursing care seems to be conditioned on two aspects: first, on the proof that nursing care is an expression of an indispensable action in certain circumstances in life, a service not provided by other professionals[1]; second, care should be offered based on what is significant in someone's life, understanding someone's meaning, establishing bonds important for a given person.

From this perspective, nursing care is complex and delimited by an ample range of potential actions. Amid this complexity, one needs to consider that the field of competence for nursing rests upon an intersection between the field of patients' competence and the physicians' field of competence, situated between care and treatment[1].

Care actions aim to trigger everything that mobilizes energy of life while treatment is intended only to limit the disease, stop it, and mitigate its effects, limiting its losses. *If the function of an organ is impeded, medical knowledge helps nature to remove the obstruction and nothing else, while nursing maintains the person in the best possible condition, so that nature can act upon her/him*[5]. It is important to understand that one can live without treatment but not without care. Hence, care actions cannot to be put aside or excluded from treatment[1].

From this perspective, it is essential to explicate the differences between the concepts of caring and treating. Not delimiting the intersections and limits between caring and treating impedes the identification of the field of competence of the nursing care, as one confuses it with the medical work itself. In other words, we argue that a lack of clarity about the real meaning of caring and the distinction between it and treating masks nursing care actions and compromises its representation and practice.

However, the possibility of changing the representation of nursing care necessarily implies in re-elaborating a new interpretation of it. This is because *social representations are both product and process of an activity of appropriating reality external to thought and a psychological and social elaboration of this reality*[6].

In this context, the representation concerning care should permit nursing to confer meaning on its procedures, understand complexity of reality in the face of the systems of references of people involved in the process.

According to one study[7], in structural terms, a representation is composed of its central and peripheral systems, which are presented as a double system in which each has a specific and complementary role.

The core system/core is given by the analysis of the history of life of a given group and its experiences, which corresponds to its historical, social and psychological bases. Hence, the central core assesses the characteristic of stability to the representation and marks its resistance to changes.

On the other hand, the system/peripheral core allows the representation to anchor on current reality, easily adapting to the current *politically correct* discourse. Therefore, its elements are more vivid, more concrete and with great mobility. Even though the peripheral system does not define social representation, it effectively contributes to its organization.

This study aimed to grasp the core of the social representations of patients and nursing professionals concerning the concepts of *caring* and *treating* in order to clarify the meaning of nursing care and reflect on its field of competence and professional identity.

METHOD

This is a qualitative study based on the theoretical methodological basis of structural approach of social representations. Data were collected in Brasília, DF, Brazil between February and March, 2009 in health centers and hospitals in the region. A total of 90 individuals participated in the study: a) 45 users of health services randomly approached in waiting rooms of health units; we opted for these services given the availability of these individuals to agree to provide information while waiting; b) 45 nursing professionals who performed their functions in health units and public hospitals; these professionals were chosen due to accessibility. Two instruments were used: 1) a questionnaire with closed questions to identify the profile of the participants; 2) and a questionnaire in which the free association technique was used. It consists in presenting an inducing word corresponding to the represented object and asking to them to express all the words, expressions, or adjectives that come to their minds. The inducing words were *caring* and *treating* and they were asked to express themselves about both the terms.

Inclusion criteria were being 18 years old or older and having received some nursing care. For the professionals, criteria were being older than 18 years old and having a bachelor's degree in nursing. Data obtained were transcribed and analyzed through the Evoc software(8). Evoked words should more frequently constitute central elements of representation. The Evoc software permits one to glimpse the central core given a double criterion: frequency and order in which words/phrases were evoked.

Based on the intersection of the criteria frequency and evocation, the relevance of the elements (words, phrases and expressions) associated with the inducing term is defined. These results are presented in four quadrants organized in two axes. The vertical axis refers to the frequency while the horizontal axis refers to the order in which the word was evoked[8].

The most relevant elements that emerge first according to order of evocation with a significantly higher frequency (central core) appear in the upper left quadrant. The right upper and lower quadrants include the elements less clear in relation to their role in the structure of representation, though significant in its organization. These quadrants constitute the first or closest periphery[8]. In the lower right quadrant the less frequent and less readily evoked elements appear, corresponding to the second periphery, which is not addressed in this study.

In accordance with Resolution 196/96, data were collected after the project was approved by the Ethics Research Committee at the Faculty of Health Sciences (protocol 140/08). All the study's participants signed free and informed consent forms.

RESULTS

The profile of the 45 users was composed of: 26 (57.8%) individuals aged between 18 and 30 years of age; 14 (31.1%) between 31and 50 years and five (11.1%) between 51 and 58 years old; 26 (57.8%) women and 19 (42.2%) men; six (13.3%) reported to have completed primary school, 14 (31.1%) completed secondary school, 14 (31.1%) did not complete higher education and 11 (24.4%) reported a bachelor's degree.

The terms *love*, *affection*, and *give* were more readily and frequently evoked in response to the inducing word CARING, indicating the likely central core of the patients' representation. In the first periphery, the terms *responsibility, prevention, attention* and the expression *sleep well* were more readily and frequently evoked (Figure 1).

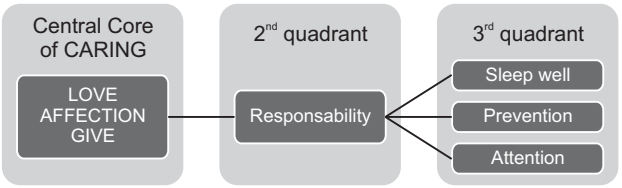

Figure 1 – Framework representing the terms that compose the likely central and peripheral core in relation to the word CARING

The terms *disease* and *treatment* more readily and more frequently appear in response to the inducing word TREATING, indicating the likely central core of the patients' representation. In the first periphery, the terms *physician*, *remediate*, *responsibility* and *attention* appear more readily and more frequently (Figure 2).

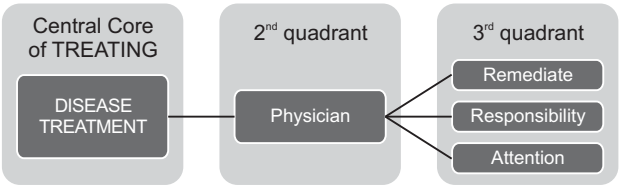

Figure 2 – Framework representing the terms that compose the likely central and peripheral core in relation to the word TREATING

The 45 professionals had the following profile: 12 (26.6%) were between 18 and 30 years old, 10 (22.3%) between 31 and 42 years old, 18 (40%) between 43 and 55 years old, four (8.8%) between 55 and 65 years old, and only one (2.2%) was older than 70 years old; 34 (76%) were women and 11 (24%) were men; 13 (28.8%) had a bachelor's degree, 27 (60%) were specialists, two (4.4%) had a master's degree and three (6.6%) had a doctoral degree.

The terms *love, attention, dedication* and *respect* were more readily and frequently evoked in relation to the inducing word **CARING**, indicating the likely central core of the professionals' representation. In the first periphery, the terms *affectionate, commitment* and *zeal, being* and *patient* were more readily and frequently evoked (Figure 3).

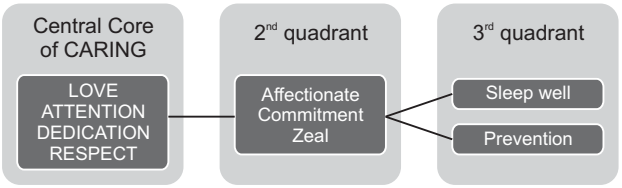

Figure 3 - Framework representative of the terms that compose the likely central core and the peripheral core in relation to the word CARING

The terms *knowledge* and *medicate* were more readily and frequently evoked in relation to the word **TREATING**. In the first periphery the terms *cure*, *medication* and the expression *being impersonal* were more readily and frequently evoked (Figure 4).

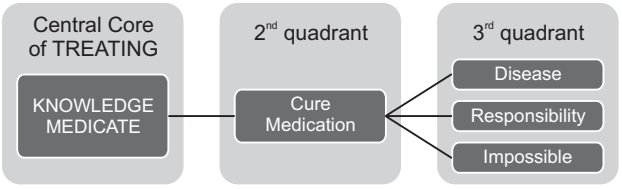

Figure 4 - Framework representative of the terms that compose the likely central core and the peripheral core in relation to the word TREATING according to the professionals**.**

DISCUSSION

The term *love* was the one that most stood out in Figure 1. This result indicates that the *likely central core* of the social representations of these patients revolves around the meanings of the verb *to love*. We can infer that according to the interviewees, the loving foundation of care involves both the feeling of affection and an attitude of giving complementary to love, an essential basis for the care action.

It is important to highlight that love and care have been distinguished as a commitment to humanization, as well as the maximum expression of ethics[9-10]. Therefore, it would be impossible to awaken the potential forces of each individual in the generation of the self-healing process. Love is configured as the base of all caring processes as well of life itself. Based on which, we can (re)affirm that, without care, from birth to the last moment of life, the human being disrupts, languishes, loses meaning and dies[10].

In this line of reasoning, we perceive that the central core of the users' social representations concerning care, that is, the system resistant to changes, asks that the primary meaning of preservation and promotion of life – love – and the recovery of emotions and feelings, that have been devalued in the model of producing of health care are re-placed in the focus of nursing care.

We reiterate that the peripheral system does not define social representation, but effectively contributes to its organization. Hence, the term *responsibility* evoked in the first quadrant (Figure 1) includes the idea that love is a responsible act and implies the establishment of an important and reciprocal relationship between another and me. However, in the daily work routine, the coldness of protocols and time pressure may lead professionals to depersonalize care. *We often caught ourselves referring to patients as the 'heart attack', or the 'TBI', forgetting or ignoring that beyond the diagnosis there is a human being just like us*[11].

In the second quadrant, the terms *sleep well, prevention,* and *attention* (Figure 1) indicate that the underlying content of each of these terms focus on the concept of health and consequently the notion of wellbeing. This aspect indicates that care practice does disregard vital concerns for the maintenance and preservation of life. Therefore, sleeping well, preventing diseases and paying attention to aspects that promote a healthy condition of life revolve around the act of care, which requires paying constant attention to the vital needs of individuals.

The results reveal that the users' structuring element of representations of caring meets the greater purpose of nursing care, which consists of *permitting patients to develop their ability to live or try to compensate for the harm to functions limited by disease, seeking to supply the deficiency in physical, affective, or social dysfunction*[1,5].

The term *disease* was the one that most stood out (Figure 2). This result indicates *the concept of disease as the likely central core of the representation. The representation of disease is the opposite of what is good, it is something unpleasant that affects the individual and disables, reveals something bad in itself*[12]. It then ratifies that only in the face of the disease is a treatment required.

In general, the individual triggers a treatment when care actions that aimed to attenuate, compensate and impede the disease from worsening did not succeed. Given this aspect, users in general, hold the elements of any diagnosis, and during a medical consultation, wait for a confirmation of the analysis they have already initiated[1]. This aspect signals the need for a dialogical approach that considers the different forms of constructing the concepts of health and disease. Thus, beliefs cannot be disregarded *because a richness of feelings that give meaning to the individuals' experiences, constructed daily in the relationships with the entire social environment that composes the reality of individuals, resides in such beliefs*[12].

The term *physician* in the first quadrant indicates that this is the professional responsible for treatment (Figure 2). It is the role of physicians to diagnose and prescribe treatment, which most of time, is performed by the user himself/herself and/or family members. Only in more severe or complex situations there will be a need to seek a more specialized competence both to initiate and follow-up treatment. In this case, this competence is delegated by the physician to nurses[1].

From this perspective, the nursing staff needs to pay attention to two important aspects that deserve utmost consideration: the first highlights that no field of professional competence in health care can be privileged to the detriment of another type of knowledge, including the knowledge of users themselves. This line of reasoning confirms that the field of nursing competence during treatment is in inter-relationship with the field of competence of users and of physicians, sharing common areas with them[1].

The second emphasizes that when the **responsibility** of treatment is shared between the nurse and the physician, the attention of the nurse should not be only fixed on the disease. Especially in this situation, nursing care is, on the one hand, related to everything that improves an individual's condition to favor prevention and health promotion, seeking to limit the disease; on the other hand, it is also related to everything that aids the recovery of and revitalizes the sick individual[1]. These two aspects constitute care during treatment.

Hence, even though treatment is object of medical prescription, *it is within the domain and initiative of the nursing staff* to put the prescription into practice, paying attention to the interaction existing between care and treatment[1]. In this context, it can be called nursing treatment.

The terms *remediate, responsibility,* and *attention* in the second quadrant reaffirm that *patients avoid everyday a number of minor ailments through self-care and avoid the onset of disease*[1]. According to common sense, to remediate means to repair or to correct disease or pain with medication. Hence, the representations of the terms *responsibility* and *attention* seem to complement the idea that the use of medication requires focus on technical and relational competencies. In this context, it is prudent not to value one competency to the detriment of another.

Hence, we infer that, from the perspective of users, treating does not only comprise technical procedures but, in an integral action, it has meanings related to the understanding of needs of people in a given conjuncture.

The term *love* stood out, indicating the likely central core of social representations concerning caring for the nursing professionals (Figure 3). This result corroborates research in which love also emerged as a likely central core for the nursing professionals[3]. In the view of Humberto Maturana, when one embraces another, love emerges as a biological phenomenon. Hence, love as a biological phenomenon occurs given the dynamics of life, from the more primary to the more complex realizations. Love means accepting another with us, there is no socialization without love, and there is no humanization without socialization [9-10].

The presence of the terms *love, attention, dedication,* and *respect* permit us to infer that the representation of care for the professionals is organized around these four core elements. It is worth emphasizing that the manifestation of feelings underling the word *respect* coincides with the maximum expression of love and translates the ability of embracing another, without judging what s/he feels, says or does. We then assert that love and care constitute the basis of social phenomena and are responsible for all the ethical implications accruing from the biosocial dynamics.

In the first quadrant the terms *affectionate, commitment* and *zeal* appear; these constitute the philology of the word 'care'. These terms confirm that care means *concern, diligence, zeal, attention* and *good treatment*[10]. Hence, the expression of feelings implied in these words refers to the essential root of the profession, that is, love for others, whose main objective was: *a concern for the feelings of others, respect and compassion, direct contact with the patient, the search for human and spiritual values, and a reflection on the human being and the conception of life*[13].

The terms *being* and *patience* in the second quadrant ratify the importance of being present in an authentic manner, manifested by the ability to be real and show yourself to another in a genuine way, through words and acts. We note here the valorization of interpersonal relationships and communicative skills (verbal and non-verbal communication) through messages that reveal attention and care.

The results indicate that according to the professionals' view, nursing care only occurs as the relationship with another can facilitate *the flourishing of care that truly humanizes: deep feeling, the desire to share and search for love*[10].

The term *knowledge* was highlighted signaling the *likely central core of the representations concerning treating* (Figure 4). The emergency associated with the terms *knowledge* and *medicate* indicates that the treatment is organized around these two meanings. Therefore, the representation has a close relationship with the action of administering medication and highlights the required technical competence concerning specialist knowledge in pharmacology and medication therapy in relation to the dose, side effects, method and precaution when administering medication.

These interpretations point to the Gordian knot of nursing practice, that is, the dilemma between caring and treating given the strangeness between one competency and the other. Here two issues require better understanding: 1) the administration of medication cannot be considered by the professionals to be an isolated task in the context of care. Hence, in the face of disease, medicating only and exclusively represents an act complementary to nursing care and can only be performed based on the consideration of the sick person and the person's disease; 2) every care action requires mastering highly complex knowledge, whether by the ability of perception, understanding, clarification of information, creativity, etc.

Therefore, health care cannot, under any circumstances, be simply considered an activity, because it has something that goes beyond a professional's practice. From this perspective, the expertise of each professional should be appreciated as part of a strategy, that is, a set of actions that ensure the quality of life of individuals, minimizing the disruption caused by the disease.

Thus, there is no space for the submission or oppression of nurses in labor in relation to medical power. Nursing professionals *are sometimes co-opted to perform tasks, not always appropriate, often related to standards and prescriptions that were not complied with, or which should already have been changed and were not*[14]. It is necessary to break with this asymmetry that ends up perpetuating losses to the value of nursing work and turns the nursing practice invisible within the health care context.

The profession should internalize the concept that nursing care is composed of what constitutes its *essence* – interpersonal relationship – and the *accessory* of the care practice – means (techniques, protocols, terminology, forms of organization, care contexts...)[15]. Nursing needs to transform care actions in a significant help in which, both adjuvant and essential, dimensions are united[16].

Care actions can be lost in the unbalance between the essential and the accessory. In a total inversion of them, care withers and dies, resulting in total neglect and oblivion. If care dies, the human being dies as well[17]. Hence, the interactions existing between care and treatment cannot be neglected. Both are embodied in knowledge and the epistemic matrix of care was, is, and will always be relevant to sustaining life and humanity.

The emergent terms in the first quadrant, *cure* and *medication*, (Figure 4) explicate the mistake of looking at the treatment as a partial task that characterizes an intervention and not the care process. Despite the urgent appeal of the technological health approach, it is necessary to be clear that medication does not work miracles, hence *medicating does not equal a cure*. What really cures is the vital force existing in each human being associated with a desire to live, and it is the role of nursing care to help awakening such force[1].

The notion of disease, a term that appears in the second quadrant, necessarily implies in the representation of a sick *person*. Thus, thinking disease is related to thinking in a sick body that requires care. It is not appropriate in the context of nursing care to deal with or *treat people as things* [...] *in an objective and detached manner*[16]. Hence, impersonality is not justified in the presence of a patient under treatment.

Every border area, margin, limit or intercession occupied by nursing care between caring and treating requires a partnership between the patient and the professional. In this context, the relationship *is not established with the disease*, but with the sick person. *When the professional relates to the disease, s/he plays the role of an adversary – the one who fights the evil. When one relates with the person, s/he plays the role of a partner*[16].

The structural core of the professionals' social representations reflects a type of health care forged in a context of fragmented work with a low level of reflection, where nursing interventions are performed but care does not actually occur.

CONCLUSION

In the consensual universe of users and professionals, the likely central core of social representations concerning the act of caring keeps the same meaning. The representation for both aligns the idea of an action mediated by an ethical, sensitive, caring, loving relationship committed to humanized care.

However, users and professionals expressed distinct views and expectations concerning the action of treating. While the first long for a treatment that is not restricted to technical procedures but rather means integral actions encompassing an understanding of their needs, for the professionals treatment assumes a merely technical and impersonal character. These representations assume specific actions for which they assign meanings with the force of reality.

Thus, this discrepancy reveals that the service offered by nursing does not meet the demands and desires of users. This quest requires imprinting the mark of care within the cold connection of organizations and marketing laws crystalized in health services.

It is urgent that nursing care re-develop the representation it forged concerning its object of work. The loving root of care forged the nursing profession, and only the nursing profession can recover and maintain its identity and value the nursing work.

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