Nursing: from traditional to new pathways

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Abstract:
The aim of this article is to share some reflections on the identity construction process of nurses. It is based on two case studies involving two nursing teams, one working in the area of *continuing care,* the other in *community intervention,* and which are integrated in two different Health Centers. In addition, information collected informally from several groups of nurses who annually frequent the *Curso de Complemento de Formação em Enfermagem* [Complementary Training Course in Nursing] has also been used as well as specialized literature on the subject.

It is argued that nurses have constructed their professional identity on the basis of the meanings presented by medicine and the hospital institution, but nowadays, as a result of profound social changes which are occurring on all levels, their experience as carers is becoming more diversified. Indeed, it has become a central point of reflection and *the relational aspect of their work with the public* is beginning to emerge as a more significant reference in the outlook of nursing as a care profession.

It has been concluded that identity construction processes become diversified in accordance not only with the contexts, but also through transformations in the actual organization of Health Services and policies.

Key words:
Nursing, Care, Health, Identity.

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NURSING: THE EFFORT TO AFFIRM A PROFESSION

As a result of changes on all levels in society, health professionals, and particularly nurses, have been confronted with the need to re-conceptualize the profession. The social, cultural, political and economic transformations of the last three decades may potentially introduce rifts as far as identities in nursing are concerned. Identity, here, is taken to be what Castells refers to as "the source of meaning and experience of a people (…) as far as social actors are concerned, identity, to me, is the process of meaning construction based on a cultural attribute, or even a set of inter-related cultural attributes, which prevail over other forms of meaning" (Castells, 2002, pp. 2-3).

As a number of studies by a wide range of national and international authors (Abreu, 2001; Costa, 2002; Dubet, 1996; Freidson, 1970; Lopes, 2001; Petitat, 1987, among others) confirm, for many years the "source of meaning and experience" of nurses was found, on the one hand, in biomedical knowledge and in the organization of the medical profession as an ideal to be attained, and, on the other, in the values, principles and rules of the hospital institution, founded on former military and religious institutions. Both have profoundly marked the way nursing has conceived and organized itself within the overall health care panorama and the way its image has been appropriated by society. Regarded as an institutionally based profession (Aiken, 1983; Dubet, 2002), having emerged and expanded *within* and *for* the hospital, nursing has received recognition and authority primarily on the basis of the legitimacy the hospital institution has bestowed upon its work.

For many years the dominant perspective in nursing was to construct an identity based on the identification of the social group's intrinsic properties which have somehow remained stable over time. In the opinion of Correia (1991, p. 23), this view corresponds to practices giving priority to an "integrating group member role, which has tended to remain identical".

Adherence to the medical model formerly offered a coherent system of thought from which the nurses were able to infer their action and find an opening for their intervention, hence, taking on the role of doctors' assistants. By the same token, total adherence to the "institutional program" implicitly, but firmly established the values, principles and rules to be defended by everyone, which made it possible for nurses to view themselves as "guardians of the institution", thus, partially escaping medical dominance and affirming their autonomy in the management of care services.

Interpretation of the "institutional program" is based on the perspective of Dubet (2002), as: "the social process which transforms the values and principles into action and subjectivity through specific, organized, professional work" (p. 22). This program is accomplished when the values and/or the principles, which directly orientate a specific, professional socialization activity, are conceived as

a vocation "and when this professional activity is geared towards producing a socialized individual and an autonomous subject" (p. 22). This author suggests that the "institutional program" be viewed as work of a moral nature, which is developed with the socialization of others in mind. Nowadays, with the complexification of institutions and fragmentation of their principles, this work is primarily ethical, as it obliges the worker to hierarchize and combine norms of justice and records of conduct judgments regarding third parties, not on the basis of an external moral, but through the work of the professional. The latter is confronted with a multiplicity of antagonistic values and principles which he/she needs to be able to mediate. This considerable change has passed decision-making to the professionals in this situation, thus, increasing their responsibility and need to affirm the legitimacy of their options through confirmation of their competence and the quality of the results obtained. The ambivalence of trying to conciliate opposing values, with full awareness that they are, indeed, in opposition, is experienced by the different professional groups as a threat obliging them to look to themselves for legitimacy for their intervention. This inner search for values and principles considered, by the individual, to be valid in the situation mobilizes the subjects that inhabit the professional and encourages the emergence of value plurality. The heterogeneity that is installed allows new ways of conceiving professionality to emerge, while simultaneously fuelling a profound feeling of frustration in the nurses. According to Dubet (2002), this feeling stems from a legitimacy crisis, resulting from the break down of old, institutional programs and, in the case of health, in the relativization of medical knowledge which has ceased to be exclusive and is confronted with a multiplicity of new health discourses, emerging from a wide variety of areas and which deserve the adherence of large sectors of society.

Discomfort regarding the nature of the previously installed professional identity sheds light on the absence of a symbolic unity conferring meaning and coherence to the group. The multiplicity of articles and work carried out from the 70s onwards on who nurses are and what they do reveals this increasing disquiet which, in spite of great effort, was not only impossible to attenuate, but, in fact, got worse. The issues the nurses began to raise were not related to identity, but rather to what the institution regarded as being the nurse's role. The "role does not belong to the person, but results from the position that person occupies in the work organization (…) it gains support more from resources than from the actor's experience" (Dubet, 2002, p. 317). Clarification regarding who they were and what they did was sought outside the group and its specific activity of providing care for the public. The institution was expected to define a clear role that was socially acknowledged and which gave meaning and unity to their work. The effect of this movement, as pointed out by Dubar (1997), was that the nurses had become a "a body of professionals, more preoccupied with internal functioning and respect for bureaucratic procedures than with the quality of the services offered to clients" (p. 153). Indeed, the specific experience of caring for others was not imposed as "a source of meaning and experience" (Castells, 2002, p. 2).

Over the last 30 years nursing has developed a number of strategies which aim to consolidate it as a profession in accordance with the canons of professional sociology. The re-conceptualization of the notion of health and care has contributed to this process by opening the possibility of reflecting on nursing beyond the institutional ghetto into which it was born.

Throughout the 60s and 70s, a profound re-conceptualization of the notion of health took place, stemming from the WHO and which impacted the discourse at the core of nursing. According to Lopes (2001), this fact provides the profession with the possibility of reformulating the notion of care in nursing which has ceased to be associated exclusively with *the humanitarian mission of providing moral support and comfort* and *the technical role of assisting the doctor*. Instead, it focuses its action and support on health promotion and disease prevention, thus, incorporating the new references which make this re-elaboration possible. For Kerouac *et al.* (1994), the clarification of nursing at the time is based on a dichotomy game which sets it against medicine. Nurses consider themselves to have the duty to care for people, while doctors have the duty to treat illness; nurses have an overall view of the problems and use a holistic approach towards the individual,

while doctors compartmentalize the individual from a partial perspective of an approach to illness. This dichotomy, profoundly criticized by many authors, particularly the doctors who refused to accept that their intervention was developed while ignoring the individual's globality, is fragile and unconvincing.

Regardless of the fragility of this argument, which Canário (2005) has also pointed out, and the conflicts it has generated with other professional groups, the nursing profession has managed to reinforce the notion of care[1], considered by Noémia Lopes (2001) to be the "central, ideological operator, the bonder of nursing practice references" (p. 58). This *symbolic operator* has contributed to the development of reflection in nursing which has opened itself to new meanings, contrary to the nurse as the guardian of institutional values or the doctor's assistant. The public has come to be viewed as the central frame of reference for professional action, not only in terms of illness but also in health promotion and disease prevention.

Similarly, from the 70s on, the nursing affirmation movement, as a unique and cohesive socio-professional group, gained impetus. The struggle for a single level of nursing professionals proved to be one of the most important closing strategies in the field of action. Former nursing auxiliaries went on to receive a nursing diploma after a short training course. Conquering intervention exclusivity in a given social field is considered to be one of the most important victories of Portuguese nursing and has not been seen anywhere else in Europe. The growing number of nurses has allowed the group to acquire significant power. The apparent homogenization of the group's values, based on the new symbolic operator *nursing care,* which is more focused on the public from the perspective of disease prevention and health promotion, seems to have constituted the profession as a credible alternative for uniting nurses in the reinforcement of nursing as a care profession.

However, as mentioned by Carapinheiro (2006), despite official discourse being centered on health and its promotion, political and economic investment in the 80s was based on secondary health care[2], in the Intensive Care Units of the hospital institutions which grew exponentially at that time. Medical knowledge and the power of cure took on unprecedented visibility and social importance which reinforced the idea of the nurse as the doctor's auxiliary. As far as Simões (2004) is concerned: "experience shows that preventive activities are not usually taken into consideration and become secondary, while therapeutic activities take up most of the health system's resources, and this is the case throughout the world" (p. 240).

At this time, the issue regarding the quality of the services rendered emerged in the management discourse, and nursing immediately became part of the list of priorities. Concern regarding the humanization of hospital services increased considerably in the 90s and most nursing boards gave strategic priority to the intervention of nurses in the *Acolhimento ao utente* [User/Patient Support Service][3], which became a great concern, due to its strong appeal to the relational dimension of nursing and to greater autonomy for the profession, but which, simultaneously, was the most integrated in the personality of the nurse.

The reinforcement of both these perspectives served to accentuate the rift between that which many refer to as the gap between theory and practice, and others consider to correspond to different conceptions in confrontation between ideal nursing, associated with holistic care, and real nursing connected to the idea of the doctor's auxiliary and guardian of the institution. In 1996 Hewison and Wildman were of the opinion that the rift was a divergence between the "managing" values of the care providing institutions and the values underlying nursing. The former gave privilege to the nurse as the doctor's auxiliary and the latter, in their aim to develop autonomous work, regarded the relationship with the patient as being at the root of care. The autonomous activities were associated with a humanist perspective that was sought after.

The 90s may, in fact, be considered the golden age of Portuguese nursing. In just a few years, the basic training of nurses became integrated in the Higher Education of the National Education System with the Baccalaureate level, and less than five years later went on to become a single cycle Degree Course. Ministry guidelines set out to invest in the increase of student entry as there was an obvious lack of nurses on a national scale. During this period the "Regulamento do Exercício Profissional

dos Enfermeiros" (REPE) [Professional Nursing Practice Regulation] was published and gave rise to the Ordem dos Enfermeiros [Nursing Association] which, from the perspective of the nursing as a profession strategies, corresponds to the state recognition of the professional group's power to regulate itself and the confirmation of its autonomy.

As far as the health institutions are concerned, legislative terms and primary health care have been reinforced and the continuing care program has been launched. The first decade of 2000 took off with many positive expectations in relation to the promising nursing rates in the previous decade. At this time the consequences of a policy intent on introducing profound alterations in the management of the health services began to take effect. The duplication of the number of nursing students from 2004 onwards was also accompanied by the emergence of new health units wich were expected to take on a significant number of these newly qualified nurses. However, for the first time ever, the latter were confronted with an unemployment crisis which coincided with what everyone considered to be an obvious lack of nurses in the various hospital services.

Despite the amazing achievements accomplished during the earlier period, the struggle to affirm the profession and acquire social recognition seemed to be a growing concern for a large number of nurses, as may be seen through consulting sites and blogs on the Internet. The discomfort created, coupled with the gap between real and ideal nursing, the perception of the fragmentation of nursing's basic values, as well as growing demands on the part of the citizens, gave rise to the development of frustration and unease among the latter. The nurses, while appealing to the values of the past, for which they felt a certain amount of nostalgia in terms of the security and stability they offered, did not have a golden age in their history to which they wanted to return, as pointed out by Dubet (2002).

It is no longer enough for the professional to have a title. In a contextualized situation, he/she has to prove his/her competence in order to intervene appropriately. It is the nurse him/herself who conquers the legitimacy of his/her action through the way he/she intervenes. If, on the one hand, there is increasing responsibility and greater autonomy in terms of decision-making which are not in keeping with the pre-defined programs, on the other hand, there is also growing insecurity for more responsibility to be taken for individual decisions. The institution no longer offers protection. Sharing such decision-making with a team has emerged as a means of supporting the risks inherent to having to make decisions on health and illness-related matters.

A study carried out in France by François Dubet (2002) shows how the old, professional model is experienced by the nurses as being clearly insufficient, and is accompanied by a strong feeling of frustration conveyed through "a continuous demand for academic recognition and prolonged studies", which, in his opinion, is "unlikely to lower the level of frustration, unless all the nurses are transformed into staff charts and all the auxiliaries into nurses" (Dubet, 2002, p. 229)[4].

This argument, which may seem exaggerated, presents itself as a possibility which should be considered. Important indicators have emerged, with tasks increasingly delegated to medical auxiliaries, the appearance of training courses for "Nursing Auxiliaries" (although this category does not exist in Portugal), the abrupt cut-back on nurses in the services and the consequent increase in the number of auxiliaries make it a feasible option in the near future, despite the many opposing discourses from organizations at the top of the professional system. In the study performed by Lopes (2001) in two, distinct hospital departments, she concluded that the majority of nurses found that it was beneficial to delegate basic tasks to auxiliaries, so that they were able to invest in the reinforcement of their competences delegated by the doctor. These competencies, associated with the cure and repair have gained considerable importance in a context in which the profession is becoming geared towards centering *on* and *around* illness at its severe stage. Secondary health care is at the core of hospital action and, indeed, it is this type of care which is best appreciated by society.

Along with the transformations in hospitals, which are now divided into different levels according to the differentiation of the care (National, Central, District, Continuing Health Care), the health centers, regarded as the main gateway into the Nation Health System, are broadening their intervention by reinforcing a curative dimension in the community, through investing in secondary health care.

Primary health care is not yet the frame of reference for action in the health sector.

The discourse on health is considerably more advanced than actual political and social investment in the health system. This is acknowledged by many authors who believe that nowadays, there is a growing tendency for overall care provided to individuals and families to focus on the community and its families. However, this apparent rotation from the centre of action in the health sector, from hospitals (which have tended to become intervention centers during the crisis), to the heart of communities and families has been accomplished through the transference of secondary health care rather than an effective investment in primary health care.

The need to re-formulate the mission of the hospital, which aims to reduce care vocation to a minimum, so as to become a centre for treatment and cure, seems to have brought about greater investment in the so-called *continuing care.* The aim of the latter is to transfer the responsibility of taking on the duty of caring and providing basic treatment to the community, where a few care organizations have started to emerge, and to families. It is through this procedure that the Health Centers have come to take on increasing responsibilities in terms of secondary prevention[5], far more than through the reinforcement of their original mission, namely health promotion and disease prevention. It is important to reflect on how nurses have intervened in this reality which has brought significant alterations to the nursing profession, itself.

CONSTRUCTING THE CARE EXPERIENCE: AN OPEN POSSIBILITY

Such transformations in Health Centers refer back to the work of re-creating professions on the basis of strengthening the relationship between the professional and the patient or families in collective, community or private family spaces, rather than in the profession's habitual territory.

Furthermore, from this perspective the aim of care has been re-established and the procedures, which, under the scope of the doctor's auxiliary, were affirmed as being an aim in themselves, are now being regarded as the means to promoting health, while giving particular attention to the individual. Performing the transformation of ends and means to break through new horizons requires a re-elaboration of work which is, as Barbier (1996) mentions, simultaneously an act of transforming work and re-constructing identity.

The lack of an absolute coincidence between the subjectivity of the actor and the objectivity of the system opens the way to the construction of experience (Dubet, 2002). It is this discordance that allows the actor to step back from the system and become open to the creativity and reconstruction of the action with recourse to critical reflection. It is this distance created between the system and the nurses which, despite causing greater insecurity through a lack of confidence, also stimulates the skill capable of re-creating professionality in nursing.

The care experience of nurses is constructed through daily practice, through the care they provide to others in a particular context which mobilizes both the professional and the patient, depending on the different conditions of each situation. It demands introspective work on the part of the professional towards, work regarding the establishment of relationships with others, as well as the conditions under which such work is carried out. Types of conditioning are, on the one hand, the established role of the nurse in the hospital organization, on the other hand the position he/she occupies in the distribution of work, the clearer references of the professional system, and, also, the way each individual re-designs these different frames of reference for him/herself when interacting with others. If, initially, the nurse's reference system had an almost absolute coincidence with the role established by the institution, nowadays, as has already been seen, there is a gap between both which is getting wider, thus, opening the way to a re-construction of the experience.

Socialization viewed as a construction process of social reality, through the confrontation of different action logics, opens the way to the construction of social experience. As far as Dubet (1996) is concerned, this is the result of articulation among three distinct action logics: an integration logic, where "the actor is defined by his/her belongings, and aims to keep them or strengthen them within a society viewed as an integration system" (p. 113);

a strategic action logic in which "the actor tries to accomplish the conception he/she has of his/her interests in a society viewed 'then' as a market"; a subjectivation logic on a critical and detached level in which "the actor is presented as a critical subject confronted with a society defined as a production and domination system" (p. 113).

The professional manages these different action logics so as to respond to the problems he/she faces, since it is the nature of the problems and the different value attributed to them which prevails over the role established by the organization and which configures his/her responses in terms of action. This path, which generates profound ambiguities, puts the different practices and conceptions of the profession in conflict.

DOCTOR'S AUXILIARY OR CHEAPER "MINI-DOCTOR"

While the role of the nurse as guardian of the institution has been difficult to let go of, the role of doctor's auxiliary is also spreading considerably. A recent study (d'Espiney, 2005) states that in a psychiatric hospital ward, young nurses are re-introducing practices based on a technological rationality related to the "technical value current", referred to by Collière (1989) and from which these kinds of departments, given their specificity, were always detached. The low visibility of a mainly communicational activity, as has been psychiatric work by tradition, is associated with the hyper-value attributed to controlling physical symptoms resulting from the administration of medication, as a way of conferring rigor and visibility on care. Work associated with cure is still the most consistent source of meaningfulness, both in terms of its connection to the magical power of cure as well as its mobilization of technical and scientific knowledge, more socially recognized due to its rationality.

Furthermore, its increasing importance in the community over recent years has emerged more through the expansion and shift of "repair" care from the hospital to the community than through value given to community work which, as Carapinheiro (2006) points out, never really obtained true investment on the part of the State.

Investment in the community and the articulation of care that was always promised and subsequently postponed from the end of the 70s onwards, gained force in the 90s with the program launched by the Ministry of Health entitled *continuing care*. This program, that stemmed from the qualification of health centers so as to accommodate those unable to look after themselves at home, and which was developed according to the degree of autonomy, gained greater force and visibility with the creation of the hospitals' "discharge management services". Transferring patients who are still dependent on sophisticated technology (ventilators, hemodialysis machines, etc.) to their homes requires the creation of community support solutions. The hospitals have created teams who go to the patients' homes, offering support and ensuring that the patients themselves or relatives are capable of handling the situation.

Only then are nurses from the health centers called in to participate in the process. They are mainly involved with old people and sporadically accompany patients with stabilized long-term disease. Articulation between the hospital teams and health centers is not always easy. Due to suspicion towards the ability of community colleagues to respond to patients' needs, the patient is only "passed on" when they have ensured the former have the necessary skills to guarantee continuing care.

Despite the fact that for many years it was common practice for nurses to make "home visits", consisting of a nurse carrying a bag of materials for treating patients at home, usually including a variety of plasters, they were regarded with suspicion by their counterparts. Due to the nurse's detachment from the hospital and frequently deficient work conditions, he/she was suspected of not having sufficient scientific grounding. Owing to the fact that work in the Health Centers was deprived of technological apparatus and since it mobilized generalist training professionals, it continued to be viewed as the poor relative of the medical profession.

Nowadays, being able to respond to the new demands of the communities means nurses have to master a set of technical skills, among others, which have ceased to be exclusively hospital-related. There is increasing concern regarding investment in competency development in the field of biomedical and pharmacological knowledge. We are witnessing

an unprecedented development of wound treatment by nurses in health centers who have adopted this task as part of their competency sphere. Inter-professional boundaries have been broken down and some situations previously requiring medical attention are now being dealt with by nurses in the community.

The nurse as the doctor's auxiliary has gradually become a "mini-doctor" and, despite the fact he/she has less autonomy in relation to the doctor, is still more socially valued. This is the paradox that Tavares (2007) and Canário (2005) underline with regard to non-medical professions in the health sector. This paradox lies in the fact that the closer professionals are to technological sophistication and cure, the more social recognition they obtain, even though they are more dependent on medical prescription. They receive less social recognition in the area where they have more autonomy. Although accompaniment of the health process requires more autonomy, since in terms of health promotion and disease prevention it is developed within the framework of a unique relationship with the population, it is less visible in terms of results. The value and social recognition obtained through adherence to the medical model reinforce this perspective, which does not seem to be restricted to hospitals. Indeed, with the new conception of care division and autonomy levels, the general tendency has been to transfer competencies, which were previously exclusive to nursing through medical delegation or prescription, to relatives and formal carers. Nowadays, the patient or close relative is expected to learn how to catheterize, tube, drain secretions, etc. The nurse has become responsible for ensuring that such learning is carried out on the part of the families. His/her educational role has gained consistency and is used in his/her relationship with the patient. This relationship is fundamental in the management of health promotion and disease prevention.

The re-structuring of the health network foresees a range of more undifferentiated health care, from health centers to more specialized care, depending on levels of gravity and patient dependency. The *Rede Nacional de Cuidados Continuados*[6] [National Network of Continuing Care] has been created to bridge the gap between the two. Such scaling on the basis of the patient's dependency level has called for differentiated attention constructed around each individual's autonomic capacity and not so much his/her pathology. This approach has given rise to the emergence of diversified care departments providing the progressive mobilization of sophisticated resources.

Owing to an increase in the academic levels and schooling of nurses, they have become more capable of intervening on different levels, especially in areas requiring more specialized, technical work. Basic care, involving "a prioritized relationship with the body that can not be neglected" (Hesbeen, 1997, p. 48), is gradually losing ground. Such cessation of direct care provision has been accompanied by the emergence of family helpers and informal carers in the community, and, to a certain extent, hospital auxiliaries who are adopting roles that are more and more related to basic needs.

The standardization of procedures in terms of diagnosis and treatment has opened the way to mass expansion of telephone help lines and triage services. These have been taken on by nurses who, on the basis of pre-conceived guidelines, conduct structured interviews, some with more skill than others, in which all the steps are established and all decisions defined with precision, classifying the categories of severity and the department the patient should go to. Here the nurses act as mediators between lay and expert knowledge, with restricted freedom for conducting the interview.

As regards the British Health System, Colyer (2004) points out that the changes which have been introduced have brought about a re-engineering of expertise and non-specific skills on the part of the different professional groups, making possible the creation of new activity groups and cheap, undifferentiated workers on a more basic level to replace some professionals, namely nurses. In Portugal the supply of training courses for "nurse auxiliaries" is already being divulged by the press, as if this group already existed in the organizations and developed at the same rate as the sudden employment crisis among nurses. While the services supplied to the population have become diversified, the work of nurses has also become differentiated on the basis of this supply. They have tended to be transformed into cheaper *"mini-doctors"* in order to reinforce their relationship with the patient, so as to ensure their autonomic

capacity, and to offer themselves as a reference so that they may help to resolve more basic health problems in the frontline of the fight against disease.

THE RELATIONSHIP WITH PATIENTS: A SOURCE OF MEANING IN THE CONSTRUCTION OF THE CARE EXPERIENCE

During the empirical research period, I discovered that it was possible to find intervention projects in health centers, which have emerged through the initiative of nurses, with a view to addressing specific problems related to particular groups with a certain risk or pathology or geared towards certain age groups (young and old people) so as to prevent disease and promote health. Such is the case of the project *Férias em Saúde* [Healthy Holidays] for old people, or the creation of conversation clubs, also for the aged, in some Health Centres. There seems to be an emergence of anonymous care for the general public which has stemmed from a concern with global care within the scope of health promotion and not only the fight against disease.

If, up to a relatively short time ago, the relationship with patients was not regarded as being worthy of reflection, nowadays it has taken on particular importance. In addition to its subjective nature and subsequent dubious scientificity, it has was also de-valued due to an absence of recognition on the part of the nurse as a unique person and due to his/her connection to activities rather than to people. The relationship could not be acknowledged as having therapeutic potential or as being relevant to the cure process. Nurses were expected to circulate freely through all the areas of the sector according to the needs of the centre. This, however, was not quite the case in the hospitals, despite being based on the same "aggregated group" conception (Lorenzi-Cioldi, 2002) and, currently, for having acquired a new outlook with its innovative management theories.

Nurses were expected to master all the basic nursing competencies and to be familiar with the functioning of all sectors, so that at any time they would be available to guarantee the running of the institution. The image of an undifferentiated group was offered, whose substitution did not represent a breach in the continuation of care. Everything functioned as if the relationship had been established in an indistinct manner with a homogeneous body, and the singularity of relations was viewed as being irrelevant. Even when the nurses state that "they spend 24 hours" with the patients, they are saying that one, or several is indifferent.

When discourse on the importance of the individualization of care emerges, it is associated with the priority of accommodating the diversity of patient needs which should be identified through observation and communication, but not as a unique interpersonal relationship that is developed around a health project.

As regards the Health Centres, the personalization of care has been transported from discourse to practice in a highly consistent manner. With the creation of "senior care" health centers, multidisciplinary teams and lists of patients per family doctor have emerged, making it possible to cultivate the sense of belonging to a group. This type of approach responds to the needs of a set of specific patients and accompanies their health process during their life course. There are all types of requests and intervention has become autonomous in certain areas such as child health care, maternal health and among more vulnerable groups such as people suffering from diabetes. Despite the fact that these patient lists are organized on the basis of medical activity, which continues to structure the organization of work in the health sector, nurses' work is regarded more as being complementary to that of the doctor than subordinate. The relationship with the patients is consolidated with time and the continuity of attention and availability. The nurse becomes a reference for those who go more frequently to the Health Centre. The fact that there are nurses of reference is the result of a real effort to personalize care, considered by the nurses to be one of the most rewarding aspects of their activity. The relationship is fundamental so that individual accompaniment throughout the health process may produce visible and positive results. This strategy involving professional affirmation has become more common in Health Centres. Furthermore, it is a strategy through which action territories are negotiated and which is played out in sites where the action of the different groups

converges, but which is beginning to be accepted in the Health Centres as being shareable.

While one can not speak precisely of a "health project" in the way Honoré (2001) conceives it, there is still concern about offering support and accompaniment to individuals and families. The image of the nurse as someone who accompanies another throughout the life course is more noticeable in community work than in patient assistance at the Health Centre, and even less at the Hospital. Work is carried out in the street or in mobile vans, thus, giving rise to the fact that the institution has less importance on the relationships established and they become less asymmetrical. Professional status is acknowledged, but the professional is seen as someone who is well informed about health issues, who knows how to mobilize the system's resources, how to bridge gaps between institutions and who has direct access to doctors and hospital services, thus, in a position to help resolve problems. Moreover, in community work the nurse emerges as someone available to listen, to be close to hand and to accompany. This work, although incipient, is beginning to affirm itself as an initiative on the part of nurses who have found a role for themselves that goes beyond that which is traditionally pre-established.

In *continuing care* performed at home, this proximity and trust is also visible. Through such intimacy, proximity encourages the development of complicities. Requests involve more than just asking for help to treat illness and are geared towards prevention. The work aims to make the individual autonomous, as can be seen in all the general guidelines on both central and local levels. Socialization work takes place in the interaction surrounding specific problems in the joint discovery of possible solutions for the situations. Internal and external resources are evaluated by the nurses who unveil and "decode" the problems. The most common request is probably the search for advice. The work of nurses in the communities and neighborhoods has emerged as intervention geared effectively towards the patient, and which is conveyed through the availability of complex situation accompaniment, where the nurse emerges as a reference to which the population resorts when help is required.

Biomedical knowledge acts here as a partial means of support which, along with a multiplicity of knowledge deriving from social and human sciences, actually competes to resolve the problems. In the community the requests go beyond the restricted supply of pills and vaccines to open the way to a philosophy that gives priority to the subjective, personal autonomy and empowerment (Colyer, 2004). In this context, health is established in the confluence of a multiplicity of factors going way beyond the professional competencies of each of the individual technicians. Teamwork is regarded as being indispensable to the success of the intervention.

The nurses who are transported by mobile units equipped with supplies for basic care provision and who work in prevention, invest mainly in health promotion and diversify their care provision, not only in view of pathologies, but of what each individual is capable of doing. The undifferentiation of the nurse's work has been lost to make way for the preferences and capabilities of each individual, with a view to making the most of a wide range of knowledge that is recognized as being potentially useful.

While conferring responsibility on the citizen gives him/her more power to decide on the care he/she feels is required, it also profoundly alters his/her relationship with the professionals. The relationship tends to shift from dependency and total commitment to medical knowledge to a kind of "horizontalization". Health, formerly viewed as a supreme asset, becomes a type of merchandise[7] to be negotiated and acquired in an increasingly more expensive market, which is less accessible to everyone. This merchandization of the relationship withdraws power from the professionals and their institutions. As mentioned by Dubet (2002), it forces the individual to obtain legitimacy, that has ceased to be provided by the institution itself, through his/her ability to intervene and establish relationships with others in a particular context. The negotiation of meanings and interventions demands the involvement of all the participants in care situations.

The direction of the work tends to be re-formulated by the nurses who, as far as the Health Centre is concerned, plan and organize their intervention. Professional concerns go beyond the mere carrying out of duties, such as vaccination, to be geared towards vaccine coverage rates. The latter are part of a broader context of health promotion

and disease prevention activities, which has been reinforced by the strategic vision of health care. Nurses refer to their activities in the health centre not in themselves or for themselves, but as interventions within the framework of health promotion and disease prevention, revealing an appropriation of the official health discourse. Indeed, despite its restricted expression in terms of practice, it has brought forward a considerable broadening of intervention horizons.

FINAL NOTE

The further away we detach ourselves from the institutional program, the less the work regarding others is presented as the accomplishment of a set role and the more it becomes a composite experience referring back to the composite experience of the objects of such work. The increasing tendency to divide work in the health sector around the autonomic skills of the patient and/ or the level of severity in terms of risk to life, is slowly introducing a new kind of work division which is based on inter-disciplinarity. Nurses participate in these transformations and adopt a set of more technical or protocoled tasks, based on a logic that views them as the doctor's auxiliary, in search of a "mini-doctor" status which, despite not conferring greater autonomy, offers them higher social recognition.

As far as the community is concerned, nurses also participate by progressively leaving the tasks connected to direct care of the body to informal carers. They supervise these processes and invest in the "management of cases", taken as totalities. They regard health education as a crucial space for establishing the accompaniment of others over a given period of time. While tending to transfer the technical care provided in hospitals to the community and the homes of patients, nurses accept the responsibility to prepare families for providing care and to evaluate their ability to deal with problems and find solutions. They invest in the furthering of a broad range of knowledge, including biomedical knowledge, but also knowledge from social and human sciences. The relationship with the patient becomes important in the attempt to gain access to others through understanding their problems and immersion in the socio-cultural context. The nurse while mastering care production means is the one who gains the patient's trust. Awareness of the limits of his/her intervention over others, which involves making personal decisions in the absence of a technician, is verbalized as an aspect urging a reformulation of the relationship, based on acceptance of these limitations as a reality which must be taken into account so that the action can be developed.

Problems related to dispensed care, the relationship with others, available resources in the health sector, among others, have emerged as work material with which it is possible to reflect on the care that is becoming a source of meaning and experience. The strategic action logic becomes visible through the ability to negotiate with other colleagues and professionals over intervention territories defined locally. The ability to take the initiative is visible, especially in community work, and is conveyed in the construction of a care supply, in a society conceived as a market. The action projects stem from the combination of the global guidelines and analysis of the local situation.

On the one hand nurses diversify their identity construction strategies on the basis of a perspective negotiated among the demands of a market logic, generating profound internal conflict, while on the other hand, among local health needs, evaluated from a broader perspective than the mere absence of illness. In this type of situation, the relationship with others is affirmed as a source of meaning and experience and the struggle for affirmation and the recognition of nursing as a profession, in the search for an image of the nurse as being worthy of respect.

Endnotes

1. The notion of *care* is used in this text as a social construct which has gained different meanings over time. I fall back on Collière (1989) to refer to the different meanings care in nursing acquires in terms of the promotion, maintenance and repair of life. Nevertheless, I interpret *care* with Honorè (2001) and Hesbeen (2000), from an existential perspective, as a basic attitude of attention and concern for others and things, which does not belong solely to either profession but which corresponds to an outlook on life that may be present in all the activities which are geared towards the individual and collective well-being of things, people and the planet in general.

2. "The distinction among primary, secondary and senior care aims, fundamentally, to rationalize the use of available resources. Logically, primacy has to be given to that which has a greater impact and population scope, namely primary care. When necessary, it is followed by more specialized or sub--specialized care, geared towards sporadic intervention with a more accentuated technological component" (Simões, 2004, p. 6).

3. The notion of *Acolhimento ao Utente* was broadened so that on entry in the profession, there was more extensive concern with attention provided throughout a patient's hospitalization. Treated in a highly bureaucratic manner, the support became transformed into a script of procedures that allowed head nurses to evaluate their subordinates on the basis of observation of non-compliance with defined indicators.

4. In the original : "une revendication continue de reconnaissance scolaire et d'allongement dês etudes" which, in his opinion has "peu de chances de faire baisser le niveau de frustration, à moins de transformer toutes les infirmières, en cadres et toutes les aides-soignantes en infirmières".

5. Secondary prevention: it is the set of actions which aims to identify and correct any deviation from normality as early as possible, so as to restore the individual's health immediately. In other words, its aim is to reduce the prevalence of the disease. It is geared towards diagnosis, treatment and the limitation of damage (Retrieved December 2007 from http://pt.wikipedia.org/wiki/Preven%C3%A7%C3%A3o_secund%C3%A1ria).

6. "Continuing care services should continue to invest in an intermediary care level, between the level of health centres and hospitals. This should involve suitable internment units, global rehabilitation day centres and home care mobile units. In this way it will be possible to guarantee continuity among preventive, therapeutic and corrective actions, on the basis of an individual care plan for each patient" (Portugal. Ministério da Saúde/DGS, 2004, p. 160).

7. Alteration in the way people who request health care have been designated reveals the position they are expected to adopt in the care process. Initially referred to as patients, due to their association with a passive position, they have gone on to be known as *utentes* [users] from the perspective of a citizen using the services to which he/she is entitled. They have now become the clients of health products sold by professionals and have accepted the responsibility of buying the right ones and using them correctly.

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