
MAPPING PAIN IN THE CLINICAL PRACTICE OF NURSES WITHIN PRIMARY HEALTH CARE¹

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ABSTRACT: We sought to map how nurses are affected during clinical practice by the pain of patients cared for in the Primary Health Care service. A qualitative study, intervention-research that used the theoretical framework of the institutionalist movement and the micro-politics of health work. Eight group meetings were held with nine nurses working within the Primary Health Care sphere. Instruments from the mapping method were used for analysis, which resulted in four plans: The meanings held by nurses concerning their own pain and that of patients; The patients' pain that mobilizes nurses to provide care; The patients' pain that discourages nurses from the supply of care; and Strategies adopted to deal with pain faced during practice. We conclude that nurses face, during clinical practice, the pain of patients as a mirror, and face the pain of providing care as pain of the soul that is expressed in terms of their work lacking meaning. The creation of spaces to discuss work may enable the production of an expanded, inventive practice.

DESCRIPTORS: Nursing. Primary health care. Clinical competence. Nurse-patient relations. Patient-centered care.

CARTOGRAFIA DAS DORES DO CUIDAR NO TRABALHO CLÍNICO DO ENFERMEIRO NA ATENÇÃO BÁSICA

RESUMO: Objetivamos cartografar o modo como enfermeiros se afetam na prática clínica com as dores dos usuários na atenção básica. Estudo qualitativo, pesquisa-intervenção que utilizou referencial teórico do movimento institucionalista e da micropolítica do trabalho em saúde. Realizamos oito encontros grupais com nove enfermeiros da atenção básica. Utilizamos instrumentos do método cartográfico para análise que resultou em quatro planos: Os significados das próprias dores e dos usuários para os enfermeiros; As dores dos usuários que mobilizam os enfermeiros para o cuidado; As dores dos usuários que afastam os enfermeiros do cuidado; e As estratégias para lidar com as dores no trabalho. Concluímos que na prática clínica o enfermeiro se depara com as dores do usuário como espelho, e a dor do cuidado como dor da alma expressa a falta de sentido do trabalho. A criação de espaços de discussão sobre trabalho pode possibilitar a produção da clínica ampliada inventiva.

DESCRIPTORES: Enfermagem. Atenção primária a saúde. Competência clínica. Relações enfermeiro-paciente. Assistência centrada no paciente.

MAPA DE LOS DOLORES DEL CUIDAR EN LA PRACTICA CLÍNICA DEL ENFERMERO EN ATENCIÓN PRIMARIA

RESUMEN: Objetivamos mapear el modo como enfermeros se afectan en la práctica clínica con dolores de los usuarios en la atención básica. Estudio cualitativo, pesquisa intervención que utilizó referencial teórico del movimiento institucionalista y micropolítica de trabajo en salud. Realizamos ocho reuniones grupales con nueve enfermeros de atención básica. Utilizamos instrumentos del método cartográfico para análisis que resultó en cuatro planes: Significados de los propios dolores y de los usuarios para los enfermeros; Dolores de los usuarios que movilizan enfermeros para el cuidado; Dolores de usuarios que distancian los enfermeros del cuidado; y Estrategias para lidiar con dolores en el trabajo. Concluimos que en la práctica clínica el enfermero se depara con dolores del usuario como espejo, y el dolor del cuidado como dolor del alma expresa la falta de sentido en el trabajo. La creación de espacios de discusión sobre trabajo puede posibilitar la producción de la clínica ampliada inventiva.

DESCRIPTORES: Enfermería. Atención primaria de salud. Competencia clínica. Relaciones enfermero-paciente. Atención centrada en el paciente.

INTRODUCTION

The work performed by nurses in Primary Health Care (PHC) has changed due to the historical-social process concerning a search for ways to supply, organize, and manage health care provided to the Brazilian population through the Brazilian Unified Health System (SUS).¹⁻²

An important component in this process is an emphasis on the Family Health Strategy (FHS).³⁻⁴ This strategy has changed the nature of care practice and the demands of health service users, allowing patients to manifest demands that had not traditionally been heeded in health services. Such demands were favored by increased access and stronger bonds established with health workers, especially community health agents, though the limitations of such changes are apparent.⁵

The clinical practice of nurses working at the PHC level has been developed amid other practices and social relationships and is recognized as such, in movements that go from the juxtaposition of knowledge and practices to movements where there is integration with staff members⁶ such as physicians, nursing auxiliaries and technicians, dentists, pharmacists and other health workers.

The clinical work of nurses and the production of care takes place in the intrinsic interrelationship of patients with the staff, in which care results from the relationships among workers, patients, and the health facility.⁷ Clinical practice and care both emerge from the intersection of different needs, interests, difficulties, strengths, worldviews, health conceptions, ways of intervening, and available resources, among other factors. These differences generate tensions that constitute this process.⁸

That is, we are saying that the nurses' clinical practice is produced in the act. Micro-political processes that express how professionals work in their daily routines take place in this act, constructing care at the time they meet with the patient. Micro-politics is characterized by the articulation of its operational components: live work, which occurs in the act, and dead work, which is used as a tool or raw material and represents prior human work. Live work takes place by means of the command of soft technology, which is used according to that which is established in the meeting between worker and patient, going through how this worker manages decision-making in his/her micro-space, self-governed.⁹

Tensions that nurses face in clinical practice performed within the PHC sphere are related to

aspects of structural and work organization, such as the recognition of such practices, and also to the work performed by the staff itself.⁸

Additionally, the nature of the problems and demands that patients present to nurses and the effort of nurses to insert the conception of enlarged/integral health¹⁰ into care actions, under the command of soft technologies, often pose complex and unspecific situations,¹¹ which the knowledge and technical skills of nurses have not been sufficient to manage. This situation triggers different coping strategies in nurses, who may either devise new solutions or reproduce already established practices.^{8,12}

From this perspective, clinical practice takes place in the meeting with subjects based on mutually produced affections, in the production of subjectivities processes.¹³

The worker opens him/herself to this affection and asks what the patient's situation is, taking differentiated actions rather than actions standardized by norms, routines and protocols. In this case, the professional is working with Clinics with a "K", "klinica", which may be defined as the production of a good meeting between workers and patients. Such practice is guided by affecting and being affected, by the uniqueness and the search for producing an event.¹³⁻¹⁴

The affections that result from the meeting between nurses and patients can be expressed through movements of the attraction and repulsion of bodies.¹⁵ In the case of health workers, the demands and pains manifested by the patients can either "pull" or "push" workers toward or from care delivery.⁸ Hence, this paper is proposed to explore this universe of affections that may take place in the clinical practice of nurses: what mobilizes nurses to provide care? What keeps them from it? What are the strategies used to produce their clinical practice?

OBJECTIVE

Mapping the way nurses are affected by the pain of patients during clinical practice within PHC.

METHOD

This mapping research-intervention study with a qualitative approach¹⁵⁻¹⁶ is part of a larger study addressing the clinical practice of nurses within the sphere of PHC that was developed by a reflection group.

This group modality is based on the techniques of Kurt Lewin and Pichon- Rivière. It is applicable in the field of teaching and education, seeks the resolution of anxieties linked to the learning process, tensions that emerge in care delivery, and desires to result in institutional coexistence.¹⁷

Nine nurses from primary care units from a health district in the city of Ribeirão Preto, SP, Brazil participated in this study. Five nurses worked in the Family Health Strategy (FHS), three in the Community Health Agents Strategy (CHAS) and one worked in a PHC unit not linked to the ESF or the EACS. A total of eight meetings were held in a room on the premises of the researchers' teaching institution, from September to December 2008, according to the participants' preferences. The meetings were digitally recorded. The nurses analyzed and reflected upon their work process, strengths, difficulties and gaps in clinical practice, which enabled the group itself to resignify meanings and learning for the participants.

Data analysis took place in two different points in time: over the course of the group meetings, during supervision performed by the coordination team of the reflection group as part of the research-intervention and after the group meetings ceased, based on the transcriptions of meetings through the mapping method. Planning of each meeting involved analysis of the previous meeting and was guided by the objectives of the research-intervention.¹⁶

Mapping is based on the report of objectives and subjective elements, on drawing, and follows the movements of the transformation of meaning of certain worlds,¹⁵ the world of affections that results from the nurses' professional practice, from their inclusion in PHC, from the production of care, teamwork, and many other potential worlds, depending on the perspective of the cartographer and the group. It refers to unique experiences of resignification of meanings at the same time in which new worlds emerge,¹⁵ also creating new health care practices, new nursing practices.

In the results, the excerpts are identified by the letter "M" with the number corresponding to the group meeting, while the nurses are identified by the letter "N" followed by a number.

The study was approved by the Institutional Review Board at the University of São Paulo at Ribeirão Preto, College of Nursing (Process n. 0832/2007). All the participants signed free and informed consent forms in accordance with Resolution 196/96, Brazilian Council of Health.

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RESULTS AND DISCUSSION

The results are grouped into four interdependent plans of the exploration of meanings of affections in the clinical practice of nurses¹³: The meanings held by nurses concerning their own pain and that of patients; The patients' pain that mobilizes nurses to provide care; The patients' pain that discourages nurses from the supply of care; and Strategies adopted to deal with pain faced in practice.

The meanings held by nurses concerning their own pain and that of patients

One of the activities proposed to the nurses in the group was to express, through modeling clay, their clinical practice and its meaning. Through this activity, they manifested pain that accrues from their work. One of the images was an interrogation mark or cane that translated the pain of uncertainty and unexpected situations they face:

[...] our day-by-day is always a surprise, an interrogation mark [...]. I guess it is a pain that reflects the uncertainty of everything we experience. Which path to follow, which way should I go? Sometimes, I'm decided to do something and then I change my mind [...]. Why is it that nurses always give in? [...] For me, being a nurse, is an interrogation mark [...] that is why I made an interrogation mark [...]. But that is because I'm questioning myself, too. But it's a pain, like: back and forth. Or not, it's a cane (M6 - N 2).

Uncertainty is an integral part of the work performed in PHC because we deal with problems of a non-specific nature.¹¹ The illusion that a structured work with a predictable routine would be less stressful, produce less pain and be more efficient, is not confirmed in the daily routine and brings suffering to workers.¹⁸

The double dimensions of the nurses' work, that of providing care and managing care, are configured as dissociated and concurrent moments.¹⁹⁻²⁰ At the same time, the image of a cane suggests that nurses can depart from the organized actions of this clinical practice and management when doing many things in a non-systematic manner, which may lead them potentially to lack commitment to the results of their work.

Another way to signify pain was through the representation of a hand, though it was not related to a broadened clinical practice, since it “lacked a finger”:

[...] *it its through the clinical practice, physical assessment, the hand represents this practice, and at the same time, the contact, the human warmth, the hand that helps [...] and the pain as if it was missing a finger [...] the pain of missing [...] (M6 - N 3).*

We understand the clinical practice as a unique meeting among subjects,¹³ which can be guided by the same purpose of the institutionalist movement, questioning and scraping off uncertainty and “identities” that originate from binary logics such as BEING and HAVING.¹⁴ HAVING, in the health field and in the meetings between workers and patients, is manifested as an expression of capitalistic subjectivity, of possession and consumption, such as having knowledge, power, access to consultations, medication, and not obtaining such things generates feelings of lack, disease, and dependency. BEING is manifested in entities such as professional being, employee, patient, user, expressions of the society’s way of functioning.¹⁴

Scraping away at these certainties means questioning them, considering them against another possibility of care delivery, one that is willing to experience the search, not in the attempt to fill in the gap with a “hand full of fingers”, halting pain and caring for “another”. The meaning of providing care shifts to occupy a place of passage, another element of the composition and the meeting with another. Hence, providing care is an act conjugated “with” and not “for” within a practice that does not listen to a format and provide a diagnosis, but a practice that emerges from affections intrinsic to this practice, in which affecting and being affected enable the creation of this unprecedented arrangement, enabling openness to what produces life.²¹

Health work has generated mixed feelings in nurses, pain and joy from providing care to some but not to others. The participants highlighted the meaning of a great sense of sorrow due to being unable to provide care to their family members the way they care for the service users.

The mixture we live with everyday [...], you have no rights in your space, you know? At the same time, the joy you experience for providing care to another [...]. At the same time that I’m very happy for being able to do things, help people, care for people, there are times I’m in need too or when my family is in need and

I can’t care for a person to whom I am close, I have to allow that a distant person provides care. It’s sometimes a bit painful (M6 - N 4).

This testimony confirms the idea that for nurses who provide care to another, giving and receiving triggers resentment for giving to others what should be given to their own, their clan, reiterating the binary logic of HAVING or BEING.¹⁴

One has to consider that the materialization of capitalist production¹⁵ crosses the micro-politics of health work with new ways to exploit exchange value at the expense of use value. The worker produces something valuable s/he does not use, reproducing the capitalist logic of exploitation and alienation.

The health work, as affective work, produces value that is directly implicated by the way we relate with another and it is this affection that the one responsible for the meanings attributes to the work itself and to the care it enables.²¹

The pain nurses experience in their work routine is also characterized as a tangle of emotions, such as networking and support. We emphasize that these were the expressions that emerged as being linked to experiences in the health family strategy.

First, I thought in pain as a tangle of emotions we experience daily. Then, I thought in the network as the support I need to deal with it: with the pain, the emotions, with the stress, with the situations we experience that are not like this (M6 - N 5).

The meeting between the health worker and patient requires, in its complexity, a network that provides support, that multiples as a rhizome, infinitely expanding points of connection to provide care and produce “klinikas”.¹⁴

In the micro-politics of health work, the live work, which takes place in the act, configures power production of connection networks, not always visible, and which often opposes what has been established, the rigidity of standards, favoring access and care delivery to patients,⁹ but which can also be subsumed by them. This is a perspective experiencing tension in the routine that can enable other ways to deal with pain in the practice of “klinikas.”

There was also the expression of pain as a Rubik’s cube, a toy recalled in the activity, seeking to express the diversity of situations, each color would represent a team, requiring reflections and positions. But the cube did not turned into a cube, it became a wheel:

[...] realizing that someone else's pain becomes yours. And then the Rubik's cube gave me an idea that seemed that [...] the components are there [...], gives me a million possibilities. It is as if each color represented a team and then you can change the sequence of these colors and build it. Sometimes, you create a sequence that triggers [...], there is no way to provide enlarged care without becoming involved [...]. The pain and the delight to see another suffering and become involved with the pain [...]. But, on the other hand, even when you want to, you can't [...]. People! [...] I guess I'm inventing the wheel again! It's more a ball than a cube. At least the wheel spins, right? (M6 - N 6).

The idea of the toy - a Rubik's cube that turned out a play - the wheel, is the expression of production in the health field as power of life. The power of the differences in histories, projects, desires, and living conditions that enables the same life to be reinvented through a child's innocence and joy, creating new meanings.²¹

The patients' pain that mobilize nurses to provide care

In one of the meetings, the nurses were invited to draw significant aspects of clinical practice. The hidden pain that spreads out was portrayed as the one that mobilizes then to provide care.

For me, this pain is a hidden pain [...] because I think that it is hidden behind the physical pain, behind the aggressiveness, anger, laughing, weeping, behind the 'I want to talk to you for a minute.' It's a crazy pain really [...], it spreads, [...] and causes a lot of other interference in others... (M5 - N 7).

The "I want to talk to you for a minute" hides intense pain with which nurses have to deal with, which generates discomfort. In this moment, the group discussion hovered in the air with a meaning of exploration/expropriation of attention, of energy.

When researchers²² deal with the theme of moving from pain to pleasure at the workplace, they highlight the pain-displeasure-work triad, which, in general, unfolds in the individual treatment of the worker's illness or in labor claims oriented to the group. The exploitation of workers, the robotization of tasks, a lack of purpose to work and a lack of creative processes, lead to an empty work. A lack of preparation in the face of complex situations expands devaluation. A potential path

to face illness is invention, the (re)creation of the worker him/herself and his/her work process.²²

This pain-displeasure-work triad is not expressed in the routine of nurses. On the contrary, it works through the naturalization of individualizing practices and resonates through the historically and socially constructed conception of a profession of selfless individuals, becoming distant from the clinica of affection.¹⁴

From the perspective of the Dejourian psychodynamics of work, the collective reflection of meanings of suffering that accrue from work had positive repercussions, enabling the creation of new meaning for work.¹⁸

Another pain that mobilizes nurses to provide care is the pain of the soul:

[...] I cannot represent it. Or, the blank paper may be the pain I guess the nurse can take care of [...] pain that perhaps only someone can sit, listen, look in the eyes, talk, be available, provide such care [...]. So, maybe a pain of the soul [...] (M5 - N 3).

Pain that cannot be expressed but that can signify practice and skills required by nurses to provide care. Why "maybe a pain of the soul"? Would it be pain that accrues from suffering and not being able to perform one's work? The meaning of the participants was pain that accrues from care such as pain of the soul, the same care that should be the soul of the health services.⁹

The nurses also reported they were sensitive to pain in excess, pain that overflows:

[...] it's a pain that grows and grows [...]. Emotions that overflow as rain in excess. So, it starts and gets you [...] poor person, starts to somatize, one thing then another... And we try to listen, have to keep this contact and keep listening [...]. The conversation reveals the distress the person is experiencing. And then, many times you also incorporate all that, and you cry also, you suffer also (M5 - N 2).

Another pain that affects is the one that is compared to a very heavy burden, as a heavy stone. The nurse testifies of the following when describing the drawing:

[...] it's a little person carrying this immense, heavy burden, shaky legs, trembling little arms. And he brings all that to us, which is stress, pain, grief, lack of money, contempt, lack of schooling, of work, hunger, quarrel with the family, poor service, bolsa familia, lost exam, anger [...]. I wanted to draw a nurse helping him*

* A program aimed to directly transfer income to benefit families in poverty. Source: <http://www.mds.gov.br/bolsafamilia>

to carry this stone, because this is how I feel. We help him, somewhat, help him a little to carry this burden, to bear the pain, give him some support (M5 - N 1).

The possibility of bringing some relief to the patient, of helping him to carry the burden of his pain draws the nurse to provide care, which despite the affection, does enable freedom and (re) invention of life.²¹ We highlight the diminutive “little patient”, an expression that reveals hierarchy, deletion of identify and control, which are aspects inherent in the established practice that is expected to be overcome.²³

Over the course of the discussion, in addition to many meanings of patients’ pain that draws the nurse toward providing care, the participants indicated a span of knowledge required for care, such as humanization, integration, bonding, subjectivity, knowledge concerning anthropology, psychology, sociology, of networks, knowledge about the Brazilian health system and also, semiology and semiotics:

[...] and semiology and semiotics are techniques that you use, inspection, palpation, auscultation, to identify signs, symptoms, and see, try to concretize the physical pain, whether it really exists or not [...] (M5 - N 3).

Such knowledge and skills are used to perform physical assessments and to establish a care plan. These are soft-hard technologies that are necessary to clinical practice but that can limit the live work that is produced in the act if they are considered the single purpose of nurses.

Therefore, we highlight the role of academic education, which often reifies the technique and fragments education, contributing to the maintenance of professional practice as subordinate and downtrodden.²⁴

The nurses also explore the meanings of the production of knowledge that result from clinical practice in the groups, acknowledging that knowledge not taught at school is acquired during practice and is important for problem-solving.

The patients’ pain that discourages nurses from the supply of care

The routine and perception that problems appear repetitively in practice seem not to be very challenging to nurses: *so, it is repetitively dealing with everyone: social problems, biological problems, emotional problems. It’s... I guess nurses’ practice is very repetitive (M3 - N 6).*

Additionally, some situations cause nurses to distance themselves from care delivery.

Then I thought about doing this yin and yang little ball [...] so I put this closed little eye and opened little eye, what is this pain that touches me? [...]. I wanted to close this eye because there is pain that we, when close to another, affects us directly [...]. I guess that there is pain that mobilizes nurses differently [...]. The pain that affects nurses is a pain they are able to encode [...] and sometimes, we don’t succeed (M5 - N 6).

The nurses realized that there are times when they close themselves to the pain of patients; they cannot bear the pain, and sometimes the pain of patients is very much alike that experienced by the nurses themselves. Also, in an attempt to defend and protect themselves, they “close their eyes”, and become distant.

They refer to the pain of the history itself, of an excluded profession, one that is of submission, with little visibility: *we only recognize what we know. And we are talking about pain, problems, about coping situations that patients bring to us [...] we’ve already lived it. Our nursing history, we have already lived this [...] it is rooted in our profession [...] (M5 - N 1).*

Nurses and nursing, constructed as a minority, assume their bodies are fragile, and consequently “cannot bear” and feel repulsion at pain, and also the impossibility of supporting another person. And, no matter how strongly the established care model is reaffirmed, the model centered on the biological body, seeking to maintain the nurse’s *status quo*, that of nurses providing nursing consultations and/or systematizing nursing care, nurses may not recognize themselves when implementing this practice, after all, what is this practice? Is it the same as the physician’s?

On the other hand, “not being able to bear” may function as a device used to move toward more libertarian forms of care, refusing the hegemonic way of care delivery.²¹

Feelings of disgust that are produced in the meetings with patients were explicitly expressed:

[...] I don’t get along with you. There are people like this [...] So, if I’m by myself, I provide care to the person, no problem. But, if I have a colleague with me, I leave in order to avoid problems, to avoid conflicts. I guess this is also a way of providing care (M5 - N 7).

Affections are vibrations captured by the body. They are not visible¹⁵ but they are concrete in the relational space and in the conformation of care delivery. In this movement, the nurses perceive the paradox that the same pain that causes

them to become responsible for the care, is also the pain that often causes them to get away from care or refuse to listen and establish bonds.

N 7: *we see ourselves in people.* N 6: *and sometimes, there's this person I don't identify with. I have no interaction, no empathy and it doesn't work.* N 3: *the pain doesn't emerge* (M 5).

The nurses realize that they become somewhat "anaesthetized" during clinical practice, become somewhat "blinded" in relation to another's pain, a paradoxical situation that is part of the context of health workers, since the basis of any technique is the relationship.²¹

Does the modeling clay, a child's toy, become an object that hinders expression, prevents workers from expressing themselves in the group meeting, with a fear of expressing what they feel? Or, because it is too malleable, does it mobilize primitive and contained emotions? At this point of the discussion, the pain of nurses overflowed in tears.

I can't look at my pain!! [weeping] (M6 - N 7).

A welcoming and supportive climate is created and the group has a mutual acknowledgment of the unsaid: partnership, tensions and conflicts experienced in the everyday life were shared. Histories and histories of pain and doings. Care that is woven together in the research-intervention group.

Instead of asking "what does this pain say?", they become stuck in the endless stream of tasks and do not even permit it to emerge.

But they did ask in the reflection group: Why do I do everything? They reported actions such as: being responsible for the key of everything; attending unexpected meetings; taking care of general issues; having their work area invaded by demands of a varied nature. The "do-everything", also reported as multifunctional,²⁰ generated discomfort:

[...] but after I left I realized, I became so upset with that. I could have done it and not become bothered by it, you know? (M6 - N 5).

[...] based on what you said, it seems you'd like to have done it differently (M6 - N 2).

But the do-everything has advantages; what would they be? Self-affirmation that one is capable of doing? But in order to do everything, one has to stop doing what is specific to one's profession and that defines one as a nurse, which leads us to refer to the clinical practice of nurses as a unique practice focused on the needs of patients as one of

the responsibilities of nurses in PHC. Are nurses prepared for this practice?

Strategies adopted to deal with pain faced during practice

Sharing with patients and other workers seems to be a way to deal with pain that accrues from care. The analysis of the clinical work process led the group to confirm that the clinical practice is constructed with the patient and that the production of care involves helping patients to deal with life problems, considering all the complexity inherent to the proposition of change.

When you contact her and show her how important it is to take the medication, how she will include it in her everyday life, which is what I understand of this enlarged practice, there is no prescription. So, when you really work with other social political aspects concerning the change of the disease. This is what we are constantly called to do (M2 - N 6).

This perspective corroborates a study addressing the aesthetic perspective in care delivery and education.²⁵ The possibility of relying on other workers in the staff is important but teamwork is a inter-game of relationships that dialectically materializes competition/cooperation.²⁶

The distress people express and the proximity to them makes us feel like we are inside their homes, their families, having very close contact with suffering in Family health [...]. I guess nurses listen a lot and come into deep contact with suffering, but I see other people on the staff, the community agent, who is also in the homes of people [...] and deals with suffering and reports it to the staff. We also share (M5 - N 5).

The Family Health Strategy allows the staff to come into contact with the patients' lives, with their pain and suffering and also enables sharing with others new ways to provide care, to bear and overcome, to live with their reality of life. Hence, a collective construction of care may replace the fragmentation of knowledge, the juxtaposition of tasks. Doing together, or teamwork, is confirmed as meaning for clinical practice in the health field.

FINAL CONSIDERATIONS

The nurses' clinical practice within the PHC sphere was presented in this paper in four plans in which the meanings of affects intrinsic to such practice were explored. Having to face the patients' pain causes nurses to face their own pain, generating movements that enable the production

of care but that, at the same time, can also generate feelings of withdrawal and revulsion.

This study reveals that the routine clinical practice of nurses is in agreement with their education that is focused on the biological body and disease, even though they make an effort to develop practices that overcome such a perspective. Hence, we stress the need to invest in the education and qualification of nurses to develop a practice that is more suited to the task presented in the PHC, in which the production of care is possible, providing care to themselves and to others.

In this context, the study shows the importance of paying attention to how the family health strategy and the work of nurses has been implemented, because we need workers with management competencies and skills to systematize the nursing work focused on the population's needs, and nurses who master the technologies required for the exercise of an enlarged practice and integral care in the context of the Brazilian health system.

The pain of the soul expresses the pain of nurses when they face a lack of meaning in their own work. This loss of meaning concerning what it is to be a nurse has the power of "come to be" connected to the worker's projects, interests and desires, patients and staff, especially if this loss of meaning is the nurses' object of reflection.

The collective spaces for reflection upon routine work may enable a "clínica" of an unprecedented creation of care, the primary purpose of which is not the diagnosis and guidance of others, but rather it is the recreation of oneself, of another, of work, and ultimately, of life.

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