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Conceptions of care and power relations in women's health*

Concepções de cuidado e relações de poder na saúde da mulher

Conceptos de cuidado y relaciones de poder en la salud de la mujer

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The objective of this study was to analyze the trajectory of the conceptions of care, the theoretical bases that support the care planning and the power games that interweave the relationship between professionals and assisted women. We investigated articles in the *Scielo, Lilacs* and *Medline* databases, and interviews were conducted with health professionals. Care conceptions and care planning often remain limited to scientific technical knowledge. The professionals interviewed cited the work process as a determining factor to limit the conception of care to technical principles. Although the health work process, in general, favors the asymmetrical relationship between the assisted person and the professional, reinforcing and establishing power relations by indicating who holds the legitimate knowledge to provide care and to plan the care, professionals should question the "place" they assume and the knowledge they hold as a representation of a truth to be followed.
Descriptors: Standard of care; Women's health; Power.

Este estudo teve como objetivos analisar a trajetória das concepções de cuidar, as bases teóricas que sustentam o planejamento para o cuidado e os jogos de poder que entrelaçam a relação entre o profissional e a mulher assistida. Investigou-se artigos nas bases *Scielo*, *Lilacs* e *Medline;* bem como, foram realizadas entrevistas com profissionais de saúde. As concepções de cuidar e o planejamento do cuidado, frequentemente, permanecem reduzidos ao saber técnico científico. Os profissionais entrevistados citaram o processo de trabalho como um fator determinante para limitar a concepção do cuidar a princípios técnicos. Embora o processo de trabalho em saúde, em geral, favoreça a relação assimétrica entre a pessoa assistida e o profissional, reforçando e fixando as relações de poder por indicar quem detém o saber legítimo para cuidar e planejar o cuidado, o profissional deve questionar o "lugar" que ocupa e o saber que detém como representação de uma verdade a ser seguida.
Descritores: Padrão de cuidado; Saúde da mulher; Poder.

Este estudio tuvo como objetivo analizar la trayectoria de los conceptos de cuidar, las bases teóricas que sustentan la planificación para el cuidado y los juegos de poder que entrelazan la relación entre el profesional y la mujer asistida. Se investigaron artículos en las bases Scielo, Lilacs y Medline; así como, fueron realizadas entrevistas con profesionales de salud. Los conceptos del cuidar y la planificación del cuidado, frecuentemente, permanecen reducidos al saber técnico científico. Los profesionales entrevistados citaron el proceso de trabajo como un factor determinante para limitar el concepto del cuidar a principios técnicos. Aunque el proceso de trabajo en salud, en general, favorezca la relación asimétrica entre la persona asistida y el profesional, reforzando y fijando las relaciones de poder por indicar quien detiene el saber legítimo para cuidar y planificar el cuidado, el profesional debe cuestionar el "lugar" que ocupa y el saber que detiene como representación de una verdad a ser seguida.
Descriptores: Nivel de atención; Salud de la mujer; Poder.

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INTRODUCTION

In the health area, many conceptions of caring coexist and influence the plans of care. In the perspective of scientific production, the definitions of caring/care are based on different theoretical-philosophical currents. These conceptions are formed according to the time, the culture of each society, and the technological development.

In a brief historical retake it can be said that in the Middle Ages the medical and nursing practices were disconnected; the nobles received in their homes the health care provided by doctors. The plebeians who needed care were assisted by the sisters of charity, usually in a place away from the city[1].

Care was based on the paradigm of the Catholic Church as a means to achieve the divine salvation of the caregiver and the comfort of the soul of the sick. Caring for the body consisted of treating wounds, bathing, preparing teas, washing clothes, ensuring personal hygiene and cleaning the environment, and providing physical and spiritual comfort to all the sick. The idea of care was linked to the mastery and control of practices such as baths, teas, massages for physical and soul comfort[2].

The intensification of mercantilism provided greater trade of goods and transit of people, but also the spread of diseases. In addition, wars facilitated the onset of diseases. In this scenario, there were changes in the care model: from home care to hospital care.

Instead of relief for the pain of the soul, care began to have as its main objective the healing of the body[2]. The model change was accompanied by changes in conceptions of caring; the assistance provided with natural measures - baths, massages - were replaced by medicinal substances with scientifically tested and proven effects.

The flourishing of capitalism in the eighteenth century and the rise in the nineteenth century brought novel medical knowledge and practices: monitoring the sick, supervising and coordinating care, since the etiological agents were visible through the microscope and, could be transmitted.

Hospitals were organized in a hierarchical way and conceptions of caring were based on the actions of separating, isolating and classifying the patients, who were now inserted within the hospital routine[1]. In this respect, Foucault[3] says that the hospital started to be characterized as a therapeutic space for interventions aimed at diseases and patients.

In the twentieth century the conceptions of caring were based on scientific advances and technological logic. The planning of care began to be guided by the results of exams supported by technological methods:

"Until nowadays, the need to care has been minimized by technical, bureaucratic and administrative functions, which are only an approximation of care"[2].

Despite the efforts of health professionals to preserve the individuality of assisted women, to identify and meet the needs presented, and to respect habits, values and beliefs, care planning is usually linked to the representation of the historical trajectory of the exercise of power over who seeks health care in general, and specially women.

Cestari et al.[4] understand that care is an action that needs to be carried out in an effective but also affective way:

> *(...) there is a need for more effective and affective care in which women (...) play an active role in the health process and interactions are real (...). Inauthentic care has been demonstrated in women's statements when they say that they underwent examinations and procedures without understanding their reason or, when they simply did not participate in decision making about their health status.*

Public Health Policies such as Humaniza SUS Notebooks[5], point out the availability of information as a fundamental subsidy to the quality of health care. This availability could be one of the fundamental keys to stimulate the questioning/problematization of health practices, on the part of the professionals.

The National Policy of Integral Care to Women's Health emphasizes that, regardless of the methodology used for health care:

> *"it is of fundamental importance that the educational practices have a participative character, allowing the exchange of information and experiences, based on the experience of each individual"[6].*

The effectiveness of this health policy is difficult because health professionals have conceptions of care strictly and "naturally" endorsed by technical-scientific knowledge. Such situation leads professionals to understand other ways of caring as "deficiencies of information about the care with the body"[7], rather than conceiving such discourse as one of several possibilities of narratives about the representation of care.

The conceptions and planning of care are grounded only on scientific technical knowledge. A relationship of professional power over the bodies of the assisted women is thus established, leaving the women apart from the knowledge about their own body.

Despite considering the work process as a discouraging factor to explore other ways of practicing health care, the constant questioning by health professionals regarding the 'place they occupy' and the 'truth' that they utter should favor perspectives of constructing conceptions of care and planning of care that are not tied only to a technical, medicinal character.

Thus, this study had as objectives to analyze the trajectory of the conceptions of care, the theoretical bases that support the planning of care and the power games that interweave the relation between professionals and assisted women.

METHOD

The research is classified as exploratory and descriptive. The study is exploratory because there was an attempt to approach the identified problem by means of interviews with health professionals, and descriptive because the goal is to describe the fact and phenomena of the reality experienced in the Basic Health Unit investigated.

Exploratory research has the main purpose of providing a greater familiarity with problem-questions, in order to build hypotheses[8]. Descriptive research aims to describe the facts and phenomena of a given reality[9].

For the development of this study, two steps were taken: the first consisted of a bibliographic review in *Scielo*, *Lilacs* and *Medline databases* using the following descriptors combined by the *boolean operator and/or*: Care plan/planning; Nursing care/caring; Maternal Care Standards; Women's Health**.** In *Medline*, the following descriptors were used: *planning patient care; nursing care; maternal care; women's health*.

Articles published between 2003 and 2016 were analyzed. This methodological step was guided by the following question: What is the concept of caring/care and planning of care in the field of women's health? What does the literature say about that?

The second step was developed in a Basic Health Unit (BHU) in the eastern zone of the city of São Paulo-SP-Brazil. Interviews were conducted with health professionals who had higher education; the interviews were guided by a semi-structured script, held in a private room or empty office. The interviews were recorded and transcribed later.

Each health professional interviewed agreed to participate in the study and signed the Informed Consent Form (ICF). The study was approved by the Ethics Committee of the Municipal Health Secretariat of São Paulo and by the Ethics Committee of the School of Arts, Sciences and Humanities of the University of São Paulo. Opinion Nº 862,890 of 07/11/2014.

This step was guided by the following question: Upon which theoretical basis are the care plans drawn up?

The interviews were analyzed based on the ideas of other studies[2,3,7] addressing the theme on:

1 - health work process;
2 - caring/care, care plan/planning; and,
3 - power relations.

RESULTS

Records of 2671 studies were found with the descriptors: care plan/planning; nursing care/caring; maternal care standards and women's health.

Of these, 389 articles were considered adequate for this work, since they fully contemplate the subject, and their abstracts were read; 203 theses and editorials were excluded. A total of 186 articles were read in full length.

The interviews were conducted with 05 professionals: 04 nurses and 01 doctor. At the time, the team of professionals in the BHU investigated was composed of 06 nurses and 05 doctors. Among the 05 professionals interviewed, 02 had graduated more than 20 years ago; one 18 years ago; one 11 and the other 08 years ago. Among these 05 professionals, 03 had been working at the BHU for 04 years, one for 06 years, and the other for 03 years.

As for the interviews in general, health professionals reported using the Protocols/Manuals developed by the Ministry of Health, by State Health Department - SP; the Nursing Diagnoses established by the North American Nursing Diagnosis Association (NANDA) and the Nursing Process (NP) prepared by Wanda de Aguiar Horta (1926-1981).

As a theoretical basis for preparing the care plans, the statements showed the following:

(...) we take into consideration the *theories of Wanda Horta (for the plan/planning) (...) which address the importance of paying attention to the context and the family of women, considering biopsychosocial aspects.* (*Light*).

My plan of care is elaborated upon the needs presented by the woman. We do the NANDA care plan. (*Star*).

All the interviewed professionals talked about the health work process as a determining factor that makes it difficult to provide quality care to the user:

(...) sometimes you would like more time in the consultation to prepare it (the care planning), but our time is short, the nurse has twenty minutes, and sometimes the person cries for an hour in your office (...). For example, today we have fifteen people to do the Pap smear in three hours (...). (Sun).

The statements of the professionals seem to show that there is an effort to establish a relationship of trust with the assisted women and based on this, to explore other health care arrangements. However, the service remains reduced to narratives oriented by biological-clinical, technical-scientific aspects, minimizing the possibilities of questions about what they represent and why their uses are unique in health care:

(...) I will focus on (...) signs and symptoms because I have little time to do the anamnesis, which are the questions of your life process (...) unfortunately the stipulated time and the requirement of production causes a dizzying drop in the quality of the consultation (...) (Moon).

(...) *so, sometimes we fill in the papers that need to be filled out, requests for exams, the registration number (...) this has to be, this has to be ready for the patient to continue until prenatal and be supported there, but I think that we end up not leaving time for the other observations of the pregnant woman, which are also important. (Mars).*

Most professionals believe that the relationship between them and the assisted woman is limited, and this limit is attributed mainly to the work process existing in the Basic Health Unit:

(...) a prenatal visit has to be done in 20 minutes and we know that there are more pregnant women out there waiting, so we can not do things the way they should. (...) is the great demand for public service, it is the work process that sometimes prevents us from doing the best we can. (Moon).

DISCUSSION

As for the first stage of the research, the articles with the descriptors nursing care/caring; maternal care standards in the field of women's health show, in general, that the quality of care depends on health professionals, their attitude and their sensitivity towards humanized care.

In these works the perception of nursing care/caring is demonstrated by the words solidarity, cooperation and autonomy involving the assisted women. Some works[10-12] pointed out the need for care to be based on the dialogue between women and health professionals. These are works that, to a certain extent, emphasize the importance of the information-communication process as the basis of the care provided:

> *(...) care (provided by doulas and/or midwives during and after the parturition process) was described as "positive energy" and "strength". In order for care to be provided, listening is necessary and perceived as a communicational process that has consequences[10].*

It is possible to establish a symmetrical dialogue between health professionals and the assisted women. This possibility may be made possible through the openness provided by the professional to question the meaning of the practices, the objects, the facts and how these meanings circulate in a given cultural context and are constantly renumbered according to interests of different orders: economic, social, scientific, spiritual.

In this line of reasoning, guidelines and recommendations on body care can not simply be strictly rational recommendations; their acceptance can occur as an act of violence or of power, of imposition. According to Veiga-Neto[13]:

> *(...) we do not accept a truth because it has been rationally justified to us, fully and thoroughly demonstrated as a truly true truth. Either we accept it as an act of visible violence (...) or we allow ourselves to be captured by it, as an effect of power, which, being subtle and insidious, imposes on us such truth as natural and therefore necessary.*

The study by Rodrigues et. al.[7] analyzes the social representations of puerperal women about nursing care and the instructions received during the puerperal cycle, about self-care and caring for the child.

Most of the time, the woman is considered as ignorant, necessitating a network of care to make her fit in the satisfactory performance of motherhood[7].

The planning developed by nurses during prenatal consultations should be based on attentive listening without judgments, with respect for needs, availability, authenticity, trust, dialogue, preservation of the individuality of the other, and exchange of experiences, so that care may transcend biology and encompass aspects of the various dimensions of the human being[7].

Women are considered to be 'ignorant' and lacking information precisely because the logic of the information necessary to take care of the body is based on the original scientific knowledge at the birth of the clinic. From the birth of the clinical practice, in the age of Enlightenment, in the eighteenth century:

> *An absolutely new use was then defined in the scientific discourse: the use of unconditional fidelity and obedience to the colored content of experience - say what you see (...) the formula of description is at the same time a gesture of unveiling. And this unveiling is in turn implied as the field of origin and manifestation of truth[3].*

The study "*Childhood in the almanacs: nationalism, health and education (1920-1940)*"[14] shows care as a way of disciplining the bodies of the Brazilian population to fit the era.

Through the bibliographic survey on pharmacy almanacs, the research shows that these were not only restricted to advertisements of drugs, they had other roles such as: agricultural, religious and civic calendar, health education vehicle, substitute of inaccessible doctors, activity and reading books for adults and children[14].

During this period (1920 to 1940), care was linked to the project of modernization of the Brazilian society, through a well-cared and disciplined childhood. Concern was focused on the educational aspects of activities such as games and hobbies, articles and editorials on care with bodily hygiene.

Some studies define caring/care as a need of every human being[10,15]. Most studies define caring/care as the establishment of the link between health professionals and the assisted women. This bond is expressed in several ways: through embracement, solidarity, technical actions, dialogue, among others[16]. Caring/care is often seen by health professionals merely as the realization of technical procedures, which legitimates them as authority to guide the care of the body of the assisted person and firm their conception as true, disregarding other possibilities of conceptions of care.

The study *Cultural care practices of mothers of newborns at risk in southern Brazil*[17] reveals the disregard of health professionals towards the women's knowledge on manifestations of their own body.

Most of the times, the woman's understanding of the care with her own body, her worldview, her way of thinking, feeling, and acting are not taken into account[17]. Health care should be guided by a complex perspective of the human being, welcoming the contradictory, contemplating the experience of the assisted persons, listening to their life project and allowing to embrace the other in its authenticity.

In the production of care, there should be attentive listening to allow the person receiving care to understand the situation experienced, including understanding the non-adherence to the proposed treatment, the disinterest in preventive guidelines and even the revelation of detachment with the own health[18].

Horta's study [19] defines the Nursing Process (NP)/Systematization of Nursing Care (SNC) as a planning and care to be provided.

In the speech therapy field, Goulart and Chiari[20] showed that the planning of care is prepared based on the complaints of users who seek the health service. The speech therapist and the multiprofessional team would be responsible for developing this planning. This would be based on clinical evaluations: the so called structured evaluation would correspond to the completion of protocols, and the unstructured evaluation would correspond to the questions brought up by the patient and/or family.

This study also shows that there is a valorization on the part of health professionals of scientific knowledge and that this valorization ends up establishing a hierarchical, vertical and caring relationship between the professional and the person assisted[20].

In the field of reproductive health, even though the planning of care is based on the demand of the couple that seeks health services, health professionals are responsible for the planning[21].

This prevalence of professionals over the actions pertaining to others can be understood through the ideas of Foucault[3] when power relations become violence:

> *(...) acts on a body, on things. It forces, it submits, it breaks, it destroys; it closes all possibilities; therefore, it has no other pole than that of passivity; and if there is resistance, the only choice is to try to reduce it.*

The second step of this research shows a brief historical account of the attempts, mainly in the field of nursing, to organize the care provided to the assisted person.

The Nursing Process created in Brazil by Wanda Aguiar Horta in the 1970s to organize and systematize care, the Taxonomy of the North American Nursing Diagnosis Association (NANDA), established in 1982 in St. Louis University - USA and Clinical Protocols are important tools for organizing nursing actions and qualifying health care.

In the 1970s, a transformation in the Brazilian nursing field was brought about by the gradually broader understanding of care. This understanding considers the person as being in constant interaction with herself and with the environment in which she lives. Nursing would have the main role of meeting the basic human needs of the people assisted[19]. It would be responsible for the care, its object of work and study.

The clinical protocols elaborated by public agencies are the results of efforts by public policies to improve the SUS's care system and to qualify the attention to users. Protocols are usually based on technical knowledge and scientific evidence.

The question is whether the restricted use of protocols/manuals by professionals to plan care would enable an understanding of the complexity that permeates integral health care and, in particular, the health of the woman.

Otherwise, would the restricted use of protocols and manuals be capable of allowing 'openness' for the professionals to rethink and re-signify their practices in order to ground them on built truths and that do not meet hegemonic interests that reinforce social inequality?

The efforts of the interviewed professionals to elaborate an individualized and meaningful plan for the women are remarkable.

Some studies[1,15,22] recognize that no matter how much effort is made to manage a collective work aimed at embracing a person who needs care, health work still persists as partitioned, fragmented, and senseless for both workers and the assisted persons.

The health work process tends to be done mechanically, impersonally, and centered on the biomedical model and medical care[16]. This makes it difficult to draw up a plan to meet the demands of the population and also makes it difficult to design a plan with the participation of women, offering them information about the anatomical-physiological functioning of their body and autonomy in their care.

The work ends up as a production line, which must be rigorously executed, aiming to achieve goals, but hindering the establishment of bond and trust between professional team and the person assisted,

and also undermining the professionals' view of health that takes integral care into account.

The work process in Primary Health Care, including Family Health, is characterized by two aspects: the first concerns the complexity of this type of work and the second is the difficulty of systematizing actions, resulting from the continuous demand for these services[23]. The whole work process is aimed at achieving some goal(s) and these are the ones that direct all actions[23].

The health work process has as peculiarity the implication of the purpose of supplying basic human needs, translated into well-being integrated to physical, mental, spiritual aspects, among others. This indicates that the health work process is linked to the fulfillment of the expectations of human beings in their most 'original' way of expression of life: to be accepted in the state of illness/aggravation and guided towards health promotion/maintenance.

The overload of services and disarticulation within health teams result in lack of interest of professionals to learn the outcomes of their own work. If the professional was inserted in an environment where their own practices were questioned, this would favor a dynamic exchange of information and knowledge about the families they assist. There would be a possibility of greater involvement/participation and recreation of daily life.

The understanding of the complexity of decisions, actions, getting sick, being healthy, the understanding of the complexity of living beings should be the basis of the concept of health care. This base that is questioned at all times for being complex and under constant internal and external influence of the environment, can not be reduced to explanations that are interpreted and meant as true and permanent.

The relationship between health professionals and assisted women should be decentralized. Each narrative, on both sides, does not express the truth, but rather one of several possibilities of care and planning of care.

CONCLUSION

The results of this research show how conceptions of care and care planning are based exclusively on technical bases, and this also favors the continuous medicalization of the population.

The relationship between health professionals and assisted women is asymmetric and can subjugate women to the power of scientific technical knowledge, while women are considered unqualified. This makes it difficult to provide quality care in the SUS despite the efforts of health professionals and government agencies to reverse this situation.

The efforts do not seem to reach the goal of maintaining care conceptions and care planning exclusively focused on the biomedical model, making it difficult to question this model that has been perpetuated in health care for centuries and which is valued by the exclusionary hegemonic social sectors.

Besides the reductionist conceptions of caring and care planning, the logic of the health work process, in general, completes the vicious circle: purpose of the work process and meeting goals.

Goals are interpreted as quantitative data, i.e. number of consultations and procedures performed. This model of work process divides the whole into parts and studies them separately, in an isolated way. In consultations, each organ that composes the human organism is analyzed separately: the treatment is for the uterus, the organ causing the complaint and not to the person contextualized in her diverse forms/ways of being, belonging, interpreting and signifying the world.

The assisted person, ontologically integral, suffers constant interference from his environment; difficulties, contradictions, anguishes, fears, joys, emotions and worries are directly related to all the responses and manifestations of the body-mind.

This understanding would be compatible with conceptions of caring and care planning, guided by questions, by 'openness' to possibilities of new health care arrangements.

The issues mentioned here are complex and are not limited to theoretical analyses that are distant from practice scenarios. It is understood that the reductionist logic maintained by the exclusive use of the biomedical model in health care could serve as a driving force to reverse this logic if it were submitted to questioning whether this view of being the only and 'true' form of care.

The concept of caring in the training of health professionals should be debated based on concepts that interconnect the humanities, health and social sciences, such as knowledge-power, complexity, information-communication, sign-object-interpretant.

This would facilitate understanding of discourses, truths, and narratives constructed by humans as a possibility of their own survival. It would also facilitate the understanding of diverse interests, including exclusion, which contribute to valuing certain 'truths' to the detriment of others.

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CONTRIBUTIONS
Eunice Almeida da Silva participated in the conception of the research, literature review, discussion, preparation of the manuscript and final review. **Quézia Rebeca Silva Flores** contributed to the literature review, data collection and discussion. **Maristela Belletti Mutt Urasaki** participated in the critical review.

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