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Nursing care in Specialized HIV/Aids Outpatient Services

Cuidado de enfermagem em Serviço Ambulatorial Especializado em HIV/Aids

Cuidados de enfermería en Servicio Ambulatorio Especializado en VIH/SIDA

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ABSTRACT

Objective: to analyze the discourses about the care provided by nurses operating in Specialized HIV/Aids Outpatient Services in four public institutions of the city of Fortaleza, Ceará, Brazil. **Method:** descriptive and exploratory study with a qualitative approach, which used as a method the discourse analysis. **Results:** when titling the "care as negative", such title came from the analogy proposed by Freud (1912) with the photographic negative, represented by what that care can configure from the unconscious movement, since nurses did not perceive themselves in the care actions developed by supporting the work of other occupational categories, contributing to maintain the ideology of biomedicine. **Conclusion:** it is necessary to justify and theorize a nursing clinical practice from epistemological issues of the profession, in such a way that nurses can understand their relevance within the care provided.
Descriptors: Nursing Care; Patient Assistance; Acquired Immune Deficiency Syndrome; HIV; Language.

RESUMO

Objetivo: analisar os discursos acerca do cuidado produzido por enfermeiros que atuavam em Serviços Ambulatoriais Especializados em HIV/Aids em quatro instituições públicas do município de Fortaleza, Ceará. **Método:** estudo descritivo e exploratório com abordagem qualitativa, que utilizou como método a análise de discurso. **Resultados:** ao intitular o "cuidado como negativo", tal denominação surgiu a partir da analogia proposta por Freud (1912) com o negativo fotográfico, representada pelo que o cuidado pode se configurar a partir do movimento inconsciente, uma vez que os enfermeiros não se percebiam nas ações de cuidado que desenvolviam pelo fato de amparar a atuação das demais categorias profissionais, contribuindo para manter a ideologia da biomedicina. **Conclusão:** faz-se necessário fundamentar e teorizar uma prática clínica de enfermagem a partir de questões epistemológicas da profissão, de forma que o enfermeiro perceba sua relevância no contexto de cuidado.
Descritores: Cuidados de Enfermagem; Assistência ao Paciente; Síndrome da Imunodeficiência Adquirida; HIV; Linguagem.

RESUMEN

Objetivo: analizar el discurso sobre el cuidado de enfermeros que trabajan en servicios ambulatorios especializados en VIH/SIDA en cuatro instituciones públicas en la ciudad de Fortaleza (estado de Ceará – CE). **Método:** estudio cualitativo, descriptivo y exploratorio que ha utilizado como método el análisis del discurso. **Resultados:** al poner el título "cuidado como negativo", este nombre proviene de la analogía propuesta por Freud (1912) con el negativo fotográfico, representada por el cuidado que puede ser configurado desde el movimiento inconsciente. Los enfermeros no se percibían a sí mismos en acciones de atención que desarrollaban porque apoyaban el trabajo de otros grupos profesionales, lo que contribuye a la ideología de la biomedicina. **Conclusión:** es necesario apoyar y teorizar una práctica clínica de enfermería desde las cuestiones epistemológicas de la profesión, para que los enfermeros perciban su relevancia en el contexto de la atención.
Descriptores: Atención de Enfermería; Atención al Paciente; Síndrome de Inmunodeficiencia Adquirida; VIH; Lenguage.

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INTRODUCTION

The discourse analysis is configured as one of the references of contemporaneity that is dedicated to address ways of signifying, considering the production of meanings as part of the life of the subjects or members of a particular form of society. The processes and the conditions of language production are analyzed through the relationship established by the language with the subjects that speak it and the situations in which the saying is produced[1].

In this sense, discourses are understood as impregnated with culture, context and intentions of what is expressed in them, considering the interpretations of these materials a difficult art of capturing the not apparent meaning of the discourse. Through discourse we understand better the relationship between language-thought-world, since it is configured in one of the material instances (concrete) of this relationship[2-3].

In the field of health, notably regarding clinical care to patients with HIV/Aids, we perceive that it is important to know how these discourses are constructed by the approach and inclusion of language in an abstract system, in which individuals produce meanings to highlight their understandings about the determination of the health-disease process. To approaches of the understanding of this context, the subjectivities and the peculiarities of individuals must be explicit, but added the structural particularities and issues.

Thus, the analysis of the discourse outstands as an important instrument of subjective production, and it may be applied to the further development of issues that pervade the professional practice of the nurse in the context of assistance to subjects affected by HIV/Aids. We highlight that identifying the formation of discourses on Aids, to which needs they respond, how they change and move, has central importance for understanding health practices, as a strategy of integral attention directed toward the promotion of autonomy and protagonism of the subjects in the process of health production and HIV/Aids prevention[4].

This article is part of a research developed aiming at analyzing the discourses about the care provided by nurses who work in Specialized HIV/Aids Outpatient Services, seeking to identify the conceptions of care that pervade the professional's performance. The analysis culminated with the construction of four cores of meaning, representing the discourses that are intersected in the nursing assistance context: pedagogical discourse, moralizing discourse, humanistic discourse, and the discourse of denial of care.

In this article we will analyze the last of them, which we would conventionally call "Discourse of denial of care". In this modality of discourse, nursing care is situated not by its positivity, namely, the assertion of certain qualities that could conceptualize it, but by a sort of negativity, which points to an invisible care, one that cannot be said.

The discourse of denial of care is defined here from an analogy proposed by Freud[5] with the field of photography. Before configuring itself as a positive reality, i.e., the photograph itself, the material undergoes a "negative" state. Equating photograph to what is held in the consciousness, Freud states that each photographic image has to undergo the "negative process", and only some of these negatives, which have been approved, are admitted to the "positive process", which is finally concluded in the photographic image. In the unconscious level, therefore, would remain a part of the elements rejected by the constitution process of consciousness, but which seek to be expressed in the conscious discourse through lapses and misconceptions, as if an unknown knowledge is said besides the conscious understanding of what is being said.

In addition, the theorization of the field of discourse analysis points to the fact that the interdictions that affect the subjects' discourse show its connection with desire and power, being not just that which translates the domination fights or systems, but that why and what you fight for, the power of which you want to seize on. Thus, the discourse is, at the same time, controlled, selected, organized, and redistributed by procedures that aim to conjure its powers and perils, to dominate its random event, to evade its heavy and fearsome materiality[6].

Therefore, we believe that this modality of discourse that makes present the nursing care for its negativity situates unconscious and unsaid elements of the subjective production context of these subjects. That does not mean they are less important, reflecting directly in the way care is directed to the patient.

Here, we emphasize the relevance to think and discuss about the care provided by nurses as a way of contributing to the development of a theoretical support about care in HIV/Aids, as well as a possibility of constructing or reconfiguring a clinical practice in nursing care.

METHOD

This is a descriptive exploratory research with qualitative approach. The data collection field consisted of the Specialized HIV/Aids Outpatient Services of four public institutions of the city of Fortaleza, Ceará, Brazil.

Specialized Outpatient Services carried out actions of secondary assistance to people living with HIV or Aids, whose aim is to provide an integral care to users, focusing on consultations with specialists and more complex tests, developed by a multidisciplinary team[7].

Data were collected between March and June of 2011. The subjects of the research were composed of ten nurses who worked in Specialized HIV/Aids Outpatient Services. We defined as inclusion criterion: nurse of both sexes who work in the specialized services under study for at least 6 months.

The instruments used were the open interview and direct observation with field journal. Through direct observation, we sought to capture aspects of reality by meanings, which allowed the understanding of the assistance dynamics in the services studied. The interview was conducted by applying the following guiding question: how do you provide the care in the Specialized HIV/Aids Outpatient Services?

To ensure the anonymity of these subjects, the identification of speeches through letters (A, B, C, D) representing the institutions of study was used as the coding procedure,

followed by randomly chosen numbers (1, 2, 3, 4) that represent the subjects, in such a way that this numbering has no correlation with the order of interviews or any other attribute that allows the identification of authorship of the speeches.

The interviews were recorded from the playback in MP3 format and subsequently transcribed, seeking to guard all the pauses, ruptures, and the linguistic misconceptions identified in the discourses, which composed the corpus of the study. We used, therefore, the application of textual markers, which were configured in symbols used to characterize each specific situation.

This study has as its basis the discourse analysis of the French school, whose main theoretical affiliation began in 1970 with M. Pêcheux, concerning the question of the meaning and the historical determination of meaning processes. To find the regularities of language in its production, the discourse analyst considers the man in his story, relating the language to his exteriority[1-3].

From the corpus of texts, existential situations were demarcated in a series of analytical frameworks that allowed the thematic coding, seeking to explain the mechanisms of meaning production used by subjects in their discourses. To this end, the following analytical devices proposed were used for discourse analysis: paraphrase, polysemy, interdiscourse, and metaphor.

By identifying the different discourses that pertain the provision of nursing care in the services under study, we decided to name them cores of meaning, and from the convergence between these, we obtained the theoretical construction of four cores of meaning, considering that, in this study, one of them will be exposed, named "discourse of denial of care".

The research project has been evaluated and approved by the four institutions in which this study was conducted, considering that three of them, being of state administration, relied on their very Research Ethics Committee (CEP), demanding the submission in the CEP of the institution, regardless of the opinions of approval issued in other locations. Only one of the Specialized HIV/Aids Outpatient Services had a municipal administration, counting on the body named by the Municipal System of Health School, and it have been developed to analyze the research projects applied in institutions linked to the city of Fortaleza, where the project must also be submitted.

RESULTS

The abstraction of nursing care

Professional ED1, when questioned about the provision of nursing care, made explicit other occupational categories activities, highlighting them as most relevant to the monitoring of the patient:

> *Regarding the patients who are monitored here, one of the things that help them to understand the importance of the treatment is the psychological care, the medical care.* (ED1)

> *It's not just me that is going to have, it's not, it's having a huge weight in what he will have, in his conduct, from the time I deliver an exam, much will be the contribution of the psychologist.* (ED1)

We identified in the speeches of nurses the presence of misconceptions, lapses and negative particles that evidenced elements not previously explained by the subject interviewed, showing what sought to omit in the discourse so far, as noted in these two fragments:

> *[...] He is a professional* (nurse) *who really works with care, isn't he?* (EA1)

> *[...] coming back to the question of care.* (EA1)

The repetition of the expression "it is not" in the discourse of this interviewee is configured as a mechanism of denial that is presented each time she tries to situate what is the nursing care, also retaining a search for any sign of approval by the part of the researcher who can confirm what she is explaining in her discourse. In addition, we notice that the discourse is given to the third person, as if the interviewee were not involved in the performance of the care.

Another expression of this negativity of nursing care in the speech of interviewees refers to the difficulty in carrying nursing consultations, since the patient does not often return to them. When patients return to the service, they do it for several other reasons, primarily for the medical consultation and for receiving antiretroviral medication:

> [...] *I think it's very important for them to actually return, this is an issue that we don't have.* [...] *These returns do not happen because patients do not return, they do, but because they come to the pharmacy, because they come for tests, they return because of the medical consultation.* (EA1)

> *For patients who are going to start medication, we schedule for them to come back, for them to do the CD4 test when they come back, to go back to the doctor, for them to talk to us again, for us to see if they are really sticking to medication.* (EA3)

As a natural consequence of the abstraction that is observed in the conduct of care, in which this cannot be clearly understood not even by professionals that perform it, the nurse seeks to materialize the care through the implementation of tangible, measurable tasks, as observed as follows:

> *So, if they come to medical consultation, they come here to get a transit pass or they go to the pharmacy and there are no condoms, they come here to get a condom.* (ED1)

Relationship between nursing and other occupational categories

The professionals also reported the importance of referring patients to other occupational categories that could contribute in their monitoring or the convening of family members to participate more actively in the therapeutic process, since this process happens to ensure the patients' compliance to treatment, as identified next:

> *Patients who have difficulty in adhering to treatment, to monitoring, then we identify what their affected difficulties are and we intend to / refer to a psychologist, to the social worker, we call the relatives, some neighbors for help.* (EA4)

> [...] *then you identify whether they need a psychological care, if they need to go to the dentist, if they need the monitoring with social services, if they have any STDs, if they need to go to the doctor who takes care of STDs, then you will articulate with several / several / several things they need.* (EA3)

> [...] *also some that start the therapy and need to speak, and we listen, we do some kind of forwarding required for a secondary service,* [...], *then we demand both for the social service of the institution and to psychology.* (EC1)

The nurse, when issuing a critique of the limitation that is observed in medical conduct, to restrict medical diagnosis and drug treatment of the patient, this was carefully enunciated, seeking not to express a general statement, using the metaphor "heavy" as a mechanism of justification, not to compromise the category that had played a central role in the assistance.

> [...] *the medical work is too heavy, because they have to write a lot, they have to see everything, and at the end they are limited, isn't it, to medication, diagnosis, and medication. It's not their fault, it's not the doctor's fault.* (EA1)

> [...] *to make these patient's cost clear and, at the same time, saying, isn't it, trust your doctor, and everything, you need to talk, because I already did that for making my own cost clear, because the doctor set the bar very high.* (EA1)

The emotional distress experienced by nurses

At the time of the interview, one of the nurses was emotionally distressed because of structural changes in the dynamics of the service imposed by the institution, and that, according to her, assaulted her as a professional, having been that day the first of the deployment of such changes.

> *After a tractor has passed over me* (laughs), *I don't even know how I perform the care anymore, I want to be cared for now* (laughs). *Surprisingly, I want to be cared for today. That's because today it had a lot of changes here at the hospital, you know, a lot of changes that hit me, it assaulted me both as a professional and at every...* (EA2)

DISCUSSION

To approach the discourse of negativity of nursing care, it is necessary, initially, to situate the difference between discourse and speech. The word discourse, etymologically, has in itself the idea of course, of journey, of running for something, of movement. The discourse, therefore, is the word in motion, the practice of the language. In this analysis, we seek to understand the language making sense, as a symbolic work, seeking to know better what makes men a special being with their ability to mean and to be meant[1].

Considering the individual psyche as the source language, established as part of the act of creation of that who speaks, this is characterized for being subsidized by the psychic energy, and for being an uninterrupted stream of verbal construction. However, not everything in a discourse is spoken. Beyond what is explicitly said, we also find in the organization of a discourse the voids of silence and the unspoken. That void is at the root of the particularity of the constructions of phrases, syntax ruptures, and style specificities that allow you to conceal, hide, or to not clarify anything that is ideologically repelled, but present in the experience and in the internal discourse of subjects[8-9].

It is on incompleteness of language that the question of silence subscribes, which is always accompanied by sense. In principle, silence do not speak, it means, and when this silence is translated into words there is a transfer; thus, a sliding of senses, which produces other effects. The possibility of movement, displacement of words between presence and absence produces a fundamental relationship between language and the time, a rhythm between the saying and the silence, characteristic of the whole meaning process[3-10].

We can distinguish two kinds of silence, namely the founder silence and the politics of silence. Founder silence is regarded as the beginning of all meaning, i.e., the very condition of meaning production, which means the unsaid, producing the conditions for language to mean. In politics of silence, in contrast, is the division between what can and what cannot be said, being developed in two forms of existence: the constituent silence and local silence. The first indicates that to say we must not say, i.e., saying "x" not to say "y", in such a way that all saying necessarily erases other words, producing a silence over the senses. The local silence is the interdiction of the saying, restricting and prohibiting what is said, determining what it is forbidden to say in a certain situation[1-10].

For psychoanalysis, this impossible to be said is the basis of the concept of the unconscious. For Freud[5], the unconscious is the place of the negative. The negative is not taken as the opposite of positive, but the basis of this. A feature is necessary to inaugurate this unconscious. Therefore, there is what has become to be photographed, someone who looked at the photo, another. The negative is constituted from an experience between the subjects. The features of this relationship, however, remain; and the negative would be an unconscious mark and is constituted from something that has been lost.

This photographic image shows us that there is no photo of what has not been there yet. Thus, it does not work in a void, something has to be present for, when lost, to leave a mark, a photographic negative that was forgotten. Thus, when titling the "care as negative", such designation appears represented by what the care can configure from the unconscious movement, in which you do not know that you know, in which there is always something to be revealed.

The first way of making this negativity nursing care present is given for the non-demarcation of what configures its practice, assuming an abstract dimension of this care, considering that, at times, they do not clearly perceive the actions they perform as a way of caring and they assume roles that are not necessarily their specificity.

Returning to the image of the photograph, it would be as if the nurse is not viewed in the picture, perceiving only the presence and, consequently, the performance of the other occupational categories. However, their presence being there, this is perceived as the negative of the photograph as a background, what is behind, giving support in such a way they can act effectively.

Through the speeches, it was evidenced that the nursing care was supporting the assistance developed by other occupational categories, since the hegemony being in medicine, and the psyche or the subjectivity being object of psychology, nurses assume the supporting role in this context, often not perceiving themselves in the actions developed, although these are also configured in a way to take care of the patient.

The release of transit passes or condom is put by the nurses as attempt to configure visibility and concreteness to their actions. Outstands, today, the need for recovering the care within the context of nursing assistance, doing a retelling of and expanding its interpretation, considering it not only a technical and scientific activity. However, when seeking an explicit positioning of the care in nursing, the fear that the care is not perceived with features of scientific theories and systematic and technological actions that bring relevant results remains[11].

Furthermore, nursing faces a conflict when trying to develop differentiated practices, to construct new theories about the body and ways to care, however, it remains with almost no flexibility in the ways of thinking and acting, since it cannot find enough force to "break" and "disassemble" the clinical model, in which it remained inserted over the years[12].

Thus, we identified the performance of nursing to subsidize the activities of other occupational categories, and when this was not enough to convince the patient to properly adhere to the treatment, according to the medical prescription required, family members or relatives who could contribute with this function are summoned.

To provide a care based on biomedical hegemony and that is positioned as support for the other to act does not comprise a situation free of suffering for the nurse, since the relations established between the staff and the patient pertain subjective issues immersed in the context of care.

Before the situation of not knowing how to deal with the suffering of the other, even because the confrontation of this situation will also be a generator of suffering for the professional, they seek as a "safety valve" to plug all the anguish and promote a necessary separation from subjective implications of the patients; and, to do so, the patients are forwarded in such a way they can be monitored by another professional.

Thus, we noted that the service logic occurs around the medicalization and the physician performance, being the nurse the professional that offers the necessary conditions for this logic to be maintained. It evidenced the need to return the patient to the assistance provided by the nurse in such a way that the technical guidelines regarding the pathology are strengthened as well as to observe if these are being properly followed. In addition, we can notice the care perceived from a capitalist-oriented perspective, in which customer must return as a way to keep the flow of the health system.

Modern and capitalist subjects are both free and submissive, determined (by exteriority) and determinator (of what is said), being this the condition of their responsibility (legal subject, subject to rights and duties) and consistency (not contradictory) to ensure that, together, their impression of unity and control of (for) their will, needing, therefore, to have power[10].

This reality is reflected as a consequence of the way the care was being directed at the practice of the nurse, who returned to the control of behaviors as a way to adapt to biomedical parameters, in such a way that patients will internalize these principles and highlight them in the therapeutic process to the detriment of other occupational categories.

The placement of the discourse in words has a necessary relation with the symbolic and political, since all saying has a significant direction determined by the material articulation of the signs with power relations. Such relationships are defined by its application in different discursive formations that represent different relations with the ideology, configuring the functioning of language governed by imaginary[10].

In a few moments, the nurse acts intermediating the delicate relationship between the physician and the patients, in which the patients repress themselves before that hegemonic knowledge and do not allow to reveal the implied questions that cause anguish and suffering in their illness process. Thus, the nurse uses the metaphor "make the cost clear" of the patient when the physician decides to "set the bar very high" with him, representing the way relations develop on site of the study.

In this perspective, we have a clinic that conforms a way of organizing medical discourse, configuring knowledge and practices as instruments of biopower and biopolitics within health actions and services and, consequently, in the field of nursing. These forms of power, though often implied, were assimilated and legitimized by nursing, outlining its way to produce health care and leading it to act more to interests external to the subject when being based on an exacerbated emphasis on the body, tied to the consumption of technologies and products[12].

Scientific knowledge, allied to the physician's knowledge, will be the instruments on which the biopower will be supported, legitimizing truths in modern culture, regulating and creating marginal bodies. The constitution of this biopower reinforces the ways the biomedical model was institutionalized and produced a logical understanding of the process of illness and healing based on medicalization[13-14].

Through the discourses, it was possible to identify that nursing, when subsidizing the activities of other occupational categories, stands alone, without support of the staff of the institution, dealing with a patient who suffers, who experiences anguish shared with professionals who do not have theoretical, psychotherapy, and supervision support to deal with such contents that are not addressed in their academic education.

To support the activities of other occupational categories, nursing remains "negative", which, although not seen in the photo, it is known that it was present in this process, seen here as a process of care. What reaches the level of consciousness is the performance of the physician, the psychologist, but who supports and provides subsidies in such a way they can

perform is the nurse. What remains in this other photographed and now lost is the abstraction of a care configured as negative, not because their actions do not represent care or that this is negative in the context of patient care, but for a movement that is unconscious, that directs its actions to contribute to the other to exercise its power over the patient, represented, especially, by the biomedical knowledge hegemony.

It becomes worrisome that nursing care is understood as derived from a medical prescription, and not as an individualized evaluation of the nurse. Nursing is an autonomous profession, which has a body of knowledge that supports its actions carefully; and its direct performance along with patients, providing most part of health care, ensures the importance of the work carried out[15].

FINAL CONSIDERATIONS

The concepts of unsaid (in discourse analysis) and unconscious (in psychoanalysis) allowed us to think a dimension of nursing care that appears as negative. In this conception, the negative is not the absence of care, but a specific form of situating this care from its negativity.

The analysis of this discourse shows that the several modalities of denial that pertain to the speech of nurses make present an ideological game of knowledge and power supported on the model of biomedicine, in which nursing care is the background needed for this model to develop, but which, for this reason, may not appear. From this interaction between the positivity of the biomedical model and the negativity of nursing care, arises a photograph in which nurses can barely recognize themselves, developing a care that is unknown, which is not perceived, but which everybody knows it is there. This care allowed other categories to act and contributed to the biomedical hegemony to be remained.

Therefore, nurses develop assistance strategies to support the patient and other occupational categories, although they do not find the support they need to deal with the subjectivities immersed in the process of care.

It is necessary, hence, to justify and theorize a nursing clinical practice from epistemological issues of the profession, believing that, when critically analyzing their actions of care, nurses will be able to see themselves in the photograph, recognizing the importance of their activities, to achieve a care that focuses the subjected and their needs.

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