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RESEARCH

O trabalho clínico da enfermeira: para além das doenças crônicas

Nurse's clinical work: beyond chronic diseases

El trabajo clínico de la enfermera: más allá de las enfermedades crónicas

Silvia Matumoto ¹, Bruna Turaça da Silva Manso ²

ABSTRACT

Objective: analyze one case of nurse's clinical care at the primary health care (PHC) level. **Method:** qualitative approach that shows a research cutout on nurse's clinical practice at PHC. Three nurses from Family Health teams participated in the matrix support stage. They thought through cases where they provided care, selected and narrated during support meetings, highlighting what has mobilized them, which were their concerns, what they thought at the time of service, and what they think at the time of case report. **Result:** we analyze the case of a woman with chronic illnesses in mental health, hypertension, diabetes, and obesity that emerge throughout her life. The nurse takes an attentive and respectful listening position, seeking to develop autonomy through user's awareness of her own situation. **Conclusion:** it is concluded that the nurse has powerful tools for longitudinal monitoring that go far beyond the disease. **Descriptors:** Public health nursing, Primary care, Continuity of patient care, Work.

RESUMO

Objetivo: analisar um caso de atendimento clínico da enfermeira no nível de atenção primária à saúde (APS). **Método:** abordagem qualitativa que apresenta um recorte de pesquisa sobre a prática clínica da enfermeira na APS. Na etapa de apoio matricial participaram 3 enfermeiras de equipes de Saúde da Família. Elas realizaram reflexão sobre casos por elas atendidos, selecionados e narrados nos encontros de apoio, destacando-se o que as mobilizou, quais eram suas preocupações, o que pensaram no momento do atendimento e o que pensam no momento do relato do caso. **Resultado:** analisamos o caso de uma mulher com agravos crônicos em saúde mental, hipertensão, diabetes e obesidade que emergem ao longo de sua vida. A enfermeira se coloca em posição de escuta atenta e respeitosa, buscando o desenvolvimento da autonomia a partir da consciência da usuária sobre sua própria situação. **Conclusão:** conclui-se que a enfermeira tem ferramentas potentes para o acompanhamento longitudinal muito além da doença. **Descritores:** Enfermagem em saúde pública, Atenção primária, Continuidade da assistência ao paciente, Trabalho.

RESUMEN

Objetivo: analizar un caso de atención clínica de la enfermera en la atención primaria de salud (APS). **Método:** abordaje cualitativo que presenta un recorte de investigación acerca de la práctica clínica de la enfermera en la APS. Tres enfermeras de equipos de Salud de la Familia participaron en la etapa de soporte matricial. Ellas hicieron examen de los casos que atendieron, seleccionados y narrados en las reuniones de apoyo, destacando lo que las movilizó, cuáles eran sus preocupaciones, lo que pensaban en el momento del servicio y lo que piensan en el reporte del caso. **Resultado:** se analiza el caso de una mujer con enfermedades crónicas en salud mental, hipertensión, diabetes y obesidad que surgen a lo largo de su vida. La enfermera toma una posición de escucha atenta y respetuosa, buscando desarrollar la autonomía desde la conciencia de la usuaria acerca de su propia situación. **Conclusión:** se concluye que la enfermera tiene poderosas herramientas para el seguimiento longitudinal que van mucho más allá de la enfermedad. **Descriptor:** Enfermería de salud pública, Atención primaria, Continuidad de la atención al paciente, Trabajo.

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INTRODUCTION

Nursing work provides the healthy or sick individual, family and community, with care, taking actions to promote, maintain, and recover health¹, thus contributing to implement and consolidate the Brazilian National Health System (SUS).

In the process to implement SUS, nurse's work at primary health care (PHC) has undergone transformations and changes, requiring more clinical actions.^{2,3} This movement emerges within services, whose hegemonic practices maintains the predominance of working focused on the physician, emphasizing the disease, something which establishes daily practices more frequently related to urgency care and production of procedures. Especially at the Family Health Strategy (FHS), new care demands have been assigned to the nurse, leading to a need to reframe her clinical work so that it becomes a practice aimed at the user, comprehensive and problem-solving.⁴

Expanded clinical work shows up as a tool for health work processes aimed at the production of care focused on users, in a practice that goes beyond the disease, the subject, her/his context, and the community. Expanded clinical work, or subject's clinic, extends the study object and the clinical practices, its means and purposes. It aims at healing and relief of suffering, development of people's autonomy to tackle their problems and actual living conditions, through the predominant use of soft technologies and dialogued construction between health care worker, user, and team.⁵⁻⁷

The expanded object⁷ involves discussing the field and core responsibilities of each professional, concerning health problems from the perspective of risk and vulnerability, considering the senses, the dynamics of variables in risk analysis, and their actual meanings.

An increase in the means of intervention depends on the unique co-production between worker and user, for constructing the therapy project, which operates in 'co-management spaces,' sharing knowledge and risk and vulnerability assessment of an individual and the community.⁷

The clinic is a relationship and intervention-producing space that results from a game of dispute and sharing of needs, interests and technological ways of acting. In addition, the clinical practice is directly related to organizational support of health services to the facility's practices and mission.⁸

Thus, the clinic is characterized by the focus of actions within the individual sphere, but it extrapolates the individual meeting time, by unfolding into actions that go beyond this unique worker-user space, within the collective sphere. Just as the actions aimed at the collective domain cannot do without individual approaches to provide diagnosis and health prevention and promotion actions.⁷

We may claim that the challenges for a nurse in expanded clinical production cover the effectiveness of co-production of actions and subjects; focus of the work process on user's needs⁸; and establishment of nursing practices through relations with other practices, in a dynamic process of reconfiguration of the core thresholds and competence and responsibility fields⁹, considering the specific knowledge topics of each profession, workers' potential, users and community resources, and the needs of each case. Care from the expanded clinical perspective requires a nurse's work also driven by an expanded health care design, as well as relational skills and reflective ability.

In daily life, the nurse is faced with difficulties to fulfill her clinical work¹⁰, which involve, among other factors, an overlapping of tasks and responsibilities in the organizational and clinical context¹¹, worsened when they pursue a managerial position¹²; and affections with regard to the pain and suffering of users and their families.¹³

Believing that such work may become easier if it can resort to matrix support⁹ or supervision, we provided in one of the research stages, 'the expanded nurse's clinic in primary health care,' matrix support to FHS nurses. We seek to grasp the characteristics of the nurse's clinical practice, the way how she faces the difficulties of working from the comprehensive perspective through expanded clinic, and the nurse's self-reflection process concerning her job.¹⁴

It is noteworthy that self-analysis leads the worker to think through her/his own practice, looking at her/himself and the other, the way how she/he operates in this action, analyzing her/himself as a subject in relation to it. The professional is also mobilized to look at the other, to the person who is provided with care, as well as to grasp how such other affects her/him, i.e. what she/he (user) brings that pushes and mobilizes a professional for care.^{6,13}

In this movement, the nurse goes through self-analysis and self-management procedures, i.e. she analyzes her own work, review her daily practices, recognizing restrictions and possibilities in face of the results achieved or not and, in the same process, having in mind affections of the self-analysis process, she gets involved and mobilized in decision-making, then driven by the new meanings and possibilities of action.¹⁴

We used as theoretical and methodological framework the health care working process¹⁵, its technologies and micropolitics⁸; the expanded clinic^{5,7}; and some concepts of institutional analysis¹⁴ from the perspective of intervention research¹⁶ and matrix support as the pedagogical support.⁹

Analyze one case of nurse's clinical care at PHC, exploring the clinical practice levels.

METHOD

This is qualitative research that was carried out through intervention research.¹⁶ This, in turn, is a participatory research mode, where researcher and participant are co-authors in the research process.

In the proposal of institutional analysis:

[...] the survey time is the moment of theoretical production and, above all, production of the object and the person who knows it; the survey time is the time for intervention, [...] intervention research has as its theme asking about the 'meaning' of action.^{16:73}

Thus, the matrix support time was also regarded as a data production moment, relying on researcher and nurse participation. During the meeting, we sought to grasp the meanings of practices¹⁷ for nurses, through the accounts of cases, what has mobilized them, which were their concerns, what they thought at the time of service, and what they think now, when reporting the case. Thus, the research route took place simultaneously as a process of intervention and knowledge production.

This simultaneous production took as its starting point the nurse's objective and subjective accounts, who, in turn, has shaped a drawing of psychosocial landscapes with meaning transformation movements. Such transformation took place at the same time by dismantling and creating certain worlds, which are created for(by) expressing affections.¹⁷ The survey took place as a kind of 'journey,' one and only, unique, and unrepeatable, where the most significant thing is novelty, difference, and uniqueness. Registering it in a 'logbook,' a 'book machine,' whose movement, speed, longitude and latitude, density, intensity contributes to 'make up worlds.' Research, as a 'map,' may serve so that other travelers build their own route, their adventure.¹⁸ To do this, it makes use of tools from the cartographic method.¹⁷⁻¹⁹

Within the period from January to June 2013, 27 meetings with 3 nurses were held, in order to discuss cases that were monitored/provided with care. The meetings were held on a monthly or fortnightly basis, varying according to nurse's availability of time.

For registering data, a logbook was used, a researcher's instrument where her impressions and emotions about the moments experienced were recorded; and there was digital recording of matrix support meetings, which were transcribed for rereading at a later date for apprehension of new meanings, relying on the contribution of researcher's journaling and theoretical framework.

We select one of the cases narrated by one nurse to address the expanded clinical practice.

The investigation was approved by the Research Ethics Committee of the Ribeirão Preto School of Nursing of the University of São Paulo (EERP/USP), under the Procedure 0832/2007. All

participants signed a free and informed consent term, as required by Resolution 466/2012, from the Brazilian National Health Council (CNS).

RESULTS AND DISCUSSION

Case: *Learning to self-care*

Mary (58 years old), fictitious name, case brought by a community health worker (CHW) to the nurse as someone who moved into the neighborhood and had no clinical and psychiatric monitoring, because she had failed to attend the mental health appointment. She also had hypertension, diabetes, dyslipidemia, and obesity, among other illnesses.

In the process of monitoring Mary, the nurse realizes that she does not comply with the treatment prescribed and adopts 'natural' treatments, such as using propolis for skin lesions, soy milk instead of the calcium prescribed by the gynecologist, and teas instead of the medicines indicated by a psychiatrist.

One of the nurse's concerns during the appointment was gathering information about her health status and treatments, medicines, who had prescribed them, in which health service, her diet, trying to reconstruct the route. Thus, she could discuss with the physician from her team so they could expedite the steps needed to help improving the patient's health status.

The nurse surveys Mary's life story. There is much suffering in childhood, she underwent a kind of child labor, as a servant to her cousins, whose parents were richer. She felt humiliated and, at school, due to her feelings of inferiority, she did not join groups, and became discriminated against. She got married at a very young age, and started caring for her husband and his family. When reporting her story, Mary realizes that it is easier to care for others than for herself. Mary also reports that at 19 year of age, she had an emotional crisis and needed psychiatric care. She married a man from the same church and had no children. In the church, her husband had a role that made him help families and individuals and Mary accompanied him in this activity, until she could no longer accompany him, staying home without any mood, just lying, something which brought conflicts to the couple's relationship. Mary also reports difficulties in getting mental health care.

The nurse, after confirming Mary's efforts to schedule her appointment, due to difficulties involved in organizational access, as it involves routines, rules, and standards incompatible with the conditions and situations of users who need specialized mental health care, sends a written request to the Mental Health Coordinator of the town, in order to enable the appointment with a psychiatrist. After several weeks, and until discussing the case, the response on the application for Mary had not been received, yet.

[...] as sometimes the person is not emotionally capable, it is difficult to her having the initiative to go there, right? Attend a scheduled appointment on time, in some occasions, events happen, right? I also do not know whether within psychiatry this need to go in person has any... [...] the requirement to adhere to a treatment, as a whole, patient's will, this is expressed in that action, right? But, then, if I could provide this [...] he [name of the mental health coordinator] will be able to help, certainly, he will help her. (Nurse 1 - Case 2)

Through monitoring, the nurse tries to make the user feel cared for by the team, in order to grasp her thoughts and beliefs about her treatment and the diet prescribed. It becomes clear there is a need to persist in providing advice on diet, the medicines that woman should take, the nurse believes that a professional should not be discouraged. In her report, the nurse takes into account the time Mary needs, even her difficulty to change the way of relating to people and herself, she has always provided others with care.

In the movement to grasp patient's difficulty to adhere to treatment, the nurse identifies Mary's guilty feeling for not providing her own mother with care, who is currently in a long-term health care facility; Mary reports that her father died three years ago, with a history of alcoholism and stroke.

The nurse analyzes Mary's appointments sequence. She reports that, when Mary failed to attend one of them, she (nurse) called the patient to check whether she was okay and recalls that this contact was crucial so that the user resumed treatment. Then she speaks of the user again, her new home of residence, the fact that it has required a change of mindset, because she felt her life was a mess. In her former home she had a place to pray and she just could not find such a place in her new home... Despite the difficulties, the user refers some improvement, though she does not know how to describe it, but she says that now the distance between her home and the health center is much smaller.

The nurse goes on with her work, in order to identify the resources the user and her family possess. The professional tries to make her husband participate in the treatment, concerning the procedures the Brazilian National Social Security Institute (INSS) for retirement, by accompanying her at the specialized health care facilities she needed to attend, such as dermatology, ophthalmology, and scheduling of psychiatric care.

Looking for strategies to make Mary learn to care for herself, the nurse investigates patient's beliefs and religious positions, showing a respectful attitude; and she proposes the patient engage in pleasurable activities, such as reading and praying; and also proposes the practice of breathing exercises. This has led the very user to realize that sometimes her breathing decreased, so she related this fact to her very will to live, which followed the breathing rhythm.

In a dialogue with the user, the nurse identifies another issue to address, menopause, and what it represents for Mary. The cessation of menstruation was expressed as malaise, dyspnea, feeling of swelling, noise in the ears, headaches, hot flashes, and anal bleeding. For her, the blood that does not come out through menstruation produces bad odor in her body. This issue is taken to the doctor, who would see her soon. At the same time, the nurse keeps

Mary's weekly visits to move forward with the plan to help her to adopt self-care practices. In this way, the nurse lists on a sheet of paper all medicines so that Mary does not get lost in her treatments. This strategy was followed up by the CHW, who reported that in the early days the drug list hang on the refrigerator worked, but then it fell into oblivion. The nurse took up the issue with the user in one of the sessions and started working on self-awareness, in the process of learning how to provide self-care. The nurse reports what Mary says:

"I am looking only at the other side for a long time and I just forgot. Now that I have this opportunity to speak, I have never had it, indeed... I had so much trouble to schedule a doctor, I went there for six months before attending an appointment. And now, here, I can come every week, there are people going to my house!"

So, I guess now she has this ability to look and be looked at, right? (Nurse 1 - Case 2)

Besides, the nurse devotes the very service time to the user, weekly, and also schedules other times to her, before and after the contacts were triggered and she sought for information to make problem-solving easier, e.g. the contact to the mental health coordinator so that Mary can attend the appointment she lost with the psychiatrist; discuss with the physician from the team what was the appointment about and the behaviors needed so that they can devise a shared health care plan also involving the CHW, another health professional actively participating in the case.

Another aspect that draws attention concerns the respectful attitude with regard to the moment, user's movement, who had always just provided others with care and now she has to learn how to provide herself with care. Nurse's willingness to provide people with care is also noteworthy, demonstrated by her outstanding sensitivity and listening skills.

Clinical practice consists in successive meetings⁶ between nurse and user. In the case resumption process at the time of matrix support some meanings of work have been confirmed, other meanings have lost their relevance and they were reconstructed from new perspectives, and new meanings and doubts have been shaped, in this exciting hidden world of life as it actually is.

In the movement to introduce the case, some aspects of the meanings of clinical practice have been drawn, from the perspective of sharing with a focus: "what has happened?"²⁰

Starting from the literature, Deleuze and Guattari²⁰ explore the novella as a literary genre, in search of findings. The novella carries a memory of the past, but it also leads the reader to the expectation of what will happen. It keeps within itself, in a way, a secret to be unveiled, and at the same time it puts into play "attitudes of the body and spirit, which are like folds or wraps, [...] states in which the body is surprised when something has just happened."^{20:65} "The novella is defined in terms of live lines, meat lines, and it operates in relation to these lines, in turn, there is a very special revelation."^{20:66}

Deleuze and Guattari²⁰ point out three kinds of lines, tangled each other in us, which goes through us in the social living space. The first line might be hard segmentarity, which may be binary and it works with binary choices, such as men/women, rich/poor,

inside/outside, home/street. In operation, these segments set the code and territory and they imply a power device. Segmentarity operates the organization of State social space into segments, it defines the forms of movement between these segments, building a hierarchy and a bureaucracy that become very inflexible. The second kind of lines, circular segmentarity drawn in circles, operates in a rather flexible way or not, according to its operation. In a rather flexible regime, the circles do not resonate all together, they do not fall into a central point. When there is hardening of circular segmentarity, all circles resonate and they fall into a same central point of accumulation and significance, which goes through all circles and it goes again through all segments, such as the State apparatuses with its bureaucratic machinery. And the third kind of line, i.e. escape lines. These are imperceptible, they are movements hard to grasp, which begin in the middle, they are in the middle, in the entanglement of lines, and they have some kind of mystery. They express molecular flows of becoming, creation, which “break” the pace of the usual daily life, they cause a break of certainties, cause dispossession, so that no one can come back to the previous situation.

In the clinical practice, a well-delimited and strict line shapes a plan, a certain starting point towards other experiences. The line of knowledge and practice instituted about such pathologies, i.e. hypertension, diabetes, obesity, and mental illness, for which there are previously outlined forms.^{1,11}

Control devises a clinical practice plan for the nurse.

The mode set for this clinical practice is observed, making the focus of attention lie on formal issues, programmed actions, structured, within the scope of control: medicines, diets, examination; these actions are defined as its abilities and responsibilities. This course of action is grounded in the technical division of knowledge and practice, which is delimited by hard segmentarity lines.²⁰

In the hegemonic way of health work, such segmentarity has appeared in a standardized configuration, having an only core - physician's work. Some investment movements for change have contributed to make things more flexible, so that the circles do not have a single core, bringing more movements, other viewpoints, such as: the FHS, focusing on the family, community, and teamwork, considering singularity¹; the proposed work aimed at the user⁸; and other proposals for interdisciplinary work, humanization.²¹

Thus, to the extent that the nurse takes the clinic aimed at the user and follows the path of knowing, sharing, and seeking ways to make care quicker along with the physician and the CHW, other circles are strengthened so that, here, the circular segmentarity²⁰ has a function with no single core, which provides a rather flexible nature to the clinic in construction.

Going further in the search, the nurse focuses her clinical work on the user and she has this main question: “What does bring suffering?”

The attitude interested in understanding the case constituted another level of clinical practice.

The search for information goes beyond the collection of clinical history; an attitude interested in grasping the case, which seeks to apprehend some element that proves to be very subtle, between the lines, which is on the prowl, waiting for the best time to show up,

waiting for a situation of greater security and confidence to be revealed, it becomes key to the expanded clinic.

This movement of search makes room for the perception of the third kind of segmentarity lines, the escape lines.²⁰ They emerge amid the process, with little demarcation, this curiosity movement interested in solving the problem, involving some availability to be with the other in the process of a rather comfortable and painlessly situation.

The escape lines operate very closely to the soft technologies of the working process⁸, they often seem not possible to be distinguished from each other. Both operate with the power of change, rupture, creation.

And, in the movement of search, aiming her work to reduce suffering, the nurse uses the tools at her disposal. In this way, the construction of the bond constitutes another level of clinical practice.

The construction of bond requires an investment by nurses, an attitude that embraces suffering, looking beyond the immediate complaint or need, which unfolded in concrete actions such as the active search in a situation of lack of response, making the agenda more flexible, with closer responses, interest in monitoring users in other services, when referred to them, among others.

Another established plan was delimited by the search for resources to tackle problems and situations along with users. A blend of elements was activated, some of them are more traditional, such as the list of medicines hang on the refrigerator; others have already been announced, but they are not always used, such as calling the husband to collaborate to the care, asking the mental health coordination to require agility to schedule a specialized appointment.

Considering the concept of technologies as resources of the health work process, we also include the knowledge tools that nurses carry on this clinical practice plan. In this case, we highlight education in the mental health field and mastering a brief intervention as elements that converge on the expansion of the clinic.

In support meetings, another level has been shaped as a nurse's clinical practice plan, the time level of (in) care.²²

This plan was expressed at the crossroads: providing the other with time (nurse's availability) and waiting to be provided with care by the other (the user). On the other hand, this time, somehow, was also established in the very act of survey data production, in listening to the cases, providing time so that something happens. This is the time of (in) care. One's own availability to be with the other, aiming attention, looking, interacting. As a fold, this nurse's time is also the waiting time, the other's time to do something agreed, as a change in the diet, the onset of a physical activity, the right dose of medication, and many others over which, at PHC, there is no control.⁵ There is a need for the nurse to do that, and the worker is committed to the work done and waits. Such waiting expresses complicity, agreements, limits, risks, understanding in case of a relapse... The time of (in) care is the time of creation.²²

Time also emerges as a frequency. This is the chronological time, observed in daily life, showing us finitude, the limit. In the case introduced, the meetings took place on a weekly basis, the nurse handled frequency in a unique way, with a view to building care.

Clinical practice unfolds in the record time. Nurses need to document the cases they provide with care, both on the computerized system and on the user's medical record. Often, the time designed for an appointment does not allow the record to be made on-the-spot or immediately afterwards, and the records accumulate.^{11,12} The many other records that the nurse should provide are also a burden: Brazilian Primary Health Care Information System (SIAB), Brazilian Prenatal Care and Childbirth Humanization Program Monitoring System (SisPreNatal), Brazilian Health Information System (SIS)...

Care is constructed with the user, her material, family, inner, and other resources, and also with nurse's resources. Here, another sort of time is demarcated, that of nurse's experience. This time bifurcates into other times. The time of nurse's experience in providing that case with care, as an event²⁰, something which brings out a break that makes herself and also the user change. The other time of nurse's experience refers to the length of time working with that team, at PHC, providing nursing care, might be time as a thickness that is there and does not appear, but it gives support and confidence to provide care, and take certain risks... gives room to share doubts and certainties, negotiate steps, devise alternatives... This experience time is also the time of knowing: knowing the territory, knowing families, knowing people, knowing colleagues in the team, knowing the cases, knowing the community resources, knowing one's own resources. Experience and knowledge, when properly exploited, bring intensity to the time of providing care.

CONCLUSION

The case of providing clinical care for a user with chronic illnesses, performed by a nurse in a Family Health team enabled addressing clinical practice plans that go beyond the focus on disease.

Neither the case nor plans are replicable, since they are unique.

The plans demarcate some potential surfaces that shape the nurse's clinical practice, surfaces whose contour is provided by lines of established segmentarity, flexible and enabling escape.

The treatment control plan, whether based on medicines or not, may open up at the intersection with other plans towards new creative possibilities, new discoveries, such as the search for grasping the case, constructing bonds, joint search for solutions to problems, a willingness to assign time to care and experience it as an event.

Thus, the case instantiates nurse's power at PHC to make life go on when the disease ceases its process.

This article has the limitation of dealing with an only case, but it contributes by providing some knowledge on nurse's work at PHC, bringing elements to the debate on the expanded clinical practice, at the crossroads of qualitative and quantitative perspectives. After all, nursing as a social practice needs to respond to this need of society.

REFERENCES

1. Brasil. Portaria n. 2.488, de 21 de outubro de 2011. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes e normas para a organização da Atenção Básica, para a Estratégia Saúde da Família (ESF) e o Programa de Agentes Comunitários de Saúde (PACS). Brasília (DF): Ministério da Saúde; 2011.
2. Matumoto S, Fortuna CM, Kawata LS, Mishima SM, Pereira MJB. Nurses' clinical practice in primary care: a process under construction. *Rev Latinoam Enferm* [serial on the internet]. 2011 [cited 2015 Sep 13];19(1):123-30. Available from: <http://www.scielo.br/pdf/rlae/v19n1/17.pdf>
3. Kawata LS, Mishima SM, Chirelli MQ, Pereira MJB, Matumoto S, Fortuna CM. Os desempenhos da enfermeira na saúde da família: construindo competência para o cuidado. *Texto & Contexto Enferm* [serial on the internet]. 2013 [cited 2015 July 16];22(4):961-70. Available from: <http://www.scielo.br/pdf/tce/v22n4/12.pdf>
4. Malta DC, Merhy EE. O percurso da linha do cuidado sob a perspectiva das doenças crônicas não transmissíveis. *Interface Comun Saúde Educ* [serial on the internet]. 2010 [cited 2015 July 16];14(34):593-605. Available from: <http://www.scielo.br/pdf/icse/v14n34/aop0510.pdf>
5. Cunha GT. A construção da clínica ampliada na atenção básica. 2. ed. São Paulo: Hucitec; 2007.
6. Vieira AN, Silveira LC, Franco TB. A formação clínica e a produção do cuidado em saúde e na enfermagem. *Trab Educ Saúde* [serial on the internet]. 2011 [cited 2015 July 16];9(1):9-24. Available from: <http://www.scielo.br/pdf/tes/v9n1/v9n1a02.pdf>
7. Campos GWS. Clínica e saúde coletiva compartilhadas: Teoria Paidéia e reformulação ampliada do trabalho em saúde. In: Campos GWS, Minayo MCS, Akerman M, Drumond Júnior M, Carvalho YM, organizers. *Tratado de saúde coletiva*. São Paulo: Hucitec; 2006. p. 53-92.
8. Merhy EE. *Saúde: a cartografia do trabalho vivo*. São Paulo: Hucitec; 2002.
9. Cunha GT, Campos GWS. Apoio matricial e atenção primária em saúde. *Saúde Soc* [serial on the internet]. 2011 [cited 2015 July 16];20(4):961-70. Available from: <http://www.scielo.br/pdf/sausoc/v20n4/13.pdf>
10. Araújo JL, Paz EPA, Moreira TMM. Hermenêutica e o cuidado de saúde na hipertensão arterial realizado por enfermeiros na Estratégia Saúde da Família. *Esc Anna Nery Rev Enferm* [serial on the internet]. 2010 [cited 2015 July 16];14(3):560-6. Available from: <http://www.scielo.br/pdf/eann/v14n3/v14n3a18.pdf>
11. Santos SMR, Jesus MCP, Amaral AMM, Costa DMN, Arcanjo RA. A consulta de enfermagem no contexto da atenção básica de saúde, Juiz de Fora, Minas Gerais. *Texto & Contexto Enferm* [serial

- on the internet]. 2008 [cited 2015 Sep 13];17(1):124-30. Available from: <http://www.scielo.br/pdf/tce/v17n1/14.pdf>
12. Feliciano KVO, Kovacs MH, Sarinho SW. Superposição de atribuições e autonomia técnica entre enfermeiras da Estratégia Saúde da Família. *Rev Saúde Pública* [serial on the internet]. 2010 [cited 2015 Sep 13];44(3):520-7. Available from: <http://www.scielo.br/pdf/rsp/v44n3/AO1308.pdf>
13. Matumoto S, Fortuna CM, Kawata LS, Mishima SM, Pereira MJB. Cartografia das dores do cuidar no trabalho clínico do enfermeiro na atenção básica. *Texto & Contexto Enferm* [serial on the internet]. 2013 [cited 2015 Sep 13];22(2):318-26. Available from: <http://www.scielo.br/pdf/tce/v22n2/v22n2a07.pdf>
14. Baremlitt GF. *Compêndio de análise institucional e outras correntes: teoria e prática*. 3. ed. Rio de Janeiro: Rosa dos Tempos; 1996.
15. Mendes Gonçalves RB. *Tecnologia e organização social das práticas de saúde: características tecnológicas do processo de trabalho na rede estadual de centros de saúde de São Paulo*. São Paulo: Hucitec; 1994.
16. Passos E, Barros RB. A construção do plano da clínica e o conceito de transdisciplinaridade. *Psicol Teor Pesqui*. 2000;16(1):71-9.
17. Rolnik S. *Cartografia sentimental: transformações contemporâneas do desejo*. São Paulo: Estação Liberdade; 1989.
18. Baremlitt GF. *Introdução à esquizoanálise*. Belo Horizonte: Instituto Felix Guattari; 1998.
19. Deleuze G. *Conversações*. São Paulo: Ed. 34; 1992.
20. Deleuze G, Guattari F. *Mil platôs. Capitalismo e esquizofrenia*. Rio de Janeiro: Ed. 34; 1999. v. 3.
21. Brasil. *Redes de produção de saúde*. Brasília (DF): Ministério da Saúde; 2009. (Política Nacional de Humanização, série B).
22. Pelbart PP. *A nau do tempo-rei: 7 ensaios sobre o tempo da loucura*. Rio de Janeiro: Imago; 1993.

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