

## The interaction between doctors and nurses in the context of a hospital ward

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**Abstract** *This article addresses a fundamental, albeit scarcely discussed, issue in health studies: the relationship between doctors and nurses. We rely on a ethnographic observation and in-depth interviews undertaken in a female ward of a public hospital in order to analyze certain aspects of these relationships, based on hermeneutics and science studies. The empiric observation showed that Doctors organized their practice and clinical decisions on certain abstractions and dialogued in a structured, highly specialized and restricted language. Nurses materialized medical decisions, guided by the prescriptions. They had no room to interfere in clinical decisions, being very busy with their tasks and not dominating the clinical discourse, which is crucial for discussing the decisions. In the context of this study, physicians and nurses maintained a distance established by the theory, technique and values shared by each professional group. Thus, we suggest that knowledge, practices and medical values and nurses were incommensurate with each other, and that this directly affected the health care actions performed in that setting.*

**Key words** *Nursing, Medicine, Health work, Hospital, Incommensurability*

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## Introduction

Portuguese is a gendered language. In the Portuguese-language nursing literature, the feminine version of “nurse” (“enfermeira”) is commonly used to refer to nurses in general, as a way of signaling the gendered nature of the profession. There are articles that emphasize the importance of nursing for women’s insertion into the job market<sup>1-4</sup>. On the other hand, for physicians, the masculine term (“médico”) is commonly used. Those uses are also present in the original version of this text.

### Relationship between doctors and nurses: a taboo topic?

When we consider health practices in action, we find several subjects, each legitimized to deal with a specific topic, to act within specific situations. This shows the complexification of the health sector, which encompasses the incorporation of different instrumental and managerial technologies, multiple professionals who deal with these technologies, and new organizational models in order to operationalize all of this. A constant “state of chaos” in which dialogues are always tense and harmony seems “out of place”. Transformations are common, new developments are part of everyday life and what seems cohesive is always reconfigured into new arrangements and possibilities for dealing with “chaos”.

However, certain categories and equipment are maintained and adapt to all these transformations, becoming entangled with the sector’s own modern trajectory. This applies to Medicine and Nursing, which, though specializing and increasingly dividing into subgroups, retain a set of techniques and values that cut across time and legitimize them. In the same way, hospitals and clinics survive everything and continue to have a central role in the ways of doing health and creating subjects<sup>1,5,6</sup>.

Though retaining a certain perennality, relationships between doctors and nurses within hospitals, in the clinical context, are not more tranquil than others. That there is animosity between these subjects is common sense knowledge. However, we know little about how this animosity is treated in everyday practices and how it affects the practices themselves. We do not even know, from an academic point of view, whether this animosity exists. Based on a bibliographical search of the Scielo scientific database, using the search terms “Medicine”, “Nursing” and “Hos-

pital”, we were only able to find a single article on this subject, from the medical perspective. In this article, which presents statistical analyses of structured interviews with doctors, the authors claim that relationships are not tense, though conflict is imminent. It is imminent because different factors can trigger it, from task division to salary discrepancies<sup>7</sup>.

Thus, given the lack of studies with which to establish a dialogue, we propose discussing this relationship from the standpoint of health practice, in a hermeneutic approximation. Based on fieldwork carried out in a female clinical medicine ward of a public University Hospital, in the city of Rio de Janeiro<sup>8</sup>, we appropriate hermeneutics as proposed by Rorty: more than a method, a necessary attitude in order to deal with that with which we are not yet sufficiently familiarized<sup>9</sup>. Imbued with this attitude, we enter the ward and present the accounts and analyses from this entry in the form of a narrative.

### Hermeneutics and Science Studies as ways of translating the real

Before entering the ward and bringing forth its subjects, instruments and discourses, it is worth discussing the way in which we prepared for the “hermeneutic dive”. We were inspired by science studies, which suggest interpreting science as a historically and culturally situated human activity. We likewise view health practices in this manner. In order to deal with this contingent character, science studies practitioners make use of multidisciplinary concepts and tools<sup>10-12</sup>. Although, generally speaking, hermeneutics and science studies are perceived to be distinct and even disparate fields, we adopt Videira’s interpretation. He suggests that science studies representatives promoted the entry of hermeneutics into the natural sciences, showing that their capacity to produce truths is as provisional and situated as the one we propose<sup>13</sup>.

The research that was the basis for this article is qualitative and used the techniques of ethnographic observation and semi-structured interviews<sup>14</sup>. The hermeneutic exercise set in motion during study design was not ended upon its conclusion: it continued and was present in the production of this article, in the form of a narrative. We view this narrative as a “risk account”, as proposed by Latour for describing networks and actors<sup>15</sup>. We believe that, in this way, we are able to offer depth to those who experience the two dimensions of this screen or sheet of paper.

We chose to describe the subjects, doctors and nurses, as *experts*. Experts are subjects who know what they are talking about or doing<sup>10</sup>. This is what enabled us to frame these professionals symmetrically, since, in the professional landscape, medicine and nursing are presented with a certain unevenness. In the literature on the subject, from the “sociology of professions”, one finds terms such as “imperial profession”<sup>16</sup> and “noble profession”<sup>17</sup> describing medicine and “subaltern occupation”<sup>2</sup> and “semi-profession”<sup>3</sup> referring to nursing. If we were to following this framing, we would adopt an unequal perspective. The category *expert* seemed adequate to us because it is difficult to question the idea that doctors and nurses know what they talk about and do, while within their respective fields.

Since the category *expert* is central to our analysis, it, and the ways in which we employ it, merit further discussion. We follow Harry Collins and Robert Evans’ argumentation: in order to talk about *experts*, one must be where they act and interact; and observation is not enough, one must also interact with them. In order to support this proposal, the authors indicate that what differentiates the *experts* in a given area from other subjects is the fact that they share a “tacit knowledge”, which mingles with logical-formal knowledge and which concerns “the deep understanding one can only gain through social immersion in groups that possess it”<sup>10</sup>. It is a complex unit shared in ways the transmitters themselves would not be able to explain. Thus, the process of acquiring expertise would be “a social process – a matter of socialization into the practices of an expert group – and expertise can be lost if time is spent away from the group”<sup>10</sup>. This socialization takes time and demands effort from those who seek to become *experts*, and is a true “enculturation”<sup>10</sup> process, an adequation to a given “thought style”<sup>18</sup>. When it came to addressing this type of knowledge and this enculturation process, it was important that the research be carried out in a university hospital.

Regarding the way in which *experts* organize themselves, we adopted Fleck’s “thought collective”<sup>18</sup> concept as a reference. Within these collectives, subjects are not aware of the shared “thought style”, which is exercised through coercion of individual thought. This style flows between members, is transformed and influenced by this transit, which leads to the appearance of “new themes such as propaganda, imitation, authority, rivalry, solidarity, enmity, and friendship [...] – themes which could not have been pro-

duced by the isolated thought of any individual.” (p.43)<sup>18</sup>. In this way, while conditioning subjects, this style is also exposed to a process of social conditioning which is specific to each collective. Thus, despite its fluidity, the thought and the subjects who share it only have legitimacy within a collective, “among persons whose intellectual constitution is thought-stylized in common”<sup>18</sup>.

The “thought style” specific to each collective comprises an opinion system capable of resisting everything that contradicts it, built within the group’s history. The combination of the “self-contained nature of the system as well as the interaction between what is already known, what remains to be learned, and those who are to apprehend it, go to ensure harmony within the system. But at the same time they also preserve the harmony of illusions, which is quite secure within the confines of a given thought style”<sup>18</sup>. It is within this harmony that certain practices gain the status of “natural” to that collective.

Thus, within each collective, according to its thought style and to the necessary harmony, members use clear concepts, guaranteed by these characteristics, because they are associated with that worldview. However, “despite this clarity, direct communication between the adherents of different thought styles is impossible”<sup>18</sup>. This is because each harmony guarantees a worldview, since “words and customs already suffice to form a collective bond”<sup>18</sup>. Thus, “The very structure of language presents a compelling philosophy characteristic of that community, and even a single word can represent a complex theory”<sup>18</sup>, which enables, at the level of language, a supposed identification with the collective to which the speaker belongs.

Understanding doctors and nurses as *experts*, organized into distinct “thought collectives”, with their own “thought styles”, we went to the ward to follow them in their field of action.

### **The field of research, its collectives and experts**

For this article, it is worth briefly describing the setting in which the research took place, as well as the subjects who were interviewed and “followed” during the observation stage, for four and a half months. The observation was carried out in a female ward, which had two improvised rooms in opposing positions, recognized as the “medicine station” and the “nursing station”. These stations guaranteed a certain degree of privacy: from within them, the professionals

could observe everything that was happening in the ward. Additionally, the ward had seven beds, which were almost always occupied.

The subjects we interviewed were four nurses and three doctors. Among the nurses, two were residents – Amanda and Lúcia –, one was the staff nurse – the nurse who routinely takes on the team management and nursing tasks – and Margarete was the head nurse. All three doctors – Vítor, Tatiane and Letícia – were residents. There are peculiarities in the positions occupied by these subjects in terms of the organization of the two collectives' work, which will be briefly explored in this account. All names are pseudonyms.

### **The doctors and their clinical-physiological world**

The doctors talked with one another in a sort of clinical dialect. In this dialect, they used terms that made it impossible for a stranger to enter into a dialogue. Users were referred to not by their names, but by the technical names of their diseases; the signs and symptoms they presented were described in precise, objective and instrumental terms. A doctor was capable of articulating, in long speeches, sentences that were almost solely structured with interleaved clinical terms and parameters. More than articulating long speeches: doctors were capable of carrying out long conversations using these terms.

In order to develop this clinical language, doctors had to go through a long period of “enculturation”. Resident doctors were the basis of medical activity in the ward. They were already doctors, viewed as peers. However, they needed to prove involvement with medical practice in order to follow more promising paths. And this involvement was guaranteed by their proficiency in clinical practice, its language, and their capacity to work. Language and practice were only developed through the intense experience of clinical cases, by sharpening their discourse in debates surrounding these cases. Thus, doctors were always seeking to accumulate cases, experience more complex cases and sharpen their clinical astuteness, always seeking debate. As Tatiane told us: “the more shifts you work, the better you become and the more practice you get”. Thus, doctors' lives were molded to work, became organic with it. As in Tatiane's words:

*my life is, more or less, working... until half-way through this year, I worked everyday, Monday to Monday... over many weekends, I worked thir-*

*ty six hours straight. I worked twenty-four-hour shifts, the following day I had to visit the patients.*

In the tireless process of accumulating cases and experience, clinical debates had a central role. It was in these debates that doctors proved they “knew what they were talking about”<sup>10</sup>. In the many clinical discussions, the astuteness with which doctors built their arguments, the quickness with which they responded to suggestions, incorporating them into their hypotheses or denying them in the impossibilities warned by their experience, were valued. The “good doctor” sought to present a robust, technically codified discourse that offered a basis, in the form of a diagnostic hypothesis, for them to move forward in treatment attempts. Vítor, Letícia and Tatiane wanted to become that doctor and revealed much of what is relevant in medical practice, of the values shared among these *experts*. On many occasions, they presented convincing, though mistaken, hypotheses. On many occasions, they reworked their hypotheses as they were constructing them, based on arguments from someone who was more experienced. On very few occasions did they expose doubts regarding a hypothesis and, when this happened, it was so discreet as to be shared only with the colleague to whom they were closest.

In this context, all the objectivity of the terms they used, the numbers to which they resorted, disappeared in long sentences and technical effects they explored in the course of a clinical debate. Doctors leaned on those terms to speak, and only spoke in those terms, and their discourse had an end directed toward diagnostic decisions. However, the objectivity of the terms did not guarantee the inviolability of the discourse. Diagnostic hypotheses were intensely debated among peers and the ability to proficiently use terms and numbers and to associate them with the clinical experience they carried was crucial. As stated in the previous paragraph, proficiency in the clinical language was essential to recognition, but did not guarantee the certainty and veracity of decisions and hypotheses. These were effectively exposed to many suggestions, new elements and refutations made by peers, until they became official, in routine meetings. All it took was for two doctors to meet for them to begin a clinical discussion, beyond the official daily meetings, known as rounds. These rounds were the most awaited moment of the day, the moment when cases would be discussed, hypotheses and decisions tested; in which specialist doctors, the head physician and the more experienced clinicians

visited the ward. There, the less experienced doctors-in-training were put to the test. There, they became “quick on their feet”.

The category of the doctor who is “quick on his feet” was something that appeared rather frequently in descriptions of colleagues. In Tatiane’s words, a doctor who is “quick on his feet” was the one who: “doesn’t think very long, makes decisions quickly! The people I most admire as doctors, they know how to make quick decisions!”; because “if there’s a confrontation with someone, if you think fast, you’ll do better. If you’re here asking for an exam and the person says ‘no!’, you can’t take that no, you have to think fast; you have to get out of the situation, you have to be “quick on your feet”, to know how to go around the situation”. Negotiation, the quick articulation of elements in a convincing argumentation, is key. Among the crucial elements for Tatiane: “knowledge isn’t enough, you must know how to use your knowledge in practice. It’s knowing how to articulate what you know, what information you have, and making that work”. In general, in order to become a reference in the ward, they had to become “quick on their feet”.

There was another common characteristic among these *experts*, already revealed in another article<sup>19</sup>: the fetishized relationship with knowledge, with science, with evidence. In the interviews with the three doctors, all stated that a “good doctor” must have vast scientific knowledge and experience. With the exception of Vítor, who placed experience and scientific knowledge on the same level, the other two colleagues stated they would not trust someone with vast experience and little “science”. They seemed not to recognize the political and argumentative dimension of their own work, believing that, for the “good doctor”, it is enough to know – to have experience and science – exclusively from an individual point of view. The same thing that Collins identified among scientists happens among doctors, something like the “crystallization of certainty”<sup>20</sup>: the contingent process of medical practice is sublimated in favor of the understanding that the doctor who gets it right is the one who knows, and not the one who articulates his knowledge amid the group’s sociabilities, deftly articulating elements.

Thus, these *experts* construct themselves in their everyday lives, accumulating cases, sharpening their discourse, making their capacity to construct coherent hypotheses and, especially, debate them with their peers more robust. The cohesion among doctors was as robust as the

distance they kept from the physical materiality of the ward. This materiality was resumed at the moment in which the nurses printed the medical prescriptions in their “station”; from that point onward, all contingencies – the dynamics of the bodies, instruments and techniques in the ward, the scarcity of materials – abruptly emerged for the possible solution that only the nurses could and, knew how to, provide.

### The nurses and the “management of contingencies” – knowing by doing

The nurses spoke little, not only to the doctors, but to each other. When some clinical intervention was needed, based on the medical prescription, they were ready for it. In activity, they were almost always divided, silent; if there were no doubts, they did not even speak. They rarely debated with doctors regarding the procedures to be carried out, they seldom discussed among themselves if there was something better to be done. They did, all the time.

To them, speaking was perceived as a waste of time and confabulations. Unlike the doctors, these experts had tense relationships with their colleagues. To Lúcia, there is a clear difference between the experts who share the ward: “I see the doctors as very corporatist, one helps the other. I don’t see that among the nurses”. These questions, regarding the relationships between human subjects, seem to suffer the consequences of a rushed, costly work. In the same way, the nurses related having difficulty reflecting on what they did, or even articulating what they did with the knowledge they possessed. As Amanda told us: “why stop to talk, to have a team discussion, that doesn’t work. It’s just at the bedside... I try to bring the discussion to the procedure, during the procedure”.

In interviews, they related that the agility with which they acted, the volume of actions they accumulated, prevented personal and theoretical reflection on their practice. They revealed that this reflection was costly amid the day-to-day rush. In Amanda’s words:

*nurses face a dilemma: in the general nursing situation, in which you have to carry out many activities, if you don’t stick to the practice, to try to be able to reflect a little, you end up not being able to provide care. So, what’s your choice?*

These experts learned by doing, in a rushed and solitary manner. They stated that they did because they had to do and, sometimes, learned while doing, asking for help from whomever was

near, be that the head nurse or a more experienced nursing technician. In the intense day-to-day labor, nurses built their practical, personal and transferable knowledge within their silence.

In this silent, heavy everyday life, nurses spoke a bureaucratic-institutional language: users were referred to by the number of their hospital beds – “bed two”, “bed seven” –, practices and sentences were organized in consonance with activity flow-charts and due prescriptions. Because they had fractioned, partial actions, they also developed a fractioned, partial knowledge. They dealt with and developed very specific skills, depending on which activities they were directly connected to; in general, they were manual and managerial technical skills. If they were at a bedside, they developed efficient intervention techniques when inserting catheters and accesses, applying medication, drawing blood. They sharpened their clinical eye, though they were unlikely to develop their language as the doctors did. If they were tasked with team management, they needed to negotiate intensely with their peers the latter’s responsibilities, draft work schedules, constantly interact with other sectors, which were not aware of the ward’s reality, having to translate the meaning of “urgency” in some occasions. Technical knowledge was important in legitimating and conferring security to these tasks; however, these professionals were far more exposed to the limiting institutional and material circumstances of the ward. They needed to develop a sense of adaptation to these circumstances, which produced a body of locally-, often individually-generated knowledge, in an interminable and successive “contingency management”.

Within the hospital, they were part of the “ward world”, and biomedical knowledge was part of the tools they used to operate within it. What could be done when a procedure was prescribed and the required materials were not available? In these occasions, the nurse, bearing in mind biomedical arguments, imagined, with the material at her disposal, the possible way to prudently carry out the procedure. Here is Lúcia’s description of acting under those conditions:

*Then you see a patient in need [and say]: ‘look, I can’t give it to you, because I have another patient who needs it even more’. I see a need and I can’t act?! Then we improvise, but when improvising you have to respect some techniques; it’s like inserting an indwelling urinary catheter [a catheter inserted into the bladder used for draining urine] without*

*a tray: I use the glove’s sterile field. Am I respecting the principle [of asepsis]? Yeah, I’m trying to keep it sterile, but is it going to be 100%? Can I guarantee that?*

In Amanda’s words, the issue was similarly framed:

*[...] if you don’t have the materials, it’s complicated. Then you start to try to improvise... first of all, things don’t work as well as they would if you had the materials and, second of all, you waste a lot of time trying to put together something that doesn’t exist and that you want to create: cut something here, put some tape there... and sometimes it doesn’t work properly.*

In the previous statements, we see something of the material shortages of the hospital we studied. We will not go into detail regarding these conditions or the conditions of the Health System as a whole. But it is worth showing the weight these issues carried in the work done at the ward, especially for the nurses.

Nurses did not always take on and follow through on medical decisions. In the rare occasions in which we saw procedural disagreements between doctors and nurses, they were never resolved through technical arguments. They always resulted in conflict and dissent. When nurses disagreed with medical prescriptions or conduct, they attempted to argue their position, but medical decisions were seldom overturned. It seemed that there were no terms for dialogue, each side’s technical arguments went unheard. Disagreements almost always became conflicts, expressed in terms of everyday language and verbal and institutional violence. Since prescriptions came from doctors, theirs were almost always the decisions that prevailed. However, whenever possible, nurses carried out procedures in the manner they felt was correct, going against medical decisions.

In short, the doctors’ world is seemingly unlimited, transcendental; in it, doctors could explore multiple conjectures through their relationship with theory and clinical experience, explore more complex cases indefinitely, produce, through negotiation, multiple interpretations and decisions. The nurses’ world is materially contingent. A nurse’s actions, in her way of seeing the world, must fit between the medical decision, her colleagues’ actions, users’ desires, other services and sectors’ flows, what the institution can materially provide... They were in distinct “stations”, viewing and operating the same world in distinct ways.

### The exception that confirmed the rule: an “allied nurse”

When it comes to language and the degree to which it interfered in the relationships between doctors and nurses, it is worth mentioning the only nurse whom doctors sought out when they desired a clinical opinion, before making their decisions. It was Lúcia. She said, during the interview, doctors began treating her with respect, as a colleague, when she demonstrated that she, too, knew and was able to use the clinical dialect. She further stated that this characteristic was never interpreted by any doctor as a threat, that she was never denied the authority to use this dialect or to give an opinion when she believed it to be convenient. The doctors liked her and claimed to only rely on her. On her relationship with the doctors, she said:

[...] *in the case of the relationship with the doctors, you get a better relationship with them through knowledge. Knowledge, it is power, information has power. So, those who have more information get to feel superior; those who don't, are lacking, become subordinate.*

Lúcia revealed, in the interview and in the observation, a certain enchantment with biomedical knowledge. This enchantment led her to develop her skills with these arguments, including sharpening her clinical dialect. This made her interact with the direct, legitimate bearers of this dialect, doctors. Lúcia stated she was still uncomfortable maintaining a dialogue based on doctors' clinical language:

[...] *sometimes, if I'm honest, I'm afraid because I lack a technical term. But because I'm so imbued in practice, sixty hours everyday here, I'd like do study more, and some technical terms fall out of use. And when I need to, I can reproduce what the patient said: “it's a stomach ache”, “pain in my lower back”, but I can't immediately think of, for example, “lumbago”, “dysuria”.*

In order to deal with the difficulties of developing her use of the medical dialect, Lúcia sought to learn how to interpret exams in an attempt to enhance her interaction with doctors; and she has been successful, as she stated in the following passage:

[...] *because he [the doctor] reads imaging tests like nobody, interprets that report perfectly. I don't, because I didn't learn that. For example, analyzing X rays, I didn't have any classes on that, and they have, because their focus is diagnostic. But because I took a class on the side, I can say: ‘what do you think? There's a congested area, right?’, ‘Oh,*

*this X ray is bad, it's rotated!'; then they look at me like this [makes a gesture expressing surprise, with her eyes]*

The nurse gives yet another example regarding this attempt to interact with the medical staff, an example that clearly addresses the naturalness with which these professionals fail to interact in everyday life:

[...] *they [doctors] get the results from the blood gas test [an exam that seeks to quantify the configuration of blood gases] and come back. When they get here, [I ask]: ‘so, what's the blood gas result?’, and then they say: ‘oh, it's better.’ And I said: ‘better how? How's that pH [index which refers to the acid-base equilibrium in solutions]?’ [...] In that [episode] of the blood gas test, I showed them I could read it. Sometimes, I'll throw something like that out so they'll see I'm not out of the loop, and that's good because they [come]: ‘look here, this other result, what do you think?’. This even motivates me to study more, to always be up to the task of talking to them.*

“Being up to the task of talking to them”... There is much contained in this sentence, almost the entire distance between these professionals. When asked directly how they reacted when she surprised them with these answers, she stated: “They're surprised, then they're open to communication. I notice, when I show I know something, that they like that, and I notice that they see us as allies”. “See us as allies”...

### Doctors and nurses interacting – the dynamics of “latent conflict”

In the interview with Erika, when asked if she was able to recount some shared action with doctors that had struck her, she answered, dryly: “No. Generally, the actions I carried out were with nurses.” It was as if she could not conceive of the doctors as being articulated to her actions, as if all barriers rendered them invisible in her day-to-day life.

However, invisibility is appearance, as contradictory as this sentence may seem. In Lúcia's words, doctors and nurses routinely experienced the dynamics of “latent conflict”:

*there's a latent conflict, this is very present: you're here, then the other person arrives and doesn't say ‘good morning’; this, today, tomorrow, it's the same thing; he looks at you differently, it's behaviors that betray this latent conflict, but it's not spoken, and that gets in the way, for sure, when providing care.*

The “latent conflict” cuts across practice, the direct provision of actions. Thus, it also affected

the subjects who needed these actions. Regarding this direct interference in service provision, Lúcia said the following:

*[...] with the doctor, they come in and don't say who they are, don't say 'good morning', you're there and nothing... he'll only ask if it's of interest to him. There are patients here and they come in and say to us: 'oh, are you done? What is the stool like? And the injury, did you bandage it?'; and that's it, they're not interested in anything else. [...] You only say what is necessary, only the necessary. And what is necessary?*

"What is necessary?" In this dynamic, it seemed that medical action was what was necessary in dealing with users' "needs". Lúcia stated how this issue affects her:

*[...] with the doctor, you have to win them over, and when it's those doctors you don't interact with much, how do you win them over? And then you see, because of a non-verbal behavior, through body language, that he's treating you like a subordinate; he only turns to you when he needs you. Because I see many of them closed off, and they keep to themselves, they're like a clan. But the sector's own conformation already says that there are "stations". But, what about the bedside? Who does it belong to? [...] When it's the nurse who's there, they [doctors] come in, 'interrupt the bath for a bit so I can listen to the heart, it'll be quick'; but I'm a professional, don't you respect me? I may be assessing, and I need the patient's attention, and he robbed me of that attention; but I'm not going to argue there because it's in front of a patient... and what about the ethics, regarding another professional? But later we're like: 'oh, it's in the past...' But it always happens...*

The conflict is latent because it was normalized and naturalized in everyday life in the form of silence. Non-explicit discussions seemed to materialize as limits to practice, which is clear in Lúcia's passages, as well as in the following passage, from Amanda:

*[...] it happens that we're doing some procedure, we need to do some procedure, and then the doctor insists that we do the procedure he wants, at that moment, that he needs to do; he doesn't know how to wait, because there are priorities... so, we have to see what is the priority... which procedure takes priority? And, sometimes, that gets run over by the doctor because he thinks he has the... as if it were his territory.*

Through these statements from Lúcia and Amanda, distances between the two collectives are reaffirmed. Particularly in the preceding excerpts, we see that doctors and nurses, in everyday life,

showed little interest in, and solidarity with, each other's work. Doctors decided over there, nurses handled their demands over here, and if they had to inhabit a shared perimeter, the doctors' rush was more valuable. The tension of this divided everyday life fed the "latent conflict", which pulsed in every procedure and in the lives of every user, but which was supported by silence and by the operating order in that ward. A medical order.

### So as not to conclude...

A medical Order which, for it to become visible, we had to understand its articulation with language, with knowledge, with techniques, beyond corporatist/professional issues. An understanding made possible through the immersion into its everyday life, as was done in this research. What guarantees this Order is not merely the doctor or his professional status – though this is guaranteed –; it cuts across everything that is done in the ward: it is in the prescription and application of a medication; it is in the way by which a user is referred; it is in the male doctor and female nurse; it is in the words and the clothing of each of these professionals; it is in the nursing station and the medical station. The medical Order is invisible and structures the "latent conflict" and is reproduced under a shrill silence. As an Order, it manifests itself without subjects' clear awareness, cuts across bodies and speeches without raising questions, as can be seen in the words of doctor Tatiane, when discussing the relationship with the nursing staff:

*[...] here, it's very hard! They're much more refractory. In [the private clinic in which she worked], they're more easygoing; the nurses come in, they talk, and things are exchanged, like: 'doctor, don't you think we need to do this? Doctor, don't you think we need to do that?'... it's a little different. Not here, here you have to be on them: 'who has an access [instrument-created intravenous passage for infusing external substances]? Who doesn't have an access? You have to replace the access! Why haven't you taken it out yet?'*

To the doctor, collaborations with the nurses materialize at the moment in which they recognize her as a reference and follow her prescriptions as determined. This is natural and routine, the nurses and doctors do not call this type of speech into question: it flows. Challenges to this speech are an external element.

In order not to conclude the issues we have exposed, we will move toward the end of this article by proposing a provocation. In the 1960s,



Thomas Kuhn proposed the controversial Thesis of “incommensurability”<sup>11,21,22</sup> regarding groups that, in science, disputed political-epistemic leadership within a certain scientific field. Among these groups, based on a theoretical-practical-axiological set common to each group, there would be something like a barrier, a breakdown of the possibilities for dialogue, because the groups bore different and incompatible<sup>11</sup> – and therefore incommensurate – worldviews. There would be no possible consensus between these groups.

In the 1990s, after decades of revision and debates regarding Kuhn’s Thesis<sup>23</sup>, Mario Biagioli proposed that “incommensurability” could also occur as a result of the processes through which social-professional identities form. In this

new interpretation, the barrier between distinct groups would be motivated – through shared theory, technique and values – by specific socio-professional interests and captivated in the relationships between their representatives. Biagioli classified his proposal as a “socio-professional incommensurability”<sup>21,24</sup>.

Considering all we have addressed in this article – emphasizing the contextual aspects of this research, which took place at a specific time and place – we present the Collective Health area with the following provocation: are the knowledge, practices and values of doctors and nurses incommensurate? If so, what can be done about it?

Were we so unlucky as to research a *sui generis* institution? We would like to think so.

## Collaborations

LAP Gonçalves was responsible for conceiving and drafting the article. LAP Gonçalves, ALO Mendonça and KR Camargo Júnior were responsible for the theoretical-methodological alignment, data analysis and interpretation and final critical review.

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