



# Journal of Nursing

Revista de Enfermagem

UFPE On Line

ISSN: 1981-8963

## ORIGINAL ARTICLE

### MICROPOLITICS OF THE CARE OF A USER WITH BREAST CANCER

#### MICROPOLÍTICA DO CUIDADO DE UMA USUÁRIA COM CÂNCER DE MAMA

#### MICROPOLÍTICA DEL CUIDADO DE UNA USUARIA CON CÁNCER DE MAMA

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#### ABSTRACT

**Objective:** to investigate the trajectory of a breast cancer patient cared for by a Family Health team and by professionals from a Hospital for Specialized Care. **Method:** this is a qualitative, exploratory and retrospective study of the case study type. Interviews were conducted with the client, four nurses and one physician who work in the Family Health Strategy and one nurse in Specialized Care. The case study was presented in a descriptive way. **Results:** it was evidenced that, in the communication between the professionals in the care network, the senses produced in the statements generate confrontations and, when regulating the user's trajectory within the Unified Health System (UHS), produce assembling. **Conclusion:** it was observed that the activities that characterize the practice of care in networks, in relation to breast cancer, are not articulated with the flows established in the Health Care System and the user has shown resistance in her walk-pilgrimage through the networks of services. **Descriptors:** Health Policy; Comprehensive Health Care; Health Services Accessibility; Biomedical Technology; Attitude to Health; User Embrace.

#### RESUMO

**Objetivo:** investigar a trajetória de uma usuária com câncer de mama cuidada por uma equipe de Saúde da Família e por profissionais de um Hospital de Assistência Especializada. **Método:** trata-se de estudo qualitativo, exploratório e retrospectivo, do tipo estudo de caso. Realizaram-se entrevistas com a usuária, quatro enfermeiros e um médico que atuam na Estratégia Saúde da Família e um enfermeiro da Assistência Especializada. Apresentou-se o estudo de caso de forma descritiva. **Resultados:** evidenciou-se que, na comunicação entre os profissionais na rede de cuidado, os sentidos produzidos nas falas geram confrontos e, ao regular a trajetória da usuária no interior do Sistema Único de Saúde (SUS), produzem assujeitamento. **Conclusão:** observou-se que as atividades que caracterizam a prática de cuidado em redes, no que se refere ao câncer de mama, não se articulam com os fluxos instituídos no Sistema de Atenção à Saúde e a usuária demonstrou resistência no seu *caminhar-peregrinação* pelas redes de serviços. **Descritores:** Política de Saúde; Assistência Integral à Saúde; Acesso aos Serviços de Saúde; Tecnologia Biomédica; Atitude Frente à Saúde; Acolhimento.

#### RESUMEN

**Objetivo:** investigar la trayectoria de una usuaria con cáncer de mama cuidada por un equipo de Salud de la Familia y por profesionales de un Hospital de Asistencia Especializada. **Método:** se trata de un estudio cualitativo, exploratorio y retrospectivo, del tipo estudio de caso. Se realizaron entrevistas con la usuaria, cuatro enfermeros y un médico que actúan en la Estrategia Salud de la Familia y un enfermero de la Asistencia Especializada. Se presentó el estudio de caso de forma descriptiva. **Resultados:** se evidenció que, en la comunicación entre los profesionales en la red de cuidado, los sentidos producidos en las conversaciones generan enfrentamientos y, al regular la trayectoria de la usuaria en el interior del Sistema Único de Salud (SUS), producen sujeción. **Conclusión:** se observó que las actividades que caracterizan la práctica de cuidado en redes, en lo que se refiere al cáncer de mama, no se articulan con los flujos instituidos en el Sistema de Atención a la Salud y la usuaria demostró resistencia en su *caminar-peregrinación* por las redes de servicios. **Descriptores:** Política de Salud; Atención Integral de Salud; Accesibilidad a los Servicios de Salud; Tecnología Biomédica; Actitude Frente a la Salud; Acogimiento de Salud; Tecnología Biomédica; Actitude Frente a la Salud; Acogimiento.

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## INTRODUCTION

It is known that breast cancer is the second most frequent type of cancer in the world and the most common among women, which also occurs in Brazil. It is added that, when diagnosed and treated early, the prognosis of the disease is relatively better with the actions recommended for the screening of breast cancer in asymptomatic women. The Unified Health System (UHS) must guarantee access to diagnostic tests, treatment and follow-up of alterations found.<sup>1-2</sup>

It qualifies assistance to users for the early detection of breast cancer. It is based on the fact that 80% of the tumors are detected by the user herself through signs and symptoms. However, medium and high technology density services for these users are still a relevant problem, especially the specialized consultations and complementary examinations. The degree of organization and responsiveness of the health system is indicated by the advanced stage of breast cancer, often intractable, in which the user, male or female, arrives at the referral hospital. Cancer is detected early before the advanced stage, in the pyramidal model of health care that still marks UHS, by the Family Health Strategy (FHS).<sup>3-5</sup>

Effective strategies in the early detection of breast cancer are implemented by the FHS, in the sense of breaking the walls of health services, by the National Plan to Strengthen the Network for Prevention, Diagnosis and Treatment of Cancer, 2011, which the main objective is to strengthen the regional development of the population service network in the three levels of health care and the articulation of actions to increase mammographic coverage throughout the country, primarily in favor of women aged 50 and 69 years.<sup>6</sup>

It is explained that, according to the Ministry of Health, there is scientific evidence to justify specific strategies from the time of early detection, to rehabilitation and palliative care, also directed at the control of chronic non-communicable diseases of the National Cancer Care Policy.<sup>6</sup> These strategies include identifying and convening women eligible for the program; the holding of regulated and organized scheduling; the provision of care in the services of specialized care of medium and high complexity for cases requiring interventions and care for changes in mammographic examination.<sup>1-6</sup>

There has been progress in cancer control in Brazil since 1999, but there is still a lack of answers. This is detected because the

therapeutic practice is centered on specialized hospital care with high technological complexity and disintegrated with more effective control actions to reduce mortality, such as the early detection in the early stage of the diagnosis of prevalent cancers that benefit from these strategies.<sup>3-6</sup> It is inferred that there are several reasons for this tension in the field of care production, and one of them is the central role that medical specialists play in disputes with other categories in the field of health and with the various specialties in medicine, using technical-scientific arguments in order to intensify its role in the medicalization of life.<sup>7</sup>

The initial techno-care model of the UHS was organized in levels of complexity in health care revealing the existing barriers between these levels and making it difficult to form a network. The guideline of regionalization was achieved, ie, the articulation between the municipalities to establish a cooperative system in the provision of health services, materiality in the years 2001-2002 with the Health Care Operational Standards (HCOS).<sup>8</sup> There would be, at the base of the municipal UHS, a set of health units responsible for Primary Care (PC), ensuring access to the entire population as a gateway to other levels of higher technological density, if necessary. Secondary care services with clinical and surgical specialties, diagnostic and therapeutic support, urgency and emergency would be placed at the second hierarchical level of UHS. At the end of the UHS, the services with the greatest technological density and high cost would be located.<sup>6</sup> At the three levels of the UHS, users are seeking, however, in the therapeutic path, resisting normative planning of UHS because they move through other logics, such as health needs.<sup>9</sup>

For the sustainability of the health systems based on the medical-hospital-center models, there are evident signs of exhaustion, necessitating the development of other strategies. In this sense, the PC is a key element in the constitution of national health systems with great potential for regulating the use of resources with a high technological density, guaranteeing universal access to services that bring real health benefits to the population.<sup>6</sup>

It refers to health technologies, by another way of approaching care, classifying them as light, light-hard or hard. Hard technology is represented by concrete material such as equipment and furniture; the light-hard technology refers to the structured knowledges represented by disciplines such as

Clinical, Epidemiology, among others, and light technology is expressed in the process of producing communication, relationships, and links that lead to the user meeting with the needs of health actions.<sup>10</sup>

The National Basic Health Care Policy (BHCP) proposes the organization of the network of services with health actions in the individual and collective spheres that include health promotion and protection, disease prevention, diagnosis, the treatment, rehabilitation and maintenance of health.<sup>6</sup> The aim is to work with an integrated knowledge in the teams and developed through democratic and participatory management and health practices. The health responsibility of family health teams is assumed to recognize cancer as a preventable chronic disease based on dynamism in the territory in which the populations for which care is offered.<sup>6</sup> Educational actions are essential performed by the nurse to materialize and give visibility to this professional in the context of the multidisciplinary team.<sup>11</sup>

PCs are used with high complexity and low density technologies to solve the most frequent and relevant health problems in their territory. Practices are horizontally practiced in the first contact of users with the health system guided by the principles of universality, accessibility and coordination, attachment and continuity, comprehensiveness, accountability, humanization, equity and social participation in the continuity of care.<sup>1-6</sup>

The different ways of understanding reality and acting on it are discussed as necessary, explaining the issues that involve hospital care in this transversal articulation that supposedly gives greater visibility to the factors that put the population at risk.<sup>10</sup> It refers which service, in the network, will be triggered and supposed to be one of the main places in which the meaning of health actions should be politicized and to understand that it is fundamental to recognize the social actors involved who are constantly disputing the various institutional spaces (microsystem) or formulations of democratic (macro-system) health policies in the field of health service network management in UHS.<sup>10</sup>

It is understood that one of the tools to expand and organize the offer of health services and actions is the UHS National Ambulatory Regulation System (NARS) to regulate specialized outpatient visits and complementary exams whose access is limited

on the supply side and therefore reserve the vacancies only to those with accurate clinical indication and based on the best evidence available.<sup>6</sup>

## OBJECTIVE

- To investigate the trajectory of a breast cancer patient cared for by a Family Health team and by professionals from a Specialized Care Hospital.

## METHOD

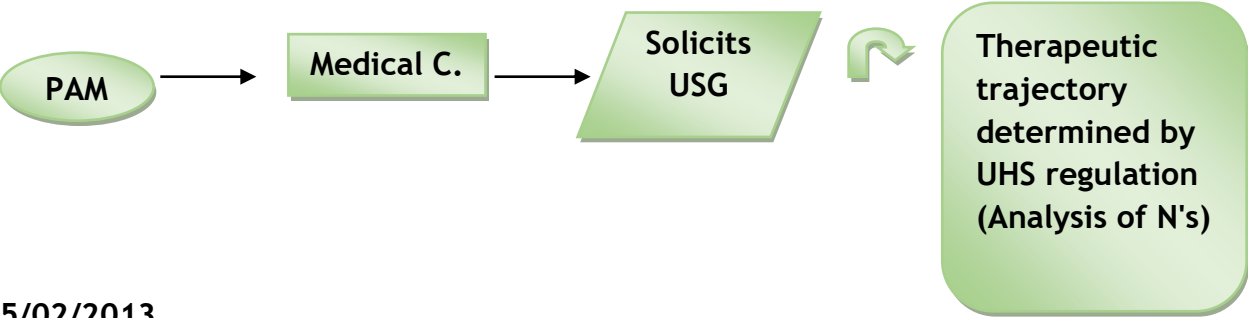
It is reported that the participants of this research were a UHS user with breast cancer, in treatment, residing in an area covered by a family health team, four nurses and one physician who work in the FHS and a nurse who works in SC, all located in the city of Rio de Janeiro. The recommendations of Resolution 466/2012 were followed.<sup>12</sup> The project was approved by the Research and Ethics Committee (REC) of the Federal University of the State of Rio de Janeiro (UNIRIO) under Opinion 782.530 and CAEE: 30193914.4.3002.5279.

This is a unique case study, called "Caso Lola", using the qualitative method, which produces contextual explanations with an emphasis on the meaning (rather than the frequency) of the phenomenon.<sup>13-4</sup> The choice of eligibility criteria with a purposive sample. Semi-structured interviews and collection of textual material were carried out in physical and electronic medical records. Interaction with the participants and their perceptions, beliefs, values, attitudes and representations about a specific issue in a non-embarrassing environment was made possible through the interview.<sup>14</sup>

A flow diagram was used to trace the user's trajectory, which is a diagram used in different fields of knowledge and, in this study, provided a way of organizing a certain work process with the following symbols: the ellipse as the beginning or the end of a productive chain; the rectangle shows works done in this chain; the diamond represents moments of decision; the parallelogram adds data or information relevant to the analysis of the production process and the letter R represents the noise<sup>10</sup> (Figure 1).

Case Analysis Using the Analyzer Flowchart

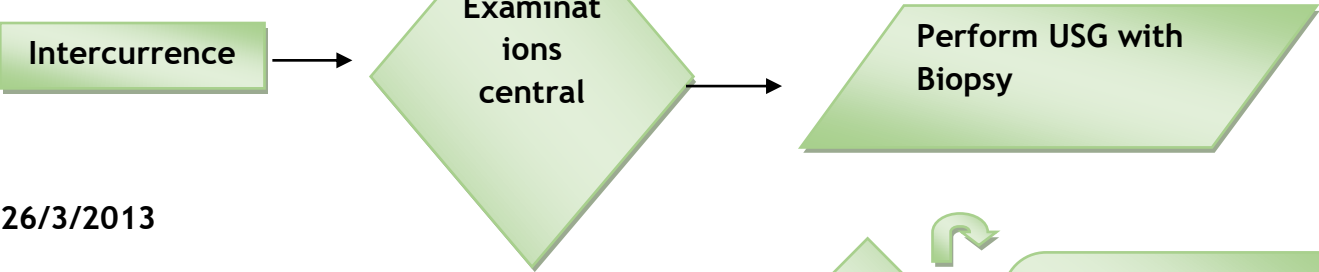
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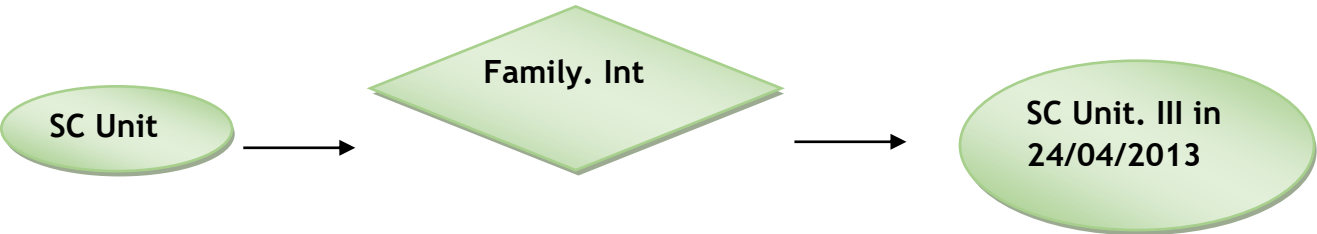
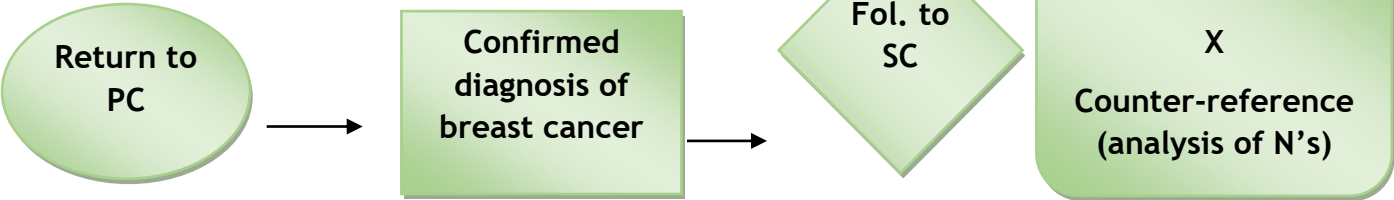
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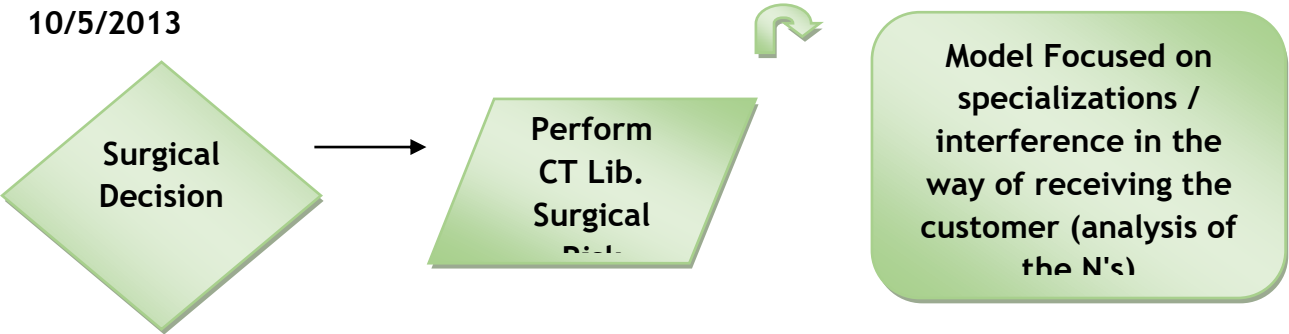
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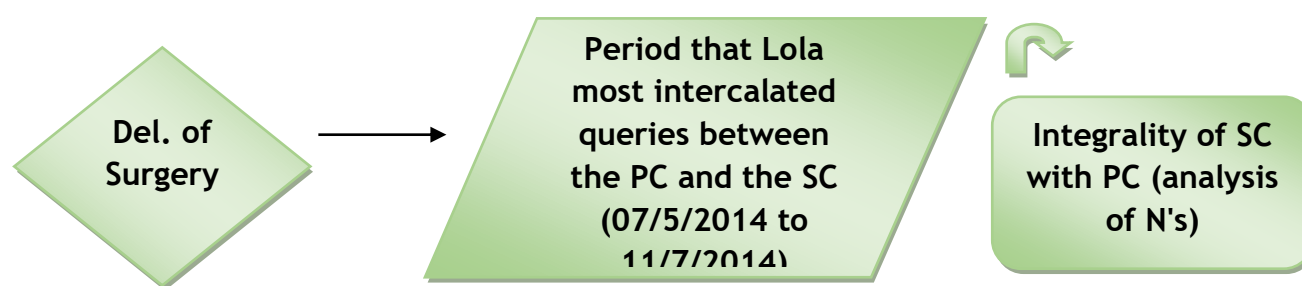


Figure 1. Flowchart of the diagnosis of breast cancer until treatment in Rio de Janeiro (RJ), 2014.

**Acronyms:** MCP = Medical Care Post; C. = Consultation; USG = Ultrasonography; CHA = Community Health Agent; FHP = Family Health Program; PC = Primary Care; SC = Specialized Care; Int. = Interference; Unt = Unit; CT = Computed Tomography; Del. = Deliberation, N = Noises.

## RESULTS

The content analysis framework was applied by similarity to discover the nuclei of meaning that composed the statements in the various moments of the interviews.<sup>15</sup>

### ◆ Description of the Case Lola: the user in their trajectory

The medical records of the user Lola in the SC were studied in detail. It was in transition, in the Basic Health Unit (BHU) to which the user was assigned, for an electronic medical record not accessed by the researchers of this study. It is reported, by the records in the medical records in the SC, that the user Lola is white, then 61, literate, domestic, married and evangelical. Her blood group is unknown and she has been hypertensive for 15 years. It turned out that she is a former smoker, was 15 when she started smoking and stopped at age 28. It was raised that breast cancer was the first case in Lola's family and that her first menstruation was at age 16 and the last one at age 50. It is reported that she became pregnant for the first time at age 20 and the last one at age 40 and had two tubal pregnancies: one resulted in spontaneous abortion and the other at the birth of a baby by cesarean section, breastfed for 48 months. Contraceptive pills were used by her, who never had hormone replacement.

The health service was accessed for the first time in the PC by the user in 2013. Lola was then a Medical Care Post (MCP) near her place of work. It is revealed that it was assigned to a BHU because the NARS determines that, when obtaining the diagnosis of cancer in routine consultation with the gynecologist, the referral to the specialized assistance should have as its starting point the PC. There were signs of the disease in the breast about a year ago by Lola, who associated her complaints of pain with carrying heavy bags of food purchases. It was discovered that, with a request for

ultrasonography (USG) in hand, requested by the gynecologist of MCP (current Polyclinic), she began her pilgrimage, took the exam and marked the first medical appointment in the PC for 5/2 / 2013.

Some highlights of Lola's first contact with the PC team.

*[...]then the health agent marked the doctor for me. [...] she gave me direction. [...] there, the health agent went and scored for me. [...] when I already got the result, I did not go there anymore, I already went here! (U1-Lola).*

*[...]Well, I, one day, I felt a business burn like that, there, I looked like that, that red, there, I put my hand, it was a lump, but then, I thought like this: "Because I carry a lot of weight, the market exchanges ". I never imagined that I could ever go through this [...] there, now, I discovered, I still spent a long time without going to the doctor, I stayed more than a year [...]. (U1-Lola).*

The analysis with the support of the Flowchart Analyzer of the care model of a health service and the narratives of the user are presented, configuring the Therapeutic Itinerary (TI) for the services.<sup>10</sup> The social valuation of the patients was also discussed. Specialties and the (dis) care of the health networks in the city of Rio de Janeiro with the definition of the flows based on the outpatient NARS UHS.

The PC team was first interviewed to diagnose the cancer in Lola and refer it to the commitment of interlocution through the regulation system. The need for planned and coordinated attention in order to solve the health problem according to the needs demanded by the user, that is, the reconquer of health, well-being and health, has become evident, through the regulation normalized by NARS and the return to their social environment.<sup>16</sup>

The user perceived the noises observed in the Analyzer Flowchart as an obligation of

attention in a delimited territory. It was referred to the researchers' thinking that power is found in the subject as if he possessed it by assignment, inheritance or contract coming from another subject. It is believed, however, that power is always an effect of a relation of power.<sup>17</sup> The hierarchical power relations represented by the power of medicine are lived in the process of health work, and relations between the other and the self are the point of departure from the constitution of any human reality.<sup>18</sup>

These relations of power in the management of TI are covered by the technological tool of the NARS and that Lola was the result of the human relationship established in a singular and legitimate way among the subjects.<sup>18</sup> Thus, it is verified that, in the micropolitics of the meetings that make up its existence, identify the places of territorialization and expressiveness in the different fields of practice that are being instituted in this walk. Most of these are based on the capacity that the user as a guide may have to take the other by his nomadism, making him realize, along with him, the various planes of connections that operate and occur in his experience of self-production.<sup>10</sup>

It is highlighted that improving the capacity of the host does not always increase the access, as well as the early detection of aggravations and of acute intercurrents does not guarantee the accompaniment of users with health problems for which the PC is placed outside the standardized actions. These facts must be credited to the experience of the UHS to obtain legitimacy of the users in the bet to adapt the services in which it is sought to correlate the shared management in its three spheres and to attend to the health needs of the users in an amplified way.<sup>20</sup> It is shown, by these experiences, that attention networks are still skillfully woven by users. The users of neoplasms continue to be impacted by the system's obstacles in their micropolitical relations. It is warned that primary prevention strategies for this type of cancer are not totally viable, besides being of high cost.<sup>4</sup>

It was favored the creation of multiprofessional spaces with horizontality in the power relations with new subjects inserted during the second moment of Lola in his TI with new strategies in the interventions of the SC. The emphasis was placed on secondary prevention actions in order to change the course of the disease. It is considered that, at this stage, the earlier the lesion is identified, the greater the possibility

of control and the lower the morbidity imposed by the treatment.<sup>4</sup>

It is understood that the fact that Lola is directed to the examinations at the levels of medium technological complexity (State Image Center) and to return to the PC did not value the participation of the professionals of the SC. It was then difficult to access the Specialized Care Unit and the confirmation of the diagnosis and the start of the surgical and chemotherapy treatment were delayed.

## DISCUSSION

It is a paradox in the FHS, the door of entry and coordination of care in the UHS, because, at the same time as it broadens access, it bars access given the conditionality of which is the same: the territorialization of the bond of people to services Cheers. The user was employed as a maid in a family home in an uncovered area of the PC, responsible for the territory of Lola's dwelling house. As a consequence, Lola's inability to be in her own home during the PC's working hours is limited, and the limitation of Lola's working hours being concomitant with Lola's work schedule led her to look for another service, in this case, a Medical Assistance Office, to take care of your health.

It is understood that defining the degree of freedom that a person can exercise to circulate through the Public Health System has uncontrollable implications, being one of them, and that affects many directly, the situation experienced by Lola, who attended the gynecologist and not, the general practitioner. It was observed by Lola, when narrating on the lump (it speaks of the interviewee), that something that appeared above her right breast was not well in her body. She used her freedom to seek help from the health service, the gynecologist, a routine in her life.

Lola experienced a moment of transition in UHS between the absence of planning of a set of disconnected health services, as was hitherto the health in the city of Rio de Janeiro, and that of a normative planning that defines the people's paths from their entrance, to the exit, including the internal transit that they must go through the UHS through NARS tool. Lola was affected by this moment of transition because the system proved to be inflexible, disregarding the users' self-government.

It is said that, when elaborating the regulations in the work spaces, it is in the SC, a sector that guarantees greater accumulation of technologies and capital, or in the PC, a

sector that allows greater integrality with care actions based on the reception and the link with the practices of care of diverse natures, it produces more life for the users. The statement above is contrasted with the power accumulated by those who produce the regulations, norms and routines and perpetuate the submission of health workers as if they were not the ones who daily care.

It shows the city of Rio de Janeiro with the greater availability of public health services that make up the UHS in comparison to other states of Brazil characterized by the offer of medium and high technology stocks. There are, however, limitations on the quality and responsiveness of services, even after the implementation of the NARS. User access to services is regulated by the impossibility of circumventing the computerized system and, when analyzing its elements critically, it would be possible to recognize a power in relation to the resolution of the PHC, in the renewal of planning within the UHS, that would help the worker to participate the user in healthier social relations.<sup>21</sup>

It is evident, when establishing the triangulation between the two points of the Health System with the user, these questions, through the noises and categories analyzed with the contents of the speeches, revealing that the networks do not articulate, as far as to breast cancer, professionals do not dialogue and what the subject does his own walk, his own pilgrimage through the networks of services.

It seeks the user in the same way that the participants of this research affirm the need to change their condition of being assembled by the system, to produce resistance, exercise their citizenship with the professionals and these, in turn, seek better ways of caring from the other.

## CONCLUSION

Lola's trajectory was studied at two levels of attention by the professionals responsible for the longitudinality of the care of a person with breast cancer. It was noticed that the PC and SC networks are not articulated, the professionals do not dialogue with each other and the subject makes his own pilgrimage through the networks of services while assembling, sometimes producing resistance. It is argued that the apparent effects of decentralization are problems of an instituted system and the movement almost absent for the advancement of integrality in a territorialized network. It is reduced by the confrontation between the PC and the SC, the

opportunity to dialogue with each other and with the subject of care.

Protocols based on epidemiological studies that generate scientific evidence convince us that there is little flexibility and sensitivity to let the interpersonal relationship work. The situations are shaped by these professionals imprisoned by knowledge and practices that consolidate a scenario captured by the rigidity of legal and scientific devices.

It is concluded that the flows are inconsistent with the UHS principle because they are not based on the needs of the user who carries out their exams in places far from their residence, they return at another time to seek the award and are induced to return to the PC to be referenced, in a late course until reaching the SC, with regard to breast cancer.

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Submission: 2018/07/25  
Accepted: 2018/09/23  
Publishing: 2018/11/01

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