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## ORIGINAL ARTICLE

### POWER RELATIONSHIPS IN HOME CARE: TENSIONS AND CONTRADICTIONS BETWEEN PROFESSIONALS, USERS AND CAREGIVERS

#### RELAÇÕES DE PODER NA ATENÇÃO DOMICILIAR: TENSÕES E CONTRADIÇÕES ENTRE PROFISSIONAIS, USUÁRIOS E CUIDADORES

#### RELACIONES DE PODER EN LA ATENCIÓN DOMICILIARIA: TENSIONES Y CONTRADICCIONES ENTRE PROFESIONALES, USUARIOS Y CUIDADORES

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#### ABSTRACT

**Objective:** to analyze the relations of power that are established in the practices of Home Care. Method: qualitative, analytical study, based on Foucauldian power referral, with data obtained through 109 visits to home care teams. Observations on the production of care were made; interviews were also conducted with Five patients / caregivers and ten professionals. The data was analyzed from the perspective of Discourse Analysis. Results indicate that the relationships that cross the production of care at home are characterized by involvement, empathy, bonds and welcoming, but also reveal the disciplinarization, control and standardization that affect care in the home. Conclusion: there are moments of production and interdiction of care that simultaneously compose two plans of the effects of power relations in home care. **Descriptors:** Home Care Services; Power (Psychology); Social Control; Informal.

#### RESUMO

**Objetivo:** analisar as relações de poder que se estabelecem nas práticas da Atenção Domiciliar. **Método:** estudo qualitativo, analítico, apoiado no referencial de poder foucaultiano, com dados obtidos por meio de 109 visitas às equipes de atenção domiciliar. Realizaram-se observações sobre a produção do cuidado; também, foram feitas entrevistas com cinco pacientes/cuidadores e dez profissionais. Os dados foram analisados na perspectiva da Análise de Discurso. **Resultados** indicam que as relações que atravessam a produção do cuidado no domicílio se caracterizam por envolvimento, empatia, vínculos e acolhimentos, mas, também, revelam a disciplinarização, o controle e a normatização que afetam o cuidado na atenção domiciliar. **Conclusão:** há momentos de produção e interdição do cuidado que compõem, simultaneamente, dois planos dos efeitos das relações de poder na atenção domiciliar. **Descritores:** Assistência Domiciliar; Serviços de Assistência Domiciliar; Poder (Psicologia).

#### RESUMEN

**Objetivo:** analizar las relaciones de poder que se establecen en las prácticas de la Atención Domiciliar. **Método:** estudio cualitativo, analítico, apoyado en el referencial de poder foucaultiano, con datos obtenidos por medio de 109 visitas a los equipos de atención domiciliar. Realiz observaciones sobre la producción del cuidado; también, se realizaron entrevistas con cinco pacientes / cuidadores y diez profesionales. Los datos fueron analizados en la perspectiva del Análisis de Discurso. **Resultados:** indican que las relaciones que atraviesan la producción del cuidado en el domicilio se caracterizan por involucración, empatía, vínculos y acogidas, pero, también, revelan la disciplinarización, el control y la normatización que afectan el cuidado en la atención domiciliar. **Conclusión:** hay momentos de producción e interdicción del cuidado que componen simultáneamente dos planes de los efectos de las relaciones de poder en la atención domiciliar. **Descriptores:** Servicios de Atención Domiciliar; Poder (Psicología); Controles Informales de la Sociedad.

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## INTRODUCTION

In this study, it is sought to discuss some issues related to power relations in the field of Home Care. This proposal is a challenge not only to overcome the classic object of health research and hegemonic organizations, but to contemplate the caregiver intrinsically involved in the care relationship. The option to embark on this path has to do with the current reality of the health system associated with the epidemiological and demographic circumstance through which Brazil goes through.

In 25 years of existence, the advances of the Unified Health System (UHS) with positive impacts on the health of the population are considerable. However, there is a long way to go for the consolidation of the System, by means of the dichotomous overcoming between the prescribed and the accomplished in the service to the population.<sup>1</sup>

One of the challenges is related to the epidemiological change resulting from the triple burden of infectious diseases, chronic diseases and external causes, as well as the variations in the demographic issues arising from the rapid aging of the population. This scenario interferes in the type of death and morbidity and demands the identification of new forms of organization of the services offer.<sup>2-3</sup>

In order to offer a comprehensive, humanized, continuous care, consistent with the demographic and epidemiological profile of the population, different care strategies are discussed. Among these, there are the actions of Home Care (HC), as a modality of care service that contributes to meet the emergency demands of the system, focusing on the production of active and humanized care.<sup>4</sup>

Currently, the public offering of HC services is regulated by the Federal Government through the "Melhor em Casa" program. In the Program, HC is defined as a modality of care that aims at multiprofessional assistance with a support team at home care. The Program composes the Health Care Network and must be integrated with other services through the establishment of care flows, clinical and access protocols and regulatory mechanisms, in a solidary and complementary relationship.<sup>5</sup>

HC is an alternative to hospital intervention in order to reduce the demand or length of hospital stay, complications resulting from long hospitalizations, and hospital care costs.<sup>6,7</sup>

The reordering of health care practices, proposed for HC, occurs through the awareness of intervention, the strengthening of strategies, mechanisms and innovative practices operating as facilitators in coping with the disease situation. It is necessary to emphasize the relevance of the attentive listening of the situations experienced by the user constituting the involvement among the participants involved in the process.<sup>8,9</sup>

It is worth emphasizing that the reality of the doctor-patient relationship, established in the context of hegemonic institutions, is strong and historically determined. It is believed that the incorporation of HCS, in a strategic way, enables a more equanimous professional-patient relationship in order to contribute to a greater strengthening of the relationship, since the program strategy, together with the change in care, there is a closer service to the family group as a whole, and consequently, the strengthening of trust, identification and bonding in the face of encounters between the agents involved in the relationship.

Advances in the production of health care are still evident in the reductionist view of the practice of health care, which indicates the importance of advancing care models that go beyond the biological and prescriptive aspects of the disease.<sup>10</sup> In this logic, one must seek the rupture of the historical conception established on health care as tax, prescriptive or even coercive and punitive practices. In order to understand this logic impregnated in health practices, Foucault's reference was used, in this study.

Power presents itself as a relation of forces that is everywhere: in the street, in the family, in the affective relationships and in the social micro-relations present in everyday life.<sup>11</sup> Power is revealed in the strategies that permeate the daily lives of the people present in all the places and holding the faculty of producing knowledge by the restlessness. Power relations have a development and inventiveness that is their own.

Power should not be conceived as a property, but as a strategy, and its effects of domination should not be attributed to "appropriation", but to dispositions, maneuvers, tactics, techniques, and workings.<sup>11: 29</sup>

Power is a central point, represented by an open, more or less coordinated beam of relations. Power relations do not act on others, but on their actions.<sup>12</sup> These actions reflect on a set of strategies that prevent the actions of others.

Strategies are considered as the trajectory or the choice of the means employed to achieve an end. In a strategic relationship, the player moves according to what he thinks about how the others will act and also designates the set of procedures to deprive the enemy of his means of combat: a way to deprive him of the fight and obtain the victory.<sup>13</sup>

In the relations of power, tactics must also be considered, that is, subterfuges, interstices, fugues, being constituted historically, established within social practices and exercised in different formats. Given this, they can be crystallized, denied and / or incorporated by strategies.<sup>11</sup>

In the specific case of HC, it is understood that its systematized conformation is relatively recent and has as its proposal the production of care in an integral, humanized way, offered in the home and in the conviviality in the reality and culture of the users, even if surrounded by relations of power.

OBJECTIVE

- To analyze the relations of power that are established in the practices of Home Care.

METHOD

Qualitative, analytical study, based on Foucauldian power. A municipality in the State of Minas Gerais was enrolled in the study that joined the Better at Home Program and, thus, receives incentives for its functioning.<sup>14</sup> The experience in the field was carried out following the work of two of the four teams of Home Care accredited in municipalities.

To obtain the data, direct, participatory and peripheral observation was performed as the central strategy. This observation is flexible allowing the presence of the researcher in some moments of the daily activities analyzed.<sup>15</sup>

A free script was used to capture the scenes experienced in the research scenarios in the context of HC, looking at the object of investigation.<sup>16</sup> Observations occurred during the activities carried out in the daily work of professionals of the HCS team.

The observation process was directed to the events of the daily scenes during the production of care between the Home Care team and family / caregivers and patient. The events are the eruptions of a unique and acute singularity, in the place and at the moment of its production, in the levels of

verbalization, behavior and structures. Events construct the interrogation of individuals.<sup>17</sup>

The observation was recorded in the field diary, which made it possible to reproduce the lived moments, reliably, through the excerpts of the conversations or the interpretation of the scenes experienced. The Field Journal of the research consisted of 235 pages of text in Word, with standard A4 formatting, single spacing, Times font and body size 12. In it, approximately 95 observation hours were recorded for 109 visits during the period of 10 February to June 1, 2015. Of this process, 46 users or possible patients participated. These people were followed up at post-death, discharge, readmission or withdrawal visits. Between one and eight visits to the same user were performed.

Complementarily, there were interviews guided by an open and unstructured script. The inclusion criteria used for the interviews with the professionals were the highest number of visits during the observational moments and among them the selection of at least one professional from each category linked to the HCS. Ten professionals (two physicians, three nurses, one social worker and four Nursing technicians) were interviewed from a total of 23 HCS professionals. As a criterion for the choice of the users / caregivers, it was followed up from the admission, totaling five patients.

The interviews, which had an average duration of six minutes and a total of 83 minutes, were recorded and transcribed in full so as to enable the formal capture of the discourse narrated on the theme.

There was care not to reveal the identity of the participants and the teams included in the study. To do so, users were identified with code A1 to A24 for one team and B1 to B22 for the other team. For the caregivers, the letter C was added, thus coding CA1 to CA24 and CB1 to CB22. In the same logic, professionals are identified in the text with the code PA1 to PA10 when referring to one team and PB1 to PB11 for the other team.

The analysis of the data was supported by the reference of Discourse Analysis with Michel Foucault as conceptual basis.

Foucault has an important contribution to the reconfigurations of research on discourse. The author establishes clues, but does not develop a methodology, a methodical step by step for discourse analysis. He treats the discourse in a historical-social perspective that involves the subject and the discourse.<sup>12</sup>

In this sense, the analysis considered, in the first moment, the accomplishment of the

organization of the data that consisted of the records in the field diary of the observations and the transcription of the interviews. The interviews were transcribed showing the pauses, the silences, the intonation, the emphasis, the incomprehensible speeches having, as base, the established convention.<sup>18</sup>

In this way, each person involved in the care scenes produces distinct actions and reactions generating events that can appear at any time and from anywhere. Therefore, for the presentation of data, it was chosen, in this study, to present the events, the results of the observations, and the interweaving of the interviews. In order to do so, we highlighted the situations that showed an early moment of care, that is, scenes that point to the events captured in the field work. These scenes were revealing of the power relations that sometimes led to the construction or tension of care production, according to the strategies and tactics of power presented by professionals, caregivers and users.

The project was approved by the Research Ethics Committee of UFMG, according to opinion number: 938.240 and CAAE: 07698212.7.0000.5149. The ethical precepts for research involving human beings were respected in accordance with Resolution 466 of December 12, 2012.

## RESULTS

In this study, 14 cases of HC patients were analyzed. The analysis of the cases presents, almost in its entirety, the presence of informal caretakers, of parental, female and affective relationship. Patients are victims of car accidents or firearms, elderly people with chronic diseases, stroke, cancer and diabetes.

In the scenes and situations analyzed, the speeches and relationships established between the characters in the scene - the team, the caregiver and the user - determine the direction and transit of actions for the production or the prohibition of care.

In general, the findings point out that the norm was used as the main strategy to maintain the power and the assujeitamento of the family, caregiver and user. The professionals also made use of the discipline, through monitoring and surveillance, as a way of controlling certain orders. For those who tried to circumvent this normalization and the disciplinary commands were sometimes attempted to reframe the commands and / or penalization by deviation from the established rules. Interspersed between the discipline and the norm are the resistances through which the family / caregiver and user made use of

tactics, with escape routes and subterfuges, to maintain the power, that is, to continue with the care by the HC team of their even when there were conditions for the suspension of care.

At all admission visits, professionals explain about the program by reinforcing caregiver standards and obligations and this is a disciplining strategy. At that time, they also check and inquire about patients' health history and guide how best to take care of the patient.

When they return, on subsequent visits, the condition of the care is ascertained by taking, as objects of examination, the cleanliness of the environment and the patient, the notes on diet, meditation, etc. The following scene portrays this understanding.

*Technicians evaluate wounds.*

*Technicians evaluate wounds.*

- CA16: *The indicated oil is not working, it's getting worse, so I'm passing another ointment and it's getting better, it looks like it's dried out more. The wound opens and closes.*

- PA3 *asks to see the ointment and when she looks, she says, "This ointment is not indicated, but I will inform the nurse so she can evaluate the patient on the next visit."*

*The technicians saw the patient to examine the other lateral wound of the buttock and verify that it is worse.*

- PA4: *Are not you becoming the patient?*

- CA16: *We turn around every two hours.*

- PA4: *You are leaving the patient more than one side. One side is worse than the other side.*

*The caregiver (CA16) picks up and shows the plastic she has bought to put on the patient.*

- PA4: *This plastic is self-adhesive. Where did you buy?*

- CA16: *At stationery.*

- PA4: *This is not the plastic we use. We use a specific plastic to try to avoid the appearance of pressure ulcers.*

- CA16: *It was my sister who bought ... the doctor [ironic tone]. [...]*

- PA3: *This is what we use. (Remove the name of the surgical patch and delivery to the caregiver.) You can go to a specific patient product store and say that you want a surgical patch.*

*The caretaker grabs and thanks. (Observational Note, A16, 6th visit, 12-03-2015, p.101.*

In the illustrated scene, it is verified the collection of the team for the accomplishment of the determined actions. There is a sustained action in the disciplinary power that makes use of the composition of meticulous techniques of obedience to the commands,



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the control over the actions of the care, through the control of the schedules for the change of decubitus.

With this understanding, it is possible to analyze that there is a careful agency of power that acts on the bodies in the HC, with constant registration in the patient's frame, for the proper regulation and control. In turn, the caregiver expresses a certain exteriority to the knowledge-power of professionals when expressing that does not identify the improvement of the patient's picture. In her own way, the caregiver traces the escape route tactic of normalization with the acquisition of products and medications not indicated or guided by the team.

This reveals the caregiver's resistance modes that arise in the clash between what the team normalizes and what it actually identifies as necessary. The caregiver, for this, presents devices beyond the direct opposition of the force field and verifies the use of singular means to achieve what is desired to normative commands of the team.

In an interview, a practitioner recognizes the presence of these fugue and subterfuge route tactics and describes that professionals use control, discipline commands, to model the behaviors of patients and caregivers monitored by the Program.

*[...] is, with the patients, [...] We have a good coexistence. Some, a little more rebellious, seek means to escape, but they are all contrived, I think. (Interview PA1).*

Thus, it recognizes the power plays that confirm the resistances in the caring process. In the caregiver-professional relationship, there is the use of a strategy to face the barriers, with complicity and dialogue, by the porosity of the workers to deal with the social vulnerability that places the caregiver with difficulties to take care of all, but also makes them how they can.

In another scene, the control strategies that result in different effects are evident. This scene presents a moment of worsening of the user in which professionals and caregiver try to seek the best alternative for the care. It is possible to capture the use of a humanized strategy and to "circumvent" the norms to become present in the care.

Due to the patient's situation, the team decides to contact the family to have her refer the patient to the team's headquarters unit. The techniques cancel the visits scheduled for the day to follow the patient's case.

*Upon arriving at the ESU, the patient was cyanotic and entering cardiac arrest.*

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*- CA23: HOW IS MY MOTHER IS? He would not let her die before her teeth arrived, for it was a mother's wish. [...]*

*PA6 enters and verifies that the patient has died, but says to the caregiver: "You can search, I think it gives time." (Observational Note, 3rd visit, A23, 07-03-2015, p.84)*

*It was of extreme importance to me. The team gave me support at such a difficult time, taking care of my mother, regardless of the time or day. [...] I recommend the program; [...] They gave me psychological support at this difficult time. I can not say much that I'm excited. It is. (Interviewee CA23, caregiver).*

The professionals present their discourse beyond the scientificity of care, breaking with the rules and establishing the true production of care, with the action that aims to serve the user in their subjective needs. Carefully, they use the knowledge to establish the production of care through actions that have contributed to the patient and caregiver. The relation of power is inherent in human relations, but they may be more knowledge producing and, in this case, the production of care. The team needed to detach itself from the power strategies that standardize the behaviors and build the uniqueness of care.

As a consequence, the satisfaction of the caregiver and her family with regard to the care offered is perceived. This contentment refers to the healing of doubts about patient care and protection at the time of intense feelings.

It can be said that, in the transience of relationships, the caregiver relies on the team when it is able to disassociate itself from the rules of the grid established by the emergency network and, in fact, surrender to the required in the rupture of the event. There is the production of singular care.

The uniqueness of care requires strategy. Professionals recognize the importance of communication and the ability to deal with differences.

*[...] we have good communication. [...] we must be able to deal with the difficulties of the patient, the family. When this cohesion exists, we can help the family grow. [...] we teach, but also, we learn from the family, they have many things to teach. I have, as a focus, the patient, we have to act for his improvement. (Interviewed PB3).*

The scene described below points to the use of strategies aimed at the continuity of health practices. In a context of difficulty for the user and caregiver to follow the prescription at the indicated times, boxes were prepared for the separation of

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medications, according to the type and schedules, in a way to guide the caregiver.

The professionals elaborated three boxes with symbolic identifications: a sun for the medicines that must be ingested in the morning; the drawing of the stove for the remedies that should be taken in the afternoon after lunch, and a moon with stars indicating the remedies that should be taken before bed. This strategy was thought together to be able to follow the times stipulated by the doctor.

*The assistance technician asks what time they wake up, eat lunch and go to bed.*

*The caregiver is talking all the time.*

- Nursing Technician (PA3): *Be calm, because we will organize the medication and then we will explain how it works.*

- Caretaker (CA12): *I'm getting disoriented. [The tone was a joke, but with a real background]*

*Then he takes the box by box and explains to the caregiver what the user should get inside each box, respecting the symbols, and that he should only take one medicine from each carton.*

*The caretaker listens and when asked if she understands, she says yes.*

*At the end of the service, the professionals say goodbye.*

- Patient (A12): *I'm sorry for the work I do.*

- (PA3): *That this: this is our job. (Observational Note, 1st visit, A12, 21-02-2015, p.27).*

After this visit, the patient was followed by the program for another 12 days to monitor the decompensated values (blood glucose, pressure and saturation) and to evaluate the evolution of wound healing. During this period, the doctor asked for a device to measure blood glucose.

The findings indicate that the professionals considered daily habits to identify and respect the routine of the family. In this work process, the caregiver-user is placed at the center of actions taken to meet health needs. Professionals assume the position of caregivers and seek to meet the needs within the process of shared intersection, professional care and family care.

But interwoven with the humanized and creative form, expressed by the symbolism of the boxes, there is also the normalization of the behaviors of the user and caregiver. There is ongoing monitoring of user actions through supervision. Boxes have this purpose: professionals may not see, directly, whether medications are being ingested at the indicated time and in the established quantity, but they have visibility, through the control mechanisms, using, as a tactic, the

measurement of the indices glycemic, blood pressure and healing.

The technologies used aimed at the education and transformation of this family to exercise self-government its governmentality. For this, there was the overlap of the team in training and modify the behavior of the caregiver to acquire skills and attitudes towards the care of the user.

Monitoring and surveillance actions are also observed in other scenes. In the following report, the user tries to convince the doctor (PA10) that he needs another prescription to buy the rest of the drugs. However, the doctor tends not to believe in the patient's speech, because she knows her habits and has experienced similar scenes with the same one regarding the acquisition of more medicines. There is the command that is directed to the control of statements to the behaviors considered as non-conformities by the Program and the norms that govern its life.

*A22 asks the doctor: You can give another prescription because, at the post, you did not have the amount requested in the prescription. With that, I just took the amount I had.*

- PA10: *I prescribed the medicine for 60 days. Let me see the recipe.*

- A22: *The popular pharmacy withheld the prescription.*

- PA10: *I gave you two ways, one stays with the pharmacy and another stays with the patient.*

*The patient informs where the prescription is and the Nursing technique picks up.*

- PA2: *If the pharmacy did not have the amount of medicine on the hour, they should give the remainder at the time he comes back to pick it up.*

- A22: *Oh, yes, I got it! I was afraid they would not accept this recipe. (Observational Note, 1st visit, A22, 10-02-2015, p. 11).*

In the case presented, the team adopts behaviors that reveal the strategies of control of the body and of life. The findings of the study demonstrate that, for prevention and correction, punishments occur. The control of actions represents the dictatorship of how, how much and which product to use built as a practice of accountability of professionals towards the individual. Therefore, the team tries to modulate the user's behavior through the hypervaluation of normative training techniques and normalization of the body. In contrast, the patient also reveals the resistance in the attempt to circumvent and subvert the normalizing control established by the team and by the norms of liberation of the medicalization.

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Faced with the resistance or indiscipline of the patient, the effect produced is the doubt of the team, which starts to question the user's conduct, establishing the punishment if he does not correct it.

There is biopower applied to the life of individuals, through meticulous methods of the body, to obtain utility and docility. But it can not be denied that this relation of power goes beyond the body, begins to act in the life of men. Thus, power over life occurs through the passage of disciplines to biopolitics, which determines the control of medication consumption, acquisition, form and time of drug consumption of the pharmaceuticals.

The punitive strategy emerges when the normative and disciplinary commands determined by the team are not met during all the visits. This is perceived in the case of patient A2. The professionals, at all visits, reported on the need of the caregiver, full time, due to the patient's condition: poor vision and amputation of the foot and thus unable to place the foot on the floor. The primary caregiver (CA2) mentions not being able to accompany the patient full time. The task of caring is arduous and of great responsibility. Therefore, centralizing care in a single caregiver is painful.

*The caregiver (CA1) says, "I came in now, I was taking the son to school." The nurse asks (PA1): "Is she walking?" CA2: "A little." PA1: "Under no circumstances can she put her foot down." (Observational Note, 1st visit, A2, 24-02-2015, p.37)*

[...]

- PA9: *As I explained at the outset, she needs a caretaker. She can not be alone and must follow the guidelines of the program so that the patient is not disconnected from the program. What could the family be doing in this situation? Can not you take it home?*

- CA2: *You can not. It has a ramp. You can not go down. No wheelchair comes in. There are two rooms.*

- The grandson says: *"In my house neither, there they are reforming, now, it has no conditions". (Observational Note, 2nd visit, A2, 03-03-2015, p.70).*

It is verified, in the patient's report, the non-compliance with the agreement. It was also verified, as a problem, the non-continuity of the guidelines transmitted by the professionals, which compromised the evolution of the treatment. In an interview, the PA1 professional mentions the importance of trusting and following the guidelines.

*The Social Worker (PA9): From the first visit the family is guided on the need for a full time caregiver. All the visits were*

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*reinforced, we gave the family time to organize themselves. We made contact with the family, but none of it solved. We have to follow the guidelines of the program, otherwise the team could be harmed. In addition, the evolution of the patient is good and her case may be accompanied by BHU.*

*The nurse sits on the couch and applies for referral to BHU. (Observational Note, 5th Visit, A2, 17-03-2015, p.114).*

The presence of the full-time caregiver raises discussion. It is possible to perceive that the demand of this caregiver generates clashes in the relation and causes the interdiction of the care. The professionals try to dialogue and seek alternatives to address this issue. They verify the possibility of the patient going to the residence of one of the children. However, they refuse, saying they have no structure to receive the patient.

During the visits, it is possible to perceive that the caregiver feels charged by the team regarding the full-time presence and the care with the patient. This is a scam. The caregiver is then subjectivated by subjection to herself, by the moral action of her self. This moral action is not distinguished from the moral actions by which the subject is subjected in the relations established with others.

In the reported situation, the triad is verified to be power, truth and discourse. Power is established by and in speech and draws a truth through behavior, language and values. The rupture of attention occurred at various moments through experiences that exposed vulnerability. In these scenes, it was possible to capture power relations emanated by the patient, caregiver, and professionals.

Power emanates from those who control and command the rules. There are countless strategies for maintaining order, as demonstrated by the vigilance that, at the same time as it tames the bodies and mind, produces knowledge. By this mechanism, visits can be made in which the patient was alone and, at another moment, the patient herself informs that the combination is not being fulfilled.

Caregivers thus created escape routes and subterfuges to ensure continuity of care. In order to do this, they used explanatory discourses and justification for the lack of care or for not following the guidelines in an attempt to convince the deviations of what had been indicated. This escape route refers to the resistance to the requested commands, which arise for purposes of defense and reaction by means of strategies that reverse the situation, avoiding the commands, of the given.



## DISCUSSION

The scenes analyzed allowed us to understand that professionals consider the economic, cultural and social conditions of the family and caregiver, but they require order and respect to the commands guided during the care. To this end, they use strategies of encouragement, support, involvement, vigilance and monitoring, through tactics focused on controlling bodies, actions and internalizing the norms.

Interceded in the caregiving scenes in HC, there is a disciplinary power relationship. There are several mechanisms for monitoring, tracking actions and conducts that reveal this logic. In general, the application of these techniques has as its objective the production of docile and useful bodies.<sup>11</sup> "It is docile a body that can be submitted, that can be used, that can be transformed and perfected."<sup>11:14</sup>

For this, the discipline has several attempts and acts in various ways to overcome or restrict the perks and options by regulating, molding, in strict rules, for survival to exist. This means training people so that they conform to the norms established in the institutions.<sup>11</sup> It is thanks to vigilance that disciplinary power becomes an integrated system, since power is manifested in multiple, automatic and anonymous forms.<sup>11</sup>

Thus, the effects of the disciplines are not bad, but can be dangerous depending on the form, the context, the place where they are used. They govern subjects operating from their subjectivity, through subtle techniques of persuasion, acting indirectly on the subjects' choices: professionals, users and caregivers.

But these subjects need the freedom to choose what they want, even if they are constantly involved in a way of living governed by standardized and normative models of truth in their relationship with themselves.<sup>19</sup>

The analysis also allowed us to understand that HC presents a terrain of dualities that sometimes emphasizes actions of autonomy and, at the same time, demands the accountability of those who care or who receives the care punishing them and blaming them for compliance with guidelines and standards. In this way, normatization prevents or hinders the autonomy of the subjects' way of life. Normalization prevents the differentiation of individuals by acting, therefore, as a process that imposes homogeneity and establishes tension by the discourse it produces.<sup>17</sup> The domicile becomes a site controlled by policies, by normalization.<sup>20</sup>

Practitioners also surrender to standards, especially with regard to the requirement of a full-time caregiver and the fulfillment of network flows and the divisions of caregiver and professional roles. Even because normalization and vigilance are combined in the exercise of discipline. For the extraction of truth, this mechanism is inseparable from the pursuit of morally correct behavior.<sup>11</sup> It must be considered that these same professionals are also watched over and punished when they circumvent or do not follow the rules. Everything so that molded subjects are produced to the established orders transforming them into a docile, useful and disciplined individual.

It is possible to resist even because resistance is intrinsic to the relations of power and its existence makes it possible to create and recreate. The clash and the confrontation make possible the transformation, a struggle that unfolds around the power. This fails to put the question of power in conditions of good or evil, but, rather, in conditions of existence.<sup>21</sup>

Choice and opposition do not occur without implication. On the contrary, they come from sanctions, punishments or ruptures of established relationships. In Foucault's view, the body presents itself chained within very tight powers that impose limitations, prohibitions or obligations.<sup>11</sup> And one of the obligations refers to the presence of the caretaker, who represents the main link for the team. If this link is broken, the quality of care is compromised and, consequently, the health professional is kept hostage from inadequate conditions. Therefore, the professionals aim to maintain this connection so that there is no worsening of the patient or the untying of the patient of the program. This is due to the disciplinary power and its monitoring mechanism that establishes actions of calculated coercion and manipulation of its elements, its gestures, its behaviors.

In this sense, anyone who does not want to comply with the rules or do not want to be disciplined receives a sanction, the exclusion / discharge of the program, as one of the aspects that stands out as an instrument of punishment. For Foucault, the methods and mechanisms of punishment and coercion aim to block the intensity of opposing forces.<sup>11</sup>

However, caregivers, on the other hand, establish other effects by making use of escape routes and subterfuges. This inflicts a process of resistance to norms, provoking a clash or confrontation with the desiring subject in the longing to exercise his particularity as a mode of existence.<sup>19</sup>



Resistance is revealed in the scenes as a way of getting rid of the imprisonment, domination, or to reestablish power. Resistance occurs through the spirit of struggle, an activity of force that is subtracted from the strategies effected by the power relations of the field of power. Freedom is in the uninterrupted exercise of resistance, revolt and refusal, self-ethics, recognition, defense of freedom.<sup>11</sup>

The findings showed that the level of education of the caregivers and the gender influence the relationships in the home care. With regard to the level of education, it is possible to mention that there is a lack of knowledge on the part of the caregivers and, therefore, of power, which makes the discourses relatively impotent, in face of the professionals' discourses.<sup>22</sup> Regarding gender , it emerges that women view caregiver responsibilities as a priority over other responsibilities including the responsibility to care for oneself.<sup>23</sup>

In order to deal with these situations, professionals should make use of discourses that consider and stimulate the development and understanding of the identity and subjectivities of users and caregivers.<sup>20</sup> To this end, they must understand that practices are strongly influenced by collective values and ideals that involve care and that new mechanisms must be found to provide better choices for caregivers without neglecting their moral concerns.<sup>23</sup>

CONCLUSION

At the conclusion of this work, it is understood that its realization enabled the researcher to enter the daily life of HC, capturing the one that is most singular, with its conflicts and tensions during the practice of caring.

HCS activities may seem routine, but they stem from the intensity and complexity of established relationships, which triggers the production or interdiction of care. It is important, in this conclusion, to emphasize that these processes are conformed by the subjective and subjective experiences of the subjects on the scene who now express their ability to act with openness by moving to the new, capillary listening and listening to wishes and desires. These same subjects also curtail, punish, are violent and block constructive acts of care, whether professionals, caregivers or users.

Capturing this reality is also perceiving its subjectivism, without moral or value judgments, once it was performed looking for

the immense wealth of details that surround this way of producing care.

The relationship between family-caregiver-professional-patient is structured in such a way as to shape behaviors so that care is taken. Thus, more than the knowledge, the professionals transmit the rules of conduct for the accomplishment of the activities.

Faced with resistances, disciplinary actions are applied and, if necessary, punishment and punishment that are presented in the exclusion or disconnection of the program. However, when the team overcomes the clashes of the orders, that is, when it disengages from the norms and rules, it is possible to establish the production of the care. Faced with this situation, they perform interventions that aim at a look at the caregiver subject, since they have longings, desires and fear, adding the caregiver as part of the care.

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