






Logic of care vs. logic of choice: reflections on shared practice in diabetes care

Lógica do cuidado x lógica da escolha: reflexões sobre uma prática compartilhada no cuidado do diabetes

Lógica del cuidado x lógica de la elección: reflexiones sobre una práctica compartida en el cuidado de la diabetes

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ABSTRACT

Objective: to reflect theoretically on the logic of care and Annemarie Mol's logic of choice in order to think about shared practice in diabetes nursing care. **Content:** this reflective analysis was framed by the contributions of Annemarie Mol, an important philosopher in thinking about nursing practice for people with diabetes mellitus. **Conclusion:** in order to engage people with diabetes in their care, it is important that institutions remodel their care practices to be guided by the logic of care. This entails a qualitative change in the kind of support offered, so that the biomedical model of "self-care" is open to negotiation, to be activated in a context of "conversation", its prescriptive nature abandoned, and be adjusted to the needs and priorities defined by the person him- or herself. Finally, care would then be modeled through relationships that feature content more strongly marked by exchange, reciprocity, thinking about action, and fluidity, rather than fixed on care processes.

Descriptors: Diabetes Mellitus; Delivery of Health Care; Interpersonal Relations.

RESUMO

Objetivo: desenvolver uma reflexão teórica acerca da lógica do cuidado e da lógica da escolha de Annemarie Mol para pensar uma prática compartilhada de cuidado de Enfermagem em diabetes. **Conteúdo:** análise reflexiva, fundamentada no referencial de Annemarie Mol, que trata das contribuições desta importante filósofa para pensar as práticas de Enfermagem às pessoas com diabetes *mellitus*. **Conclusão:** para um maior engajamento da pessoa no cuidado do diabetes é importante que as instituições remodelen suas práticas de assistência, no sentido de se orientarem pela lógica do cuidado, o que implica uma mudança qualitativa na forma de apoio oferecido, em que o modelo biomédico do "autocuidado" se abriria para a negociação, abandonando seu caráter prescritivo, para ser acionado no contexto da "conversa", e ajustado às necessidades e prioridades definidas pela própria pessoa. O cuidado modelar-se-ia, enfim, por meio de relações que apresentam teores mais acentuados no sentido da troca, da reciprocidade, de pensar a ação, a fluidez, o não fixo nos processos de cuidado.

Descritores: Diabetes Mellitus; Atenção à Saúde; Relações Interpessoais.

RESUMEN

Objetivo: desarrollar una reflexión teórica sobre la lógica del cuidado y la lógica de la elección de Annemarie Mol para pensar una práctica compartida de cuidado de enfermería en diabetes. **Contenido:** análisis reflexivo, fundamentado en el marco de referencia de Annemarie Mol, que trata sobre las contribuciones de esta importante filósofa en el sentido de pensar en las prácticas de Enfermería para personas con diabetes mellitus. **Conclusión:** para un mayor compromiso de la persona en el cuidado de la diabetes, es importante que las instituciones remodelen sus prácticas de cuidado, en el sentido de guiarse por la lógica del cuidado, lo que implica un cambio cualitativo en la forma de apoyo ofrecido, en el que el modelo biomédico de "autocuidado" estaría abierto a la negociación, abandonando su carácter prescriptivo, activarse en el contexto de la "charla" y ajustarse a las necesidades y prioridades definidas por la propia persona. Finalmente, el cuidado se modelaría a través de relaciones que presentan grados más acentuados con vistas al intercambio, la reciprocidad, el pensar en la acción, la fluidez, lo no fijo en los procesos de cuidado.

Descritores: Diabetes Mellitus; Atención a la Salud; Relaciones Interpersonales.

INTRODUCTION

Diabetes mellitus (DM) is an important and growing health problem for all countries, regardless of their development level. DM still presents challenges to be overcome to ensure success in prevention actions, diagnosis identification, treatment, control and maintenance of health conditions and recovery from injuries. Thus, international guidelines recommend multiple actions to confront these challenges, such as the use of different classes of antidiabetic drugs and/or insulin, together with lifestyle changes to achieve individualized glycemic goals¹⁻³.

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Living with DM is configured as a continuous management process which involves adjustments and self-care in practical matters referring to cultural, social, family and work contexts, with the aim of promoting adaptations in the physical and emotional spheres. Most of the time this care represents a difficult task, since it requires a lifestyle reorganization^{4,5}. Access to the health needs of people with DM depends on the effective exchange of knowledge between health professionals and system users which is capable of overcoming passive transmission and the hierarchy of technical knowledge that is often present in care meetings. Exploring these health needs under a dialogic approach is fundamental for enabling comprehensive care that is capable of understanding the individual with DM in their existential whole and consequently considering the obstacles that must be overcome to reorganize their ways of life^{6,7}.

Studies on the care of people with diabetes^{6,8,9} point to discrepancies between what subjects know as healthy through medical recommendations and the way in which they can effectively manage various aspects of their lives. These changes in lifestyle seem to belong to the order of utopia due to the difficulties of adopting a “healthy lifestyle”, which really seems to have no place in the daily reality of many individuals; but, even before, from the “utopia” of medical discourse attached to a rationality that seeks to deal with a multiple and inexhaustible reality with a technical plan that intends to be universal and total, without taking into account the subjective meanings of illness, food, physical activities and social life. Objective and rational knowledge about DM is not enough to promote care practices if it is not linked to subjective senses, which inform about the subjects’ possibilities of understanding and acting in the world⁶.

Thus, considering the importance of the relationship between people with diabetes and the health team that assists them, not only considering the team members, but the type of knowledge they transmit, the objective of this study was to develop a theoretical reflection about the logic of care and the logic of choosing by Annemarie Mol to think about nursing care practices in diabetes.

CONTENT

The choice of the perspective of the Logic of Care as a theoretical support for the analysis is due to the predominance of practices in the context of diabetes that have neglected people, failing to listen to them and isolating them from their history; working with a minimum dialogue in relation to other practices and responding to a way of life associated with consumption and disengaged choices of contexts, reproducing blame and holding individuals responsible. This reflection is the result of a doctoral thesis entitled “*Comunidades virtuais no suporte à pessoa com diabetes mellitus*”, from the Graduate Program in Public Health, developed from March 2019 to December 2020.

Logic of care x logic of choice by Annemarie Mol

In the discussion about care in healthcare services, the Dutch anthropologist Annemarie Mol considers that different kinds of logic about care are present in the interactions between professionals and the people with whom they interact. The care model inherited from clinical medicine establishes a standardized care form based on the relationship between those who care and those who are cared for. In this relationship, someone with medical knowledge informs those who need care what they should do to restore their health condition. This relationship is strengthened as the person being cared for adheres to the caregiver’s recommendations. This would be the most commonly practiced care form, defined by Mol as following the logic of choice¹⁰, as it is up to the patient to choose to follow or not the instructions received. However, there are cases in which those who are cared for demonstrate resistance and disobey the prescriptions¹¹.

Mol analyzes the traditionally observed care forms through the logic of choice, but also expands possibilities in care practices, such as the logic of care. However, her work is local and is developed in the medical area with people with diabetes in a hospital in the Netherlands, and the challenge of this study is to think about the care forms practiced in another dimension which are attentive to the singularities, engagement, negotiation and bond.

The logic of care theory proposed by Mol¹⁰ brings reflections on the relationships between health professionals and patients. Reflecting on the positions occupied by the interlocutors helps to understand the predominant type of logic. Patient or client? Is the relationship based on a product or is it considered a process? When dealing with people with a chronic disease, is health expected or is it learning to live with the disease?

Based on these questions, the logic of care theory describes two ways of dealing with the disease: the logic of care and the logic of choice, with the latter presenting two modalities: the market aspect, in which patients are situated as customers; and of citizenship, in which patients are considered citizens with rights. This logic incorporates choice as an individual, rational and scientifically clarified assessment in terms of cost-benefit of fixed variables, sustaining individual autonomy, thus attributing an active character to making choices as opposed to the patient’s passivity¹⁰.

In the market version, the patient assumes the role of a customer to whom products and technologies are offered, such as a blood glucose monitor, syringes or an insulin pen, analyzed by Mol as having the intention of recovering health or staying alive, even if this desire does not come true. The patient chooses the technology as a product, simply relating it to its purpose, implementing the knowledge based on the medical professional who determines what should be done, leaving it up to the person with DM to choose their guidelines. According to Mol, care cannot be seen as a commodity which is exchanged for a price, but as an interaction in which the action comes and goes in a continuous process¹⁰.

This logic does not include the patient's voice and that of other actors involved, enabling negligence and little engagement by the health team. It is not enough just to invert the roles of those who are passive in the logic of choice, it is necessary to evaluate each situation in which this logic would fit, and when the logic of care would fit.

In the citizenship version of the logic of choice, patients are emancipated as citizens from the centralizing domain of professionals. The individual starts to have an active posture and skills to make their own choices, but considering that a sick body affects this aptitude, being a citizen results in the patient's ability to control, instruct or go beyond the limits of their body¹⁰.

Mol understands that care is done and redone in practice. Therefore, it is necessary to see the patient as active in this process. Care is more a process where patients are doing more for themselves, not a product. Since care is above all a practical issue, one cannot so visibly differentiate one's own life from the tasks one chooses to include in it, seeking self-care. As the author illustrates, [...] you are in your life, you live it. You cannot disentangle yourself from it and establish its quality from a distance. [...] ^{10:94}.

The author establishes that the two logics are not opposites, but different. The logic of choice is the most commonly observed care form, in which professionals tell the patient what they need to do to obtain the desired health and freedom. In addition, it depends on the patient to choose to do what is indicated by the specialists, neglecting care¹². In the logic of care, being open to possible care means being open to the unexpected, which will develop creativity through engagement in practical activities and negotiation between those involved in the search for the best way to adjust. In this sense, the use of technology in care is no longer seen as a mere instrument or means, and starts to assume the function of mediation through the possibilities offered and the transformations that its use entails in practices, in forms of understanding, and in expectations.

The engagement forms are different in the two logics. In the logic of choice, looking for someone to blame for what didn't work can, in some situations, replace engagement, leading to negligence and guilt. In the logic of care, judgment is no longer important, and people need to assess the possibilities of care in a collaborative process. Neglecting the conditions made possible by care can lead to poor care. Good care, according to the author, takes place through the collaboration of those involved in the effort to deal with sick bodies and complex lives^{10,13}.

According to Mol, the logic of care is not better than the logic of choice, but, in her opinion, it is better for guidance in experiencing the unpredictable. This is only possible because the logic of care is not solid, but fluid and adaptable. The logic of care requires professionals who are attentive to the effects, attentive to the experiences, and above all interested in research, in learning from the cases, not to repeat them as parameters, but to awaken the sensitivity of incorporating all the actors in a collaborative process, negotiating. For this, it is necessary to not only learn from successes, but from mistakes and failures.

Symmetry in the relationship appears prominently in their studies, as within it lies the possibility of openness for the doctor and patient to be active in the care directions. This careful listening includes time for conversation and getting to know the person in front of you. Annemarie Mol calls this doctoring, a clinic with time to learn a little more about the person who is there, their humanity, and to then formulate solutions together with them and not just a hierarchical, prescriptive and without implication approach. The doctoring to which Mol refers invites us to a look that deviates from manuals and the ideals of illness and cure to value a look at the person who is there, since when seeking good care, we cannot fail to consider the gap between the best-ordered and tested theory and real-life history^{14,15}.

In the logic of care, the sick person is seen as a patient who suffers and who, in some way, actively participates in the treatment process, and the care is an open process, an interaction, a continuous process. On the other hand, in the logic of choice, the patient is seen as a client who can make choices about their treatment, the relationship is based on exchange, patients buy their care in exchange for money and, based on market language, the relationship presents a beginning, middle and end, as the aim of the market is for the product to change hands in one transaction. The term "patientism" suggests that rather than having to fit the model of client or citizen, Mol suggests that patients should be taken seriously for who they are, as people who are dealing with an illness that causes problems that they are trying to

alleviate and go on living in their own way. Just as feminism denies the idea that men are ideal humans, patientism denies the illusion that being totally healthy is the default situation in life^{10,12}.

The term patient does not refer to passivity, but to the fact that the person is suffering from an illness that impacts their life. The author highlights in her theory of care the contribution of the patient in their own care practices, as a patient with chronic illness performs various care practices in their daily lives and this should be considered in the relationship between health professionals and patients. In the study with patients with type 1 diabetes, Mol talks about the active participation of patients in their treatment¹⁰. She reported the need for patients to constantly measure their blood glucose, take their medications on time and going to appointments. [...] they don't "use" healthcare, they "do" healthcare. They are actively participating [...]^{12:302}.

Thinking about the training of health professionals by introducing the concepts of doctoring and patientism in a creative and contextualized way contributes to understanding Mol's criticism of existing care models and allows us to define an approach which makes this look possible, shaping ideas, transforming concepts and inspiring the theory as Mol points out.

The quest to achieve the desired glycemic control does not consider the unexpected changes that behavior, metabolism and emotions cause in the process of living with diabetes. The illusion of control according to the citizenship of the logic of choice expects a domestication of their bodies from patient-citizens, encouraging them to take care of themselves. People with diabetes seek to control their blood glucose more than they seek to be aware of events that trigger decompensation, feeding the illusion of finding a balance¹⁰. Consequently, progressive adaptations are more linked to the logic of care than to the search for control. Attempts to fit in with the recommended care when they fail lead to adjustments that suit their routines, being more incorporated into everyday life when the person is attentive to the experience^{11,16}.

By putting the possibility of control in the forefront, the logic of care accepts the viscosity and fragility of life, proposing a persistent practice of continuous adjustments between inconstant variables, in turn stimulating attention, adaptability and flexibility to deal with the erratic character of most diverse circumstances. To do so, it presupposes an active patient, subject to all types of activity, not just choice, who is respected in terms of the collectivities to which they belong, as well as their subjectivity, and who composes with all their experience the care team. In this sense, the use of technology in care is a matter of experimentation with knowledge, the possibilities offered by technology and the transformations that its use entails in practices, in forms of understanding, and in expectations. Thus, technologies are no longer seen as mere instruments or means to assume the role of inventive mediators¹⁰.

There is an important loss of subjectivity for both the patient and the professional in the hegemonic care model. This model is focused on medical-centered diagnosis and the care, while the professional and patient relationship is restricted to technical procedures, exams and medications. The health/disease process is reduced to biological characteristics, leaving out aspects of the social or subjective component, which should be part of the care process¹⁷. Meeting the needs of people with diabetes according to the logic of care involves adjustments between the actors involved. Care is not in the hands of one or the other, but in constant negotiation¹⁰.

From Mol's perspective, the usual response to guilt is punishment. When feeling guilty, people do not engage in care activities¹⁰. People with diabetes don't "choose" to measure their blood glucose less often than the nurse recommends, but it does happen. It is possible that they will not be able to do everything that is suggested, as care is not mainly about choices, but about organization in practice. Thus, the logic of care emerges regarding this view. In the case of a disease that affects a person's life, what constitutes value in this logic is not the body as a three-dimensional object, but life that includes the body as history¹⁰.

Mol advocates a shared medical practice in which the medical office is in fact demanded as a consultation space, with the exchange of experiences, knowledge, suggestions, and words of comfort, etc. being characterized as good conversation in this space; the very definition of what is good, better or worse in the treatment of diabetes is agreed in practice, instead of preceding it, and is continually re-agreed in the face of the fluidity of life and the possibilities available to the person with diabetes to deal with it every moment^{6,10}.

The two logics can alternate throughout the process according to the context of professionals and patients, and it is important to consider the interference of the subjectivities of the actors involved in care practices. The logic of care theory consists of an important tool to reflect on care practices and possibilities for improving relationships between professionals and patients in the context of chronic illness.

CONCLUSION

The reflective analysis from the logic of care perspective showed that the two logics (of care and of choice) are interposed according to the context in which the health professional and patient relationship occurs, and that the logic of care, to the detriment of the logic of choice, is shown to be a broad approach which covers the singularities of the patient in the context of chronic illness. The theory of the logic of care is an important tool for reflecting on care practices and possibilities for improving relationships between professionals and patients. Nursing can remodel its practices to promote a qualitative change in the form of support offered.

The biomedical model of self-care would be open to negotiation, abandoning its prescriptive character, to be activated in the context of the “conversation”, and adjusted to the needs and priorities defined by the patients themselves. Finally, care would be modeled through relationships that present more accentuated contents in the sense of exchange and reciprocity.

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