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Planned discharge and the inter-professional relationship from the perspective of the nursing actions during the COVID-19 pandemic

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Abstract *A qualitative-case study was carried out aimed at analyzing the interprofessional relationships generated by the planned discharge from the nursing actions' perspective during the COVID-19 pandemic. The study method was the participating observation by one nurse who works in a large SUS hospital in the city of São Paulo. The production of narratives and the micropolitics analysis resulted in two diverse visibility plans: beyond the planned discharge the anthropophagy of the technological arrangements for care and the ambivalence of the nursing staff in the production of interprofessional relationships; and the medical discharge and negotiated discharge: the intersecting with other professionals, with the families and with "real" life. The pandemic interrupted the multiprofessional visits and it was an analyzer of the interprofessional relationships. Wittingly, the nursing staff negotiates the discharges with physicians, who retain this power, and sets the team in motion using an elastic autonomy. The planned discharge alone was not able to guarantee a common interprofessional action plan, was not able to modify the constituted roles in the hospital, a situation that increased during the pandemic, but allowed the right setting aimed to increase the team's professionalism.*

Key words *Interprofessional relationships, Patient discharge, Nursing, COVID-19*

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Introduction

The restructuring of health systems requires effective changes in care practices and in the operation of hospital organizations, which must be articulated with the other services that constitute the health care network (HCN)[1]. Processes based exclusively on the rationalization of hospital life show to be insufficient for the construction of a new hospital *of* and *for* the Brazilian Unified Health System (SUS, *Sistema Único de Saúde*). Thus, it becomes necessary to produce practices that focus on care, and that think about clinical management from the perspective of interprofessional work, comprehensiveness and continuity of care.

In recent years, technological arrangements (TA) of care management have been adopted in public and private hospitals, induced by the National Hospital Care Policy[2]. They are defined as technologies that aim to improve care practices and management instances. Preferably applied in combination, they constitute intervention modalities, of a multidisciplinary nature, aimed at the application of scientific knowledge for practical purposes in the management and production of care, aiming at producing significant changes in the hospital[3]. Many of its actions are based on the National Humanization Policy[4], focusing on the health needs of people in their different and multiple modes of existence.

The TA aim to improve flows, optimize bed occupancy, speed up discharges and humanize and qualify the assistance produced in the hospital. Among these, the following can be highlighted: clinical guidelines and technical protocols; bed management and Internal Regulation Center (NIR, *Núcleo Interno de Regulação*); expanded clinic and goal-guided tour (kanban); hospital discharge management; long-stay hospital beds and home care; collegiate clinical management and boards; among others[3]. They seek, in an innovative way, to match the work of the multidisciplinary team, to increase the responsibility of the subjects involved in care and to produce operational responses.

Their institutionalization counts on improving the coordination of care, aiming to producing better clinical decisions and encouraging synergy between multiple areas of knowledge, thus adopting the best practices for safe and effective care based on scientific evidence[3]. An ever-present doubt for the continuity of technological arrangements is the real possibility of maintaining them in situations of change, whether in the management of establishments, or in the management of the Unified Health System, or even changes in the coordination of care teams. The COVID-19 pandemic brought a unique analytical opportunity to understand the degree of institutionalization of arrangements, particularly interprofessional actions in times of health crisis.

In a study carried out in a public urgency and emergency hospital, it was observed that TA, particularly the Manchester risk classification system[5,6] and kanban[7], have high adherence by health professionals. However, they take on different configurations, with an enormous plasticity given by the characteristics of the places and teams. They are recognized by professionals as powerful ways to organize care and indicate new formats of interprofessional relationships; however, it seems they do not change the relationships of power and professional autonomy[7].

This article seeks to extend the knowledge of how TA affect interprofessional relationships, from the perspective and actions of the nursing staff during the COVID-19 pandemic. This professional category inhabits the hospital; they are the professionals who walk, talk, organize, feel, perform, manage (spaces, people, medications and procedures) and give and receive orders. The nursing station is, in all hospitals, the information and control center for the ward's life; it works as a membrane, as it protects, regulates and interacts. Nursing professionals act in everyday life: the daily, the internal, the constant, but also in what is irregular: the occasional, the external, the passers-by (physicians and other professionals, family members and patients). In better words, the COVID-19 pandemic represented a spontaneous analyzer (a quasi-experiment) of interprofessional relationships and their institutionalization and their power to affect the power relations, which are so marked in the hospital environment.

In a recent study[8], it was demonstrated that responsible discharge (RD) is a more complex arrangement than its definition, since it goes beyond the process of transferring care carried out based on the "guidelines to patients and family members regarding the continuity of treatment, reinforcing the autonomy of the subject, articulating the continuity of care with other HCN care points, particularly the primary health care (PHC); and implementation of dehospitalization mechanisms, aiming at alternatives to hospital practices, such as home care agreed in the HCN"[4] . That is, when seeking integration and articulation with the world outside the hospital, it ends up generating connections with other arrange-

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ments and services, with the different professionals inside the hospital and with users and their families.

The COVID-19 pandemic was an element that crossed the aforementioned study[8]. The most serious health crisis of the last 100 years turned services and systems inside out, causing profound changes and testing their resilience. The hospital was capable of an unimaginable plasticity, in the sense of changing flows, creating care spaces, transforming wards, training and learning in action how to face an unknown disease. It overcrowded the emergencies, forced the reorganization of hospital care and exhausted the teams with illnesses and sick leaves; but COVID was also used by those who oppose TA who have aspects of humanization as an argument for disinvesting or even abandoning their use. Team meetings were suspended; family visits were prohibited; the absence of the network at the first moment of the pandemic, particularly the PHC and surveillance actions, reinforced the culture of hospital-centered assistance, including emergency services, for health care. As previously mentioned, there are strong indications that the nursing actions, their acting as a mediator of interprofessional actions, was tested during the pandemic.

Aiming to contribute to the effective implementation of management and care practices based on scientific evidence, the objective of this article is to analyze the interprofessional relationships produced from the technological arrangement of responsible discharge (RD), focusing on the nursing staff's action and perspective, during the period of the COVID-19 pandemic, in a general hospital. Thus, the aim is to understand whether RD is in fact an administration device[9] capable of influencing the power relations among the professionals.

Methodological trajectory

This is a qualitative-case study[10], which used different data production techniques, summarized in Chart 1. This article is part of a broader investigation funded by FAPESP (PPSUS-2019)[8], with the general objective of "analyzing technological arrangements of care management provided for in the PNHOSP in a reference hospital of the SUS network in the city of São Paulo".

The assumed qualitative perspective understands that the production of knowledge also occurs from the study of micropolitics[11], which allows disclosing the different and overlapping relationships produced in a creative or conservative way in the daily life of health services. Given the epistemological premise, we aimed to make actions and practices visible, understood as experiences, in the sense proposed by Lapoujade (2017)[12], that is, "What really exists is not things made but things in the making" (p.11). The main data production technique was participant observation, carried out for nine months in the selected ward of a large hospital.

The investigated hospital is a reference for medium and high-complexity care and is part of the SUS network in the city of São Paulo. RD was chosen from a workshop that listed thirty TAs implemented in the hospital before the COVID-19 pandemic. The choice of this TA and a ward, as the investigation locus, was decided in the Investigation Management Collegiate, a device created to conduct the study, consisting of the Board of Directors of the hospital and by the research coordinators. The hospital ward was not dedicated exclusively to patients with COVID-19, although there were also cases of the disease there.

The actors linked to the hospital participated in all phases of the research, including the expanded research seminars: fortnightly meetings to process field activities and analyze the empirical material produced. The return technique[13] of the findings was also used during the observation process for the multidisciplinary team of the nephrology ward.

For the socio-analysis, the return "supposes that one must, and can, talk about some things that are generally left in the shade. These things would be the commonly silenced ones, spoken only in corridors, cafes [...]" (Altoé, p. 53)[13]. It aims, therefore, not only at validating the results, but at a joint reflection with the actors aimed to construct an analytical interpretation of the findings. In other words, it is not the researchers, as specialists, who interpret the results from a hermeneutic of empiricism. For Lourau, the use of the technique "supposes a minimum of co-management, co-participation, between object and researcher" (p. 55)[13].

For the purposes of this article, in addition to the observations in the hospital ward, interviews with nurses and the shared return seminar of the nursing staff, in which the nursing coordinators and professionals, nursing technicians and assistants who work in the assessed ward, participated, will be used. This shared seminar emerged as a methodological strategy not foreseen *a priori*, as the "silence" of the nurses in the shared/return

Chart 1. Summary of field activities.

Technique	Description and products
Participant observation*	Field diaries Narratives of patients and professionals Guide user selection
Interviews with professionals	Transcripts of interviews with: Social worker Resident physician Nurses
Interview with patients and selection of guide users	field diaries Care narratives
Guide Users **	Face-to-face monitoring in services, at home, by phone and WhatsApp
1st Shared Seminar*** Return of the first analysis: the transcript of the first shared /return seminar	Participants: clinical coordination of the nephrology ward, social workers, nurses, field researchers: Trigger question: How to better understand the technological arrangement of responsible discharge? How might the pandemic have changed the responsible discharge arrangement?
2nd Shared Seminar / Return of the first analysis: the transcript of the first shared / return seminar	Participants: clinical coordination of the nephrology ward, social workers, nurses, field researchers Trigger question: *Based on what we have discussed so far and from the perspective of producing the best possible discharge for the continuity of care, what points would you highlight as strengths and as challenges/difficulties in the operation of the arrangement – responsible discharge.*
3rd Shared Seminar/Return of findings with the nursing staff (A3)	Coordinating and care nurses, NIR coordination, nursing assistants, researchers Trigger question: *How does the nursing staff discuss findings about responsible discharge?*

*start 4/19 end 12/30/2022; **EMAD - multidisciplinary home care team; ***Shared seminar: The experience of sharing the main results observed with the surveyed teams was already used by the research group in the last two investigations and proved to be more than a classic "feedback", as it showed an important analytical element of the empirical material produced, enlightening it from other angles. What is new in this methodological strategy, with the institution of expanded research seminars, with local observation teams, is the act of seeking the construction of a more polyphonic narrative policy in the sense given by cartography itself, done in a continuous and systematic way.

Source: *Relatório Técnico Científico da pesquisa "Arranjos tecnológicos de gestão do cuidado previstos na PNHOSP em um hospital de referência do SUS no município de São Paulo"*[8].

seminars with the team seemed to say something, that is, an analyzer, as defined by Lourau[13], as "those events that can [...] that make the 'invisible' institution appear at a single stroke [...]" (p. 35), of the work of nursing, the relationship of this body of professionals with the other professionals and with the RD arrangement.

For the construction of the analysis of the findings, four great narratives were produced[14,15]. They were written by three researchers and merged the data produced by the different methodological strategies employed, after extensive reading of the transcribed material (interviews and shared return seminars), of field diaries and the processing of findings in the expanded seminars, representing the empirical corpus of the investigation. Subsequently, the narratives were discussed and analyzed in four expanded seminars. Using the construction of a policy of narrativity[16] proved to be powerful for the production of analytics. Based on this process, two plans of visibility related to interprofessional work were highlighted, which will be described in the next item, divided by analytical intentionality, but which are connected and immanent to each other.

As theoretical references for the analysis, in addition to the concepts of socio-analysis[13], elements of the sociology of professions[17] were also employed, using autonomy as a marker of professional power, and the definitions of types of teams and teamwork[18-21], which are described in Chart 2.

The interviews of the seminars were transcribed, after the signing of the Free and In-

Chart 2. Definitions and concepts of teams used for the analysis of findings.

Type of teams Peduzzi et al., 2001[18]	**Work cooperation** Ceccim et al., 2018[19]	**Integration of knowledges** Furtado, Laperriere & Silva 2014 [20]; Furtado, 2007 [21]
Grouping or overlapping *fragmentation of actions*	Multi-professional: existence of different professionals who work according to their professional core, with differentiated and hierarchical degrees of autonomy.	Multidisciplinary: *aggregation of different knowledges around the same topic; each one does their part; the knowledges look at the user individually, each with its professional core; the disciplines are close but separate*
Integrated *articulation of actions aimed at comprehensive care.*	Interprofessional: *professionals act from an integration of knowledge, producing a more interdisciplinary work. Or even transdisciplinary, increased autonomy, decreased hierarchies.*	Interdisciplinary: *effective collaboration between different types of knowledge through actions and exchanges of knowledge; production of a mingling, intersection field or a common field between the different knowledges in decision-making.*
		Transdisciplinary: *absence of demarcation between the knowledges. It is not possible to recognize boundaries between the knowledges.*

Source: Authors.

formed Consent Form. The investigation was approved by the Ethics Committee of Unifesp and of the assessed Hospital.

Results and discussion

Consisting mostly of women, nursing in Brazil currently comprises different functions, roles and training, occupying positions of coordination, administration and assistance; nursing technicians provide daily care to patients and nursing assistants work in connection with patients. They occupy all spaces, interacting with physicians and other professionals, as well as with patients and their families, of whom they are often the eyes and voices, representing a powerful listening.

Beyond responsible discharge: the anthropophagy of technological care arrangements and the ambivalence of nursing in the production of interprofessional relationships

Responsible discharge from the nursing staff perspective was always associated with other arrangements, particularly with multiprofessional visits, kanban, scheduled discharge and unique therapeutic plans. When called to comment on these arrangements, they make up an anthropophagy[22] of the latter and bring to the scene unique appropriations in the daily life of the ward. About the multiprofessional visits and kanban they say:

Here we have the multi visit. [...]. We do the multi visit, right? ***But, because of the pandemic, it kind of stopped for a bit, because there's no way to go with all those people to all the beds****. And what I do is to get my kanban, which is where all the most important patient information is, I go from bed to bed, looking at these data [...].*

Kanban, which has interprofessionality as its axis, has become (or deformed into) a control instrument carried out by nursing alone. The interruption of multiprofessional visits resulting from the impacts of COVID-19 showed that nursing did not perceive it as a powerful arrangement because, as they say: "***it was good, but it was not all that good*** [...] *It particularly helped, but not much, it was not one hundred percent*". When trying to explain this perception, they bring to the scene an example of a multidisciplinary visit that was more effective, and say:

*When I worked at another clinic, there was a team [...], there was a receptor there, doctor XX; [....] we had the multi visit, which I thought worked there, different from ours. "****Nurse YY [...], what do I want nursing to do for this patient****? Let's get them out of bed, let's sit down,* ***I want a bandage there, or I don't want a bandage, the patient has secretion I don't want the wound to close, the bandage. Physiotherapist, as for your part, I want this and that...",*** *[....] "I don't want them to use technical terms, the conversation here will be*

for everyone to understand what is being said", [...] "and nutritionist, I need this, this and that from you", so it was practical, it was a practical visit, we got together once a week, and it was a pleasure to go, you know, so everyone talked, and there was the doctor's interest for us to improve that patient to give them back better to society [....].

This scene is an analyzer of the medical institution in action present in the hospital, as it is the doctor who gives directions by telling each professional what needs to be done. This view reflects a team submissive to medical power-knowledge[23,24], with no perspective of autonomy by each profession and the possibility of building a common plan of action[26]; it reveals a team with overlapping knowledge, which acts from its professional cores, attributed in different professionalization processes[17], but demanded by the medical authority.

The singular therapeutic project, another arrangement implemented in the hospital, seems not to be recognized by the nurses who work in the care area. It was remembered when a nurse said, "*that there should be a care plan*". However, it already exists and has been institutionalized by management, which attributes to each professional, including the physician, the responsibility of including their care plan into the digital platform.

Finally, another element of RD is exemplified by one of the nurses:

So, here [at the hospital], we have a protocol, which is the scheduled discharge. There is an authorization for this discharge in the system, right, which is on the assistance panel, [...], but that is not what happens because, the medical team does rounds here in the morning, and out of nowhere the patient is discharged, you know?! So the nursing team gets ready, talks to the family, explains that a discharge schedule will be made, but the medical team hardly follows this protocol.

If implemented, the arrangements outlined by the nursing staff could in fact constitute a greater possibility of responsible discharge. All of them have a multidisciplinary nature, but it was found that they were not being operationalized based on interprofessional work. Such desired relationships are in the dimension of the TA content, as little is expressed in the daily life of the ward, particularly during the pandemic, when their implementation, despite the greater complexity context, would be even more relevant and justifiable.

The team's professionals are present, the nursing staff recognizes and connects the TA, but does not act towards a more interprofessional action. The COVID-19 pandemic, which interrupts the most shared actions carried out by the team so far, becomes an analyzer that there is a recognition of actions centered on professional cores. The objectivity of the work seems to be linked to hospital routines with their demarcated times, strongly established in hospitals. The clinical demands and the different procedures and actions that the users are submitted during hospitalization command the nursing actions that, when valuing the multidisciplinary visits and/or spaces, indicate that, for the necessary agility of their work, it is better that each professional demand their own specific core of action; and that, in the end, the physician remain in charge of the interprofessional work, even though they do not necessarily assume this role either.

There is an acknowledgement that computerized processes, such as the care plans of each professional and the implementation of TA, have enabled an increase in the team's professional autonomy.

On the other hand, even with the recognition by the nursing staff of the different professionals and the care management devices implemented in the hospital, they highlight the *reluctance of physicians in not adhering to TA*. The nurses claim that this is due to *an absence of the culture of care* in the doctor's actions; a fact recognized by the physicians themselves, as care from a medical perspective remains more centered on diagnosis and clinical treatment, little inundated by the world of life. In an ambivalent way, the nursing staff deposits in the medical authority, in its power-knowledge [23,24], the possibility of an interprofessional work, while it does without interprofessional work.

Medical-centered discharge and negotiated discharge: the intersection with other professionals, with families and with "real life"

When the doctor tells the patient that they are discharged, they [the patient] call the family, the family picks them up and leaves their job, come here, [at the nursing station] where is the discharge?! This happens in the morning, will the discharge be at five or six in the afternoon?! ***So we are being pressured: "Where is the discharge? The user puts pressure on us, not on the physician.***

In the observations and returns carried out in the study, it was evident that the decision to discharge is an action performed by the physi-

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cians: [...] *The doctors talk to each other, right?! They decide, they decide about the discharge, [in the morning] and they communicate with us here at the station*, producing strangeness in relation to the organizational dimension of care[25]. The ward's internal 'norm' about discharge time reveals the relationships between physicians, nursing staff and users, that is, one more analyzer[13] of the studied TA and interprofessional work. It is possible to say that the organization of the work process related to discharge is centered on the physician and that the decision to grant it remains theirs; their work schedules and routines influence and determine the routines of other professionals, who must be subordinated to their work process, as well as those of families and users. Somehow, this fact also seems to justify the interruption of interprofessional actions during the pandemic. It indicates a discharge that belongs to the physician, it is clinical, in the sense of the illness that caused the hospital admission. However, the nursing staff perceives and deals with other clinical and social situations that influence discharge itself, as *[...] the discharge, depending on the patient's case, has several points, if one of them comes loose there is no way, [...]* ***so we have the support of the psychology, social work, nutrition, you know, and everyone's aligned, but sometimes the medical part is the part that comes loose, and makes our work difficult at the time of the discharge****. For example: "you're discharged", "what do you mean you're discharged?! The guy's in bed, totally dependent...". Then it gets difficult, and there are some cases that the family does not take, does not take, [...] Because, how are they going to take them? [...] They didn't get ready, they don't have an adequate room, they don't have an adequate bed, [...] so when the medical team fails in this part [...] when the assisted discharge protocol is not followed.*

Although it is a physician's territory, discharge is negotiated through nursing actions. They talk to the doctors, as they tend to incorporate the dimension of a broader clinic into their actions, and call on the team members:

[...] we talk to the doctor, they say that the patient is unable to be discharged because, where is the programming of the respirator? Of the aspirator? Where's the O_2 programming? Whether they are discharged with O_2 or not: if they don't go with O_2, fine, we'll stop there, but if they go with the O_2 how do you do it, if the family doesn't have O_2 available? Who will take care of this wound? Who will accompany this patient home? Sometimes on antibiotics or oral therapy through catheter, who will guide this family member at home to give this medication? Who will monitor the evolution of these wounds? ***So we show them that it's not like that, right?***

Discharge itself is much more complex than medical discharge, as it will necessarily involve other dimensions of care[26] – family, professional or those related to continuity of care. At that moment, the physician and the other professionals end up interacting mediated by the nursing actions. There is no doubt about the role of the nursing actions in expanding the perception of the patient's other needs and in creating a communication channel between the team and the family, even if it does not constitute a common plan of action[26].

Nurses justify, again, these situations "*by an absence of the culture of care in medical action*", as one nurse comments:

That's what I say, it's the culture of care, it's very ingrained, when I say it's really care, ***I'm not talking about clinical care, the care that's ingrained in nursing, physical therapy, nutrition, social work, it's not in the medical culture****, yet, for now. So, when this permeates, the medical culture, [...] of course it's not all doctors, [...] sometimes they even demand that from us, but in general, [...] 90% of the doctors don't care about that, it's like, "it's not my responsibility, OK, what's going to happen up there is not my problem".*

That way, they reinforce the fact that physicians achieve an interprofessional action, when they want to do it, because they hold the power; however they recognize that this professional does not have the culture of care, which would be present in other professionals, but that due to lesser autonomy or a lower degree of professionalism, they cannot change the vector of medical authority.

Another professional highlighted by nursing are the social workers, activated by both nurses and physicians as they hold the connection key to the network, connecting the outside world to the hospital, in an action specific to that professional core. It is the social workers, for instance, who make both the regulation for the carrying out of hemodialysis and for basic care or for the Multidisciplinary Home Care Teams.

Unlike the ambivalence shown in the previous item, in the case of RD, the nursing staff starts to negotiate the discharge, to lead the multidisciplinary team[27] based on the specific demands for the different professionals, each one in their professional core. It continues, in a way, in the control of care due to an absence of this

perspective in medical action, and this gives it professional specificity, exercising here an elastic autonomy, as termed by Carapinheiro[24].

In addition to the clinical conditions themselves, the objective conditions of life appear in nursing actions, which cross the clinical situations and constitute another element of the negotiated discharge.

There's also extreme poverty, right, there's a patient with a bag full of clothes, which her son brought, she has a son, you know, the clothes are all dirty, we can't even put these clothes on her, then you can imagine, that she is a patient in extreme poverty, understand?! You know?! You can imagine the situation, so, I don't know, I think all this makes it difficult, right? Because you know that when they are discharged there will be problems [...].

Such situations were captured both in the observation of the ward and in the reports of the interviews and in the return seminars of the findings. They reveal the complexity of responsible discharge, beyond the continuity of care in a clinical dimension, requiring the implementation of more complex care networks that can produce care beyond the mere provision of medical services. The assessed hospital reveals that, in addition to the comfortable place established for the professional cores from a professional perspective, there are existential territories, and social inequalities invade the ward.

The visibility of social vulnerability is present right after hospitalization, and the family dimension of care[25] crosses medical discharge as a neglected dimension. The attentive look of nursing, who are in the ward on a daily basis, by the bed, with the patient and their family, can foresee the possibilities and difficulties of discharge through the belongings found in the drawers of the bedside tables:

We [...] just by opening the patient's drawer, you have an image of the patient, the patient's family, the family's attention, you know, you have an idea, that if they are discharged, they will leave soon, because the family, you know, is present.

Another reported aspect is about patients who live as a single parent, alone, without a support network, a condition that is aggravated and increasingly frequent by the population aging,

We have patients in their fifties, aged fifty, sixty years, which is not such an old age group, but they are single patients, who live alone, then we need the support of the Social Worker to find a shelter for them to stay, as it has happened to some of our patients.

And the discharges that don't happen, *when the patient is very severe, when the patient has a tracheo, an ulcer, is bedridden, has a catheter, and considering that the family comes on the first and the second* ***day, on the third they disappear, then you have a patient who will have difficulty in being discharged.***

These are striking stories that reveal the "real life" and invade the ward. A responsible discharge necessarily has to incorporate the objective conditions (material and immaterial) of existence, demanding greater articulation with existential territories, with interdisciplinary and intersectoral actions.

The nursing staff inhabits the ward, knows not only the flows, regulations, but also the doctors and other professionals on the team, who can act for better care and a responsible discharge. These are professionals who are at different moments with patients and their families, recognizing other health needs of people who are hospitalized there. By intersecting knowledges, they move by negotiating discharge with physicians and connecting other professionals[27,28], but they also act towards the conservation of power and control relations instituted in the hospital.

They act from a cunning intelligence[29], as nurses, when not submitting to the medical act itself, also do not confront them directly; not even in the return seminars they attended, where they fell silent. Nursing professionals look for gaps and negotiate; have a strong analytical perception of hospital agency as the "medical" territory, with its power-knowledge[23,24]. They also reinforce the central role of the hospital in care, expressing little, or almost nothing, of the network role in the continuity of care.

The silence of these professionals observed in the multiprofessional research return seminars constitute a protection strategy, an astute intelligence that allows searching for some lines of escape[9] in the complex instituted field of forces present in the ward and in the hospital itself. Even revealing degrees of elastic autonomy, even expanding clinical action, they do not seem to substantially modify their professional processes, as they do not modify the hierarchical and power relations established in the hospital.

The return with the nursing, complementing the participant observations made in the study, comprised a narrative of the daily life of the nephrology ward. When they spoke, they gave voice to the relationships they produce with the other professionals on the team, confirming the physicians' power-knowledge[23,24], which during the

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COVID-19 pandemic intensified to the point of causing the suspension of visits themselves and the multidisciplinary meeting.

To talk about a culture of care in which the doctor is not included, who is not addressed by management in the same way as other professionals, reveals the well-known social and technical division of work[30], in addition to salary-related aspects. It is also an analyzer of the governance[31] regime of the hospital itself.

It indicates that TA itself, as a management act, may lose power to establish new work formats: centered on the users' needs, which go beyond a clinic for recovering from the disease, based on an interprofessional and interdisciplinary action, which would allow the production of singular and multiple common plans of care.

Final considerations

In the micropolitical analysis of the relationships between professionals and professions, the RD, from the perspective of nursing, technological medicine, anchored in biomedicine, and in medical autonomy is preponderant. The other types of knowledges comprise, based on conversation processes, a negotiated discharge, mediated by nursing actions. A scenario that intensified during the pandemic, which reinforced the established roles, including of the nursing staff itself.

The intentionality of interprofessional work, clearly outlined in the institutional project of the hospital, and the existence of a multidisciplinary team in the ward were not enough to produce a common field for interdisciplinary care. The professionals are activated separately; nursing interweaves the knowledges and moves by negotiating discharge and engaging professionals in an ambivalent relationship. Doctors hold and do not relinquish their power; nursing maintains a camouflaged submission to physicians and a partnership relationship with other professionals.

Multiprofessional visits were interrupted with the pandemic. This fact was an analyzer of interprofessional actions, as nursing made it clear that it did not attribute a positive value to this arrangement. The nurses' actions in the discharge process give them a certain elastic autonomy. However, the empirical nature of the study does not allow us to say that there was an increase in professional autonomy, on the contrary. Without denying the greater professionalization that the TA grant to different professionals, there is evidence that there were no changes in power relations, which could be expressed by greater autonomy of the multidisciplinary team, in the production of an interprofessional work. The hegemonic culture, centered on the physicians' knowledge and power, established in the hospital, is maintained and seems to have been reinforced during the COVID-19 epidemic.

Finally, it is possible to say there was no evidence of substantial changes in professional roles, as well as in material or immaterial spaces that could provide greater possibilities for interprofessional relationships and/or even greater connection with users and their unique histories and modes of existence. On the other hand, the TA present in the institutional project opened up material conditions for increasing the team professionalization and created spaces for implementing processes to be produced, from the nursing staff perspective. The RD by itself was not configured as a device with the power to transform interprofessional relationships, which still remain in a multiprofessional and multidisciplinary way.

Collaborations

R Andreazza and Arthur Chioro AC prepared and coordinated the project, collaborated in data collection and analysis, and in the writing and final review of the article. LM Bragagnolo, FF Silva and AL Pereira participated in data collection, analysis and final review of the article. L Mauri, EP Rodrigues, LAC Furtado and G Carapinheiro worked in data analysis and in the final critical review of the article.

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