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CIRCULATION OF POWER-KNOWLEDGE IN THE CONSTITUTION OF PROFESSIONAL PRACTICES OF PHYSICIANS AND NURSES

CIRCULAÇÃO DO PODER-SABER NA CONSTITUIÇÃO DAS PRÁTICAS PROFISSIONAIS DE MÉDICOS E ENFERMEIROS

CIRCULACIÓN DEL PODER-SABER EN LA CONSTITUCIÓN DE LAS PRÁCTICAS PROFESIONALES DE MÉDICOS Y ENFERMEROS

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Objective: analyze the circulation of power in the professional practices of physicians and nurses of an Intensive Care Center. Method: This is a qualitative research that uses data collected through semi-structured interview with physicians and nurses of an Intensive Care Center located in Minas Gerais, Brazil, and submitted to discourse analysis. Result: in general, the medical team was not very attentive to institutional norms; therefore, nurses were the most involved in normalizing and disciplinary processes. The visibility of physicians is related to the legitimacy of the domain of scientific knowledge expressed in their discourse, which gives them a position of power, as the nurses have a discourse that shows some resistance in assuming visibility and protagonism in the team. Conclusion: Intensive Care Center is a scenario where there is an intersection of several specialized knowledge, expressed in the discourses of doctors and nurses, favoring the circulation of power in the practices of these professionals.

Descriptors: Physician-Nurses' Relations. Power (Psychology). Professional Practice. Health Knowledge, Attitudes, and Practice.

Objetivo: analisar a circulação do poder nas práticas profissionais de médicos e enfermeiros de um Centro de Terapia Intensiva. Método: pesquisa qualitativa, com dados coletados por meio de entrevista semiestruturada, com médicos e enfermeiros de Centro de Terapia Intensiva situado em Minas Gerais, Brasil, e submetidos à análise de discurso. Resultado: em geral, a equipe médica não se mostrou muito atenta às normas institucionais, sendo os

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enfermeiros mais envolvidos nos processos normalizadores e disciplinares. A visibilidade do médico está relacionada à legitimação do domínio do saber científico expresso em seu discurso, o que lhe confere posição de detenção do poder, à medida que o enfermeiro tem um discurso que mostra certa resistência em assumir visibilidade e protagonismo na equipe. Conclusão: o Centro de Terapia Intensiva é um cenário onde há interseção de diversos saberes especializados, que se expressam nos discursos de médicos e enfermeiros, favorecendo a circulação do poder nas práticas desses profissionais.

Descritores: Relações Médico-Enfermeiro. Poder (Psicologia). Prática Profissional. Conhecimentos, Atitudes e Prática em Saúde.

Objetivo: analizar la circulación del poder en prácticas profesionales de médicos y enfermeros de Centro de Terapia Intensiva. Método: investigación cualitativa, con datos recogidos por medio de entrevista semiestructurada, con médicos y enfermeros de Centro de Terapia Intensiva, en Minas Gerais, Brasil, y sometidos al análisis de discurso. Resultado: en general, el equipo médico no se mostró muy atenta a las normas institucionales, siendo los enfermeros más involucrados en procesos normalizadores y disciplinarios. La visibilidad del médico está relacionada a la legitimación del dominio del saber científico expresado en discurso, lo que le confiere posición de detención del poder, a medida que el enfermero tiene discurso que muestra cierta resistencia en asumir visibilidad y protagonismo en el equipo. Conclusión: el Centro de Terapia Intensiva es escenario donde hay intersección de diversos saberes especializados, que se expresan en discursos de médicos y enfermeros, favoreciendo la circulación del poder en las prácticas de esos profesionales.

Descriptores: Relaciones Médico-Enfermero. Poder (Psicología). Práctica Profesional. Conocimientos, Actitudes y Práctica en Salud.

Introduction

In the scenario of health care practices, the hospital can be understood as an organization that incorporates constant advancement of scientific knowledge, skills, medical technology, facilities and equipment[1]. Until the eighteenth century, hospitals were primarily devoted to the care of the poor; however, over time, they became an environment for the cure of diseases, in which the physicians assumed a central role in its organization and management[2].

In the present time, even in face of a scenario with a strong emphasis on the medico-centered model, it is observed that interdisciplinary practices are opposing the reductionism of medicine. It is also verified that the various components of the multiprofessional team have increasingly expanded their scope of action in the hospital care and management practices[3]. This expansion of the scope of action can generate tensions among team professionals, with reconfiguration of the power relations established between doctors and nurses[4].

Although Foucault never considered himself a theorist, he argued that knowledge generates power, thus constituting the binomial power-knowledge. In social and professional relations, this power is legitimated through discourse, establishing the subject who exercises power and the subject who submits or resists to it[5]. In this sense, the knowledge that the subject holds in a given situation and that is expressed through the discourse determines his/her position in the relationships established[6].

However, power does not have a fixed point in the structure, but it circulates constantly, assuming a privileged position in professional relations, the one who has greater knowledge, that is, greater power[5]. In the hospital environment, the knowledge of various professionals interacts and medical practice is in a central position and is historically recognized for enabling the healing process of the diseased biological body. However, in current health practices, nurses also gained prominence for their intellectual work in the organization and in the implementation of care processes[7].

Thus, as power circulates, it generates effects on the daily work practices of physicians and nurses in the hospital context, and constitutes the process of subjectivation of these professionals[8].

Thus, understanding care practices implies searching for answers to questions that may clarify how these practices are organized in a given context. However, when searching for studies that associate health practices with established power relations among health professionals in Intensive Care Centers, it has been noticed that this topic is little explored, generating a knowledge gap.

Analyzing power and its circulation in daily practices of doctors and nurses corresponds to an attempt to explore health practices themselves as socially constituted elements, considering that such practices are structured based on relations and interactions that are sustained and contradicted in varied and complex structures[6]. Therefore, this paper aims to analyze the circulation of power in the professional practices of physicians and nurses of an Intensive Care Center (ICU).

Method

This paper is part of the results of the master's dissertation titled "Configuration of Health Practices between Nurses and Doctors in the Hospital Environment, in the Perspective of Power Relations", defended in 2018, in which a qualitative research was carried out in the poststructuralist perspective, based on the philosophical reference of the French Michel Foucault. The method of scientific investigation that focuses on the subjective character of the object analyzed was used through discourse in Foucauldian perspective.

The research was developed in the ICU of a large, non-profit hospital located in the city of Belo Horizonte, Minas Gerais, Brazil, which serves patients from the Unified Health System (SUS, acronym in Portuguese), as well as those from the supplementary health system, behaving socially as a philanthropic institution. At the time of data collection (August to October 2017), the ICU had an average of 170 admissions per month, with 30 intensive care beds and a care team comprised of 17 nurses, 100 nursing technicians, 31 intensive care physicians and 5 medical residents.

Eight physicians and 12 nurses participated in the study. The inclusion criterion adopted was the formal integration of the professionals in the care team of the ICU, regardless of the type of contract, for a period of at least 4 months, thus restricting the participation of professionals in the experience term. For the definition of the sample, it was used the saturation criterion, which is not supported by strictly numerical parameters, since there is no a priori delimitation of the number of participants, and the sample is interrupted when the collection of new data no longer lead to new theoretical insights and does not reveal new properties of the established categories[9].

Data were collected through interviews with semi-structured scripts, with some specific questions for doctors and nurses. They were based on the guiding questions for nurses: Talk a little about what it means to be a nurse for you. What do you consider to be a good doctor? In the script of the doctors there were: Tell me a little about what it is to be a doctor for you. What does it mean to be a good nurse? These were common questions to both: How are the relations between doctors and nurses in the ICU, in the everyday work? Do you believe that the way in which the interaction between doctors and nurses in the unit is established enables the best possible care for the patient? Why? If you could improve anything in the doctor-nurse relationship, what would you improve?

The data were collected at the institution during the work period of the professionals, according to a previous schedule with the medical and nursing coordinations, so as to safeguard the routine care of the unit. The interviews were recorded on Media Player equipment. Subsequently they were transcribed in full, for analysis and interpretation of the discourses constituted based on the discourses of the participants, in order to guarantee the totality and trustworthiness of the information.

The data were analyzed using discourse analysis (DA), a methodology that allows

understanding the way of functioning, the principles of organization and the forms of social production of meaning. The use of DA implies abandoning the idea that only language brings its truths in itself. The intended focus is to find the meaning of the said, transcending the written and reaching its meaning in a study on the context and the circumstances that formulated it[10]. Participants are identified with the initial letter of the category, N for nurses and P for physicians, followed by the interview order number.

The research respected the ethical precepts, following Resolutions No. 466/2012 and No. 510/2016 of the National Health Council. The project was approved in the Ethics Committees of the Federal University of Minas Gerais (COEP/UFMG), under Opinion No. 2,277,728, and the philanthropic general hospital of Belo Horizonte, chosen as the scenario for the research, under Opinion No. 2,379,540. All participants signed the Free and Informed Consent Form in two copies, one of which is handed to them.

Results

Regarding the profile of the study participants, the mean age of the nurses was 33.5 years and the physicians' was 32.5 years. Regarding gender, 8.3% of the nurses are male, which corresponds to 50% in the group of doctors. The mean work time in an ICU was approximately 8.6 years for nurses and 4 years for physicians (60% with up to 5 years, 25% from 6 to 10 years and 15% from 11 to 20 years). Regarding the time working at the institution, 5% are there for less than 1 year, 55% between 1 and 5 years, 15% between 6 and 10 years and 5% for more than 10 years.

Power relations or force relations exist between the knower and the non-knower, between the child and his parents, and so on, with society structured into thousands of such relationships. Relations of force or power use methods and techniques that are very different from one another in the search for truth[4]. Thus, data analysis made it possible to identify discourses of nurses and physicians who expressed these relationships in the day to day of the ICU, as presented in Chart 1[5].

Chart 1 – Expressions of power relations in the discourses of physicians and nurses of the Intensive Care Center (continued)

Discourse	Professional category	Expressions of power relations
(A)	Nurse	*Deal with stress! One starts cursing the other, starts using irony, jokes, you know?! Verbal aggression* [...] *it is also the fault of the nurse, because there is a certain moment when the nurse ends up getting tired, getting nervous, because he is seeing the situation and sometimes in this situation he is disrespected, and then he often goes crazy.* (N1).
(B)	Nurse	[...] *at the ICU we have* [...] *a central access punch bundle. So it is very clear what you have to do there: you cannot wear adornment, you have to wash your hands, put on a cloak, cover the patient from head to foot. Sometimes nurses identify that the doctor is doing something wrong, but they don't have the courage to speak.* (N7).
(C)	Nurse	[...] *in another place where I worked, I visited the beds with the doctors every day. ICU was smaller; patients were in less severe conditions. Then, every day, I would arrive in the morning and talk to the doctor who was on duty: - Let's visit the beds?* [...] *everything was discussed, everything explained* [...] *Besides the visit to the beds, the doctor and the nurse worked together.* (N2).

[5] In Chart 1, the "Speech" column organizes the speeches to locate them in the Discussion section of the results. Each speech is duly identified with the initials of its author, in the column "Expressions of power relations".

Chart 1 – Expressions of power relations in the discourses of physicians and nurses of the Intensive Care Center (continued)

Discourse	Professional category	Expressions of power relations
(D)	Physician	*Yes... There are periods that are more troubled, where the shift is even more stressful, with more severe patients, and sometimes there is a disagreement* [...] *But most of the time, when it's a good team, both the doctor, when he's not lazy, and the nurse who is agile and can see the changes that the doctor can't keep up with* [...] *generally it's a good relationship.* (M4).
(E)	Physician	*Yes...* [As to the standards] *usually the nurse positions himself better, you know? The doctor is a little more unruly. And it turns out that the nurse, sometimes, has to draw people's attention to some norm that we are not following* [...] (P8).
(F)	Physician	*The nurse, he has to be, above all, a person with managing skills* [...]*and it requires giving assignments, praising, telling technicians off; that's right... telling the doctor and the physical therapist off. And for that, he must have a good communicative ability too, you know? You have to know how to say and what to say it.* (P2).
(G)	Nurse	[...] *as our flow of doctors does not always turn they end up getting to know your service. So, I think it creates trust in our service for them as well.* [...] *So if I go there to evaluate, question something and debate, I think that's why they accept it. I don't see it just for me and let them figure it out. There is also my position before them* [...] *we argue most of the time, when they come... So, they accept our opinion, you know?* (N8).
(H)	Nurse	[...] *both* [doctors and nurses] *have to speak the same language, although they have different functions and knowledge within the specific area of each one. Patients benefit from this.* (N1).
(I)	Physician	[...] *one completes the service of the other, right? Everyone has its importance and is needed in the environment. So, I guess we have to respect, you know? Work together.* (P3).
(J)	Nurse	*Then at the beginning* [...] *there were visits to the beds. I could see they hardly looked at the nurse. You know, and then I started to position myself, raise my hand, and speak what I perceived of the patient, you know?* [...] *So I realized there was receptivity after a while. It wasn't right away.* [...] *I think the patient has a lot to gain. So there are people who demand more from me as a nurse, you know? People I can say that make the most of my knowledge, you know? And there are doctors who don't.* (N5).
(K)	Nurse	*Look, I think we could improve the communication issue, couldn't we?* [...] *Yes...* [The doctors] *call the nurses so they can be more active on a daily basis* [...] (N12).
(L)	Nurse	[...] *the doctor has to be a team partner; he has to come close to show beforehand the knowledge he has* [...] *Besides, they are the ones who make decisions, right? And in the face of the decisions they make, we have to go along with them.* (N4).
(M)	Nurse	*So there are the protocols, the question of central access puncture* [...] *And if the doctor doesn't do the procedure correctly, we can communicate with the medical coordinator. Now the SCIH [Hospital Infection Control Service, acronym in Portuguese] has even input it into the system* [...] *it's a document that we nurses filled out to know if the protocol of a puncture is following the orientation of the protocol* [...] (N8).

Chart 1 – Expressions of power relations in the discourses of physicians and nurses of the Intensive Care Center (conclusion)

Discourse	Professional category	Expressions of power relations
(N)	Nurse	[laughter] *Well* [...] *there were situations where the doctor began to explain to me everything he had already thought in terms of reasoning, because the patient wasn't having a favorable evolution, and from this point he started asking me:* – [...] *what do you think? Did I forget anything? That is, He was using me to help him in his reasoning* [...] (N5).
(O)	Physician	*It's really a team relationship; one helping the other; assisting in diagnosis, procedure, and patient impression. This way I think it becomes an interesting job.* (P8).

Source: Created by the autors.

Considering that power relations are present in all human relations and are not restricted to specific relationships, there was certainly no intention of exhausting the discussion about the configuration of health practices in the perspective of power relations in ICU, but of identifying nuances of these relations that are presented in an expressive way in the design of the work structure and in the configuration of the relationships of the teams.

Discussion

Through the philosophical lens of Foucault, the relations of power are intrinsically linked to knowing or knowledge, constituting the binomial power-knowledge[5]. Knowledge is what can be talked about, with domain and property in a discursive practice, and which delineates the relations of power[4], so that knowledge, legitimized by the discourse of certain individuals, is recognized as true by their peers and gives them power in established relations[5]. However, it is important to consider that power circulates, as different subjects constitute their discourses of truth, legitimizing different knowledge and truths, at different times and situations[11].

In this sense, in several discursive practices of the professionals who participated in this research, an effort was made to legitimize their real discourses, which is often associated with situations of conflict (Discourse A – Chart 1). In the nurse's discourse, conflicting relationships between these professionals and physicians, on certain occasions, are faced with attitudes of disrespect, irony and verbal aggression, so that nurses, overcome by fatigue, are subjected to a situation that is unfavorable to them, without appropriating discourses that evidence their knowledge to delimit their space and professional recognition (Discourse B – Chart 1).

Professional recognition is associated with the social visibility reached throughout history by the medical profession due to the legitimation of its scientific knowledge, expressed through its mastery of the diseases and their respective treatments, as well as techniques that heal and save lives[4]. However, Foucault considers that events that generate knowledge should be considered in their time, history and space[4], so that power relations must also be analyzed considering these elements. This means that knowledge is not definitive and permanent, so that it can undergo alteration, and also modify the relations of power supported by it[5].

From this perspective, a nurse participating in the study recognized that the practices she had previously experienced in a smaller ICU, with fewer patients hospitalized and with less severe clinical conditions, allowed for a more integrated team performance, with better patient optimization. (Discourse C – Chart 1), which favored the harmony of the environment. In a harmonious health work environment, the possibility that physicians and nurses effectively concentrate on the patients is maximized[12], with

consequent reduction in the impact of possible negative effects of professional relationships on the quality of care provided and patient safety[13].

However, it is not possible to deny that, although the ICU is the ideal place for the care of acute patients with recoverable severe conditions, its environment is one of the most tense and traumatic of the hospital, both for patients and relatives and for professionals[14]. In this sense, it can be inferred that the dynamics and logistics of intensive therapy are mechanisms that normalize the relations between the professionals who work there, and the daily dynamics is conditioned to the way each one reacts to this environment. In this context, the "laziness of doctors" and the "ability of nurses" to streamline processes appear in medical discourse as elements that delineate professional relationships (Discourse D – Chart 1). It is observed in the doctors' discourse that the fluidity of the professional relationship is conditioned to their expectation regarding the participation of the nurse in the care provided, which is associated with the professional's ability to perceive clinical changes not perceived by the physicians themselves.

Another important form of exercising power is discipline or disciplinary power. Discipline can be understood as a technique of power that crosses all institutions, in which constant vigilance and punishment are used as mechanisms for training the bodies, controlling them and adapting them to the best use in a given context, according to the established norms[15].

The nurses are professionals recognized by the team as more willing to make the care processes viable, based on disciplinary norms (Discourses B and E – Chart 1). It is observed in the speeches that nurses, through surveillance, have the possibility of assuming a role of authority in the face of medical procedures. This is because they hold knowledge about the established norms, even when they refer to procedures performed exclusively by the medical professional. However, even acknowledging the role of nurses as central subjects in maintaining the disciplinary order of the ICU, it is important to emphasize that this knowledge does not guarantee them, before the team, an active posture that is capable of effectively minimizing risks for patients. This leads to a reflection on the importance of associating this knowledge with the knowledge that underlies a given standardization.

The "rebelliousness" of medical professionals is naturalized in their own discourse (Discourse E – Chart 1) and is used as a justification for their non-adherence to norms. In addition, nurses' submission to the norm and their naturalized role of ensuring that these standards are met by the medical staff is implied. Certainly, it may not be a conscious reflection, but it subtly states medical supremacy.

It is also necessary to consider that the management skill is perceived as a prerequisite for the professional practice of the nurse. However, this managerial ability is associated, in the discourse, with the ability to communicate in order to report compliments and to apply penalties (Discourse F – Chart 1). The application of disciplinary penalties is defined by Foucault[5] as the normalizing judgment, which seeks to punish the subjects for their deviations, with the intention of also preventing new faults from occurring, in a mechanic of punishment represented by a process passing through atonement and repentance, aiming at not repeating the fault or error.

However, even in the face of medical supremacy, nurses recognize that it is possible to assume a differentiated position in power relations through a discourse that demonstrates their knowledge, which is also favored by a longer period of teamwork (Discourse G – Chart 1). It is established that the experience of working with the doctor for some time raises opportunities for nurses to show their productive potential in the team, as well as their level of knowledge. In this sense, studies indicate that, in fact, the longer the contact time between professionals, the stronger becomes the group, the teamwork, the friendship, and the companionship, establishing greater trust[16,17].

It is observed, in both the doctor's and the nurse's discourse, the perception of the complementarity of the work of the two categories

(Discourses H and I – Chart 1), respecting the differences between them, which corroborates the idea that it is necessary for both professionals to understand the importance of teamwork for the best outcome in the care provided[18]. Nonetheless, it should be emphasized that nurses are little perceived and demanded by physicians in some activities of high complexity, such as the bed visit, a situation that assumes a differentiated character, when nurses present a discourse that shows their knowledge on the health practices developed in the ICU (Discourse J – Chart 1). Nurses' search for participation in bed visits can be understood as an attempt to rescue activities that characterize their performance in the care process in its essence, since, in spite of concentrating their activities on actions directed to the management of nursing care, they must also act in the execution of this care.

Nurse's effort to modify this practice is justified by the fact that the bed-visit, with the interdisciplinary team acting, optimizes the quality of patient care and enhances medical-nurse communication, since important information can be transmitted in the face of reduction of, for example, the need for subsequent telephone calls for clarification of doubts[19]. With regard to the participation of nurses in this activity, it is emphasized that it may be associated with an increase in their self-confidence in communication with physicians[20].

However, contrary to an attitude that favors the holding of power by nurses, there are situations in which these professionals take a passive stance, remaining in a comfort zone, assuming the stability of medical supremacy and feeling free to take actions that modify this situation. They choose not to expose themselves by attributing to the physician the responsibility of inserting them into the therapeutic process, by exempting themselves from their ability to make the power circulate (Discourse K – Chart 1). In this context, it must be considered that power does not have a fixed point in the structure, that is, it is not permanently detained by a single subject; on the contrary, it is constituted in the interpersonal relations, in which a determined agent is able to lead the action of another[21]. However, it should be remembered that the exercise of power must take into account the freedom of those who suffer such exercise; otherwise it is domination and not power[2,5].

Traditionally, the physician tends to dominate the therapeutic decision-making process because the nurses themselves delegate this power to them, allowing them to assume greater authority in clinical decision-making[17]. Thus, nurses are expected to be activated by the physician, who receives the transference of the obligation to mobilize them, to occupy them, and to include them in the care process.

It is also noticed that the nurses have a discourse that shows some resistance in assuming a position of visibility and protagonism in the team. It places the doctor in a position of predictor of care, whereas it is up to them to "walk along with him," reaffirming medical supremacy once again (Discourse L – Chart 1). Nurses assume a passivity posture by merely performing what the physician determines, not assuming responsibility for the decisions made by the doctor, as they have not contributed to it in some way. Although physicians and nurses recognize that effective teamwork is essential to improve the quality of patient care[22-23], in professional practice, the value attributed to collaboration among these professionals is still more valued by nurses[22].

In the perspective of power relations, the hospital, more specifically the ICU, is considered an environment in which individuals are inserted in fixed places, where the smallest movements can be controlled and all events are recorded uninterruptedly. In this context, nurses recognize their role of controlling the activities of the physician, through mechanisms implanted and legitimized in the service, with the objective of guaranteeing the effectiveness of the standardized processes, being able, when identifying failures in a certain procedure, to report it to the medical coordination (Discourse M – Chart 1). Nurses were delegated the power to watch, report and punish, which can be interpreted as a positioning of this professional in a higher level

than the doctor. Thus, it is perceived that power circulates through the domain of the norm and the holding of normative knowledge[4].

Effective teamwork, with shared decision-making, is an alternative to minimize concentration and little circulation of power, which also implies a concentration of responsibility on certain team members. It should also be considered that there is evidence that the quality of care provided is directly proportional to the quality of the relationship among health professionals and that the lack of cooperation and collaboration hinders the effectiveness of care[24]. Thus, co-responsibility for care practices occurs through the sharing of knowledge, because, just as power circulates through knowledge, the possibility of diffusion of responsibilities occurs as knowledge is located in different bodies (Discourse N – Chart 1). Teamwork gives due credit to different professionals and indicates the circularity of power in the network of established relations (Discourse O – Chart 1), calling into question the absolute medical supremacy. The practices of both professionals go through a whole set of strategies of professional positioning, in which, in a certain situation, one struggles for greater visibility and, in another, it is achieved and there is an effort to maintain it.

Conclusion

With this study, it was possible to perceive that the ICU environment influences, in a particular way, the professional relations, because, as it is an area of critical care, it demands focused attention, technical and relational skills, knowledge and agility of all professionals of the team. On the other hand, it is a scenario in which there is an intersection of various specialized knowledge, which favors the circulation of power in professional practices.

Although there is a well-defined formal structure recognized by the workers of the unit, the relations assume amplitude and complexity that go beyond the limits established formally, evidencing tensions that emerge in the daily practices, supported in the relations that are established between the diverse actors in scene. In these relations, it can be observed that the circulation of power occurs as the knowledge is expressed in the professionals' discourses.

Historically, there is an investment of the physician in maintaining his professional supremacy in the social and economic context of health. Thus, the fact that the medical team recognizes the importance of the nurse in the context of health practices can be conceived not only as subjecting the physician to the importance of teamwork, but also as a strategy to resist the effects of disciplinary measures. Power can circulate naturally by knowing and intentionally by the necessity of its preservation.

Collaborations:

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3. final approval of the version to be published: Tauana Wazir Mattar e Silva, Isabela Silva Câncio Velloso and Meiriele Tavares Araújo.

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