The Making of the Common in Social Relations

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INTRODUCTION

ALEXANDRE COTOVIO MARTINS
AND JOSÉ MANUEL RESENDE

This book stems from a basic question: in which forms of qualification and justification do social actors support themselves to engage in common actions? This question brings to the field of sociological and anthropological analysis the need to take into account the socially accepted forms of qualifications of common action and the ways by which they are brought to social situations and, simultaneously, to understand the processes of elaboration of justifications which may demonstrate to social actors that acting in common is worthwhile. We seek, thus, to analyse the processes by which social actors qualify and communalize certain aspects of their life and also produce justifications that give sense to the ways and means of actions thus brought to the stage of social life.

The analytic intent of the book focuses on three dimensions, each one aimed at the debate of a specific mode of communalization and justification in the areas referenced above: (1) the composition of common processes which departs from conventionally established orders of worth; (2) the composition of the common which departs from the association or aggregation of individual preferences; (3) the composition of common processes which departs from personal affinities referenced to usual places.

The book brings empirical sociological and anthropological analysis to the scientific discussion about these subjects. How can it be possible to construct the common in societies when faced with proof? Why do people mobilize in order to test their capabilities or to criticize and denounce the oppressions that are imposed?

Making the common amongst individual and collective actors presupposes the existence of different formats of coordination of actions that result, on the other hand, from a past and accumulated social work. Analyzing the making of anything in common requires taking seriously social actors' practices, that is, the ways by which they critically evaluate the questions at issue, and, by contrast, the situations where there is no

observable agreement on how the order of things can be ensured by all those involved.

The analytical objects that are treated in the texts presented in this book are diverse.

Alexandre Cotovio Martins, in his text, tries to identify and analyse situations of discord between relevant actors (including members of the patient's family) around the possibility of the patient's hospital discharge, in the context of his hospital career of illness and within palliative care. The analysis conducted was carried out on data collected under the PTDC/CS-SOC/119621/2010 project, financed by the Foundation for Science and Technology (FCT), in particular the data obtained through twelve months of ethnographic observation carried out at two hospital internment units providing palliative care in Mainland Portugal.

José Manuel Resende and Luís Gouveia discuss, in their text, the introduction of the public debate on school justice during the acceleration of schooling in Portugal, and how, from the discussions about the figure of the fair, new configurations emerge in school arenas, giving rise to the emergence of various compositions of schemes of involvement in action that cause, in schools, the emergence of creative formats of a school's worth.

Catarina Delaunay and Alexandre Cotovio Martins take as a focus of analysis the ethical tensions surrounding the act of being born and the event of dying. Using as central activities in analysis those associated with Medically Assisted Procreation, on the one hand, and Palliative Care on the other hand, the authors show how delicate criticisms made by social actors in different situations lead to tensions and to the building of several compositions of action requiring a delicate making of the common, subject to constant revision.

Keiji Fujiyoshi shifts his attention to a different subject. The author wonders about the tensions that cross striking historical processes in Japan and are fundamental to understanding the investments in forms made by different institutions in order to make a common understanding and assessment of the figure of what is a man and a Japanese family in Japan.

Ana Paula Miranda and Roberta Corrêa's text focuses upon the making of the common departing from a set of public controversies generated by evaluation processes made upon the truth and authenticity of religious beliefs which religious members practice with conviction, and also by the demands on a State (the Brazilian State) which is assumed as secular and republican.

Fabio Reis Mota and José Colaço, in turn, debate how the making of the common in fishing practices can bring to the public debate the identity

forms which fishermen craft in their daily activities. Using a comparative approach between fishing activities in Brazil and Portugal, the authors use their ethnographies to understand not only the discussions around the contextualized operations that manufacture them, but also the processes of recognition of social identities either by the Brazilian or Portuguese State institutions.

Luca Pattaroni invokes, in his text, the history of urban conflicts in Geneva and the way by which the existence of these conflicts renews the issue of urban order, in the search for other senses and meanings, which result from a creative composition of the investments in forms made by social actors involved in collective discussions.

The analytical and empirical frame here advances results, thus, from a collective work undertaken in a research network between Portuguese, Brazilian, Swiss and Japanese researchers, and is based on several research projects, developed in these different countries in the last decade.

The book intends to reach the academic public, namely scholars, both professors and researchers, as well as post-graduate students, in the areas of Sociology and Anthropology and, more widely, all professionals in the field of Social Sciences, in different countries. The book may also be of interest, given the domains that are treated here, to professionals in several areas, such as the ones of health, education or urban planning.

PART I:

THE MAKING OF THE COMMON IN PROFESSIONAL WORK

CHAPTER ONE

BUILDING PATHS TOWARDS DEATH: SOCIOLOGICAL PORTRAITS OF DISCORD IN FAMILY RELATIONS OF THE ELDERLY IN PALLIATIVE CARE

ALEXANDRE COTOVIO MARTINS

Introduction

Aging as a process

Thinking about aging in a scientifically updated and informed manner implies a critical and analytical distancing relative to theoretical and methodological perspectives that tend to grasp the correlative problematic issued from a simplistic point of view around the "age cohort". Indeed, the topic of aging should be regarded not as the study of a supposed series of attributes which would define, once and for all, a specific group associated with particular ages, but rather in a *procedural* perspective. And this is how, nowadays, it has become relatively consensual among the specialists to talk about the *processes of aging*, more so than about "senior citizens", "the elderly", etc.

The idea that aging is a *process* is essentially rooted in a concept of aging that is capable of offering an account that is closely linked to the *life cycle*. As noted by Cabral *et al.* (2013), the perspective of the course of life invites analysis on aging as a process and not as a specific age cohort, "whose constitution would result from the transition to retirement and consequent abandonment of active life". This is so, from the very start, because "aging, from the biological point of view, is more continuous than discontinuous, where there is not a fixed transition to old age. Discontinuity would be derived, rather, from social divisions of age, especially that which results from the institutionalisation of retirement".

This line of thinking and work falls in line, if we situate our vision at an epistemological level, with the recommendation of Norbert Elias, in the sense that the social sciences work in their theoretical languages of explanation and comprehension of the world, with a view to shifting from the interpretation and analysis of *states* to the interpretation and analysis of *processes*. The classification of population groups of great heterogeneity into a single descriptive and analytical category, as if this involved a homogenous group of individuals, is one of the epistemological obstacles which sociological rationale should confront and tackle.

This is all the more the reason why that in the case of old age, thinking in terms of aging processes implies a clear break with static perspectives on "elderly populations", precisely seeking to give an account of the dynamic character, and comprehensible in its duration, of the phenomena to be observed.

Temporality is, thus, an essential aspect of any consequent analysis of aging. On the other hand, this conceptualisation implies that one does not think, but rather one already sees, processes as a mere transit between watertight categories, correlative of different "states" in the distribution of certain properties among population groups. Studies on aging have progressively demonstrated that this attitude is analytically sterile or even erroneous.

Therefore, many of the processes that we can study in the context of the overall topic of aging, which affect those that are aging, are not necessarily *exclusive* to "elderly people" and their condition. And this is why we can study more general phenomena, such as loneliness or violence, which can, *a priori*, affect any age category, with a view to analysing their special incidence among the older population, as well as the specific forms and consequences that these phenomena take on in these cases, without this ultimately implying the indexing of general phenomena to particular age categories.

On aging as a process towards hospital careers of illness: some analytical assumptions

From our perspective, since the aging is a process that takes place over time, which also implies alterations in the social properties that characterise successive cohorts of individuals, it is appropriate to consider it, in part, as a series of paths that are travelled along in the context of life cycles. In fact, working from a procedural point of view implies using concepts that are capable of introducing temporality in analysis, as well as the dynamics of action between different contexts and situations.

This is why we introduce in our analysis the concept produced by Glaser and Strauss, of "career", both experiential and personal (2007), which enables us to connect aspects of temporality, experience and real situations that the social actors are confronted with when dealing with the end of life. From this point of view, we can understand that patients, their families and members of the healthcare teams will probably have had different experiential and personal careers in their relationships with disease, the organisation of care and end-of-life trajectories, whose confrontation in terms of interaction can produce complex effects in social processes that occur in the context of palliative care. These processes, on the other hand, are able to affect the comfort of people at the end of their lives, as they can cause uncertainty around the definition and management of end-of-life and care trajectories (*idem*).

In this article, in particular, we address the *hospital careers of illness* that characterise the end-of-life of many during their aging process. The hospital careers of illness include the different experiences that people undergo in their relationships with hospitals and healthcare professionals. For example, some patients repeatedly return to the same hospital. When this happens, the healthcare teams might react differently to the way they react when a "newcomer" arrives. The extent of the patient's familiarity with the hospital can also influence their reactions on the path towards death. One aspect of the effect of careers of this type in terminal situations is the conception of time, for example, in the acceptance or non-acceptance of death. These careers can exert considerable importance in end-of-life processes, affecting the interaction around the terminal patient and organisation of their terminal care (Glaser and Strauss, 2007).

Palliative care and aging

This analysis makes sense if we consider that the prevalence of chronic diseases with a strong probability of becoming terminal is particularly predominant (as would be expected) among the more elderly, although it is not evidently *exclusive* to the older age cohorts.

In the case of palliative care, the National Programme of Palliative Care indeed introduces the aging of the population, along with the increased incidence of cancer and the emergence of AIDS, as one of the "causes" which lead to the "problem" of patients who need palliative care as a public health problem of major social impact.

Since palliative care is a response that is also directed at those who are aging, because of their tendency to greater vulnerability to diseases strongly susceptible to becoming chronic and inducing terminal states, we

can say, looking at aging as a process, that this care tends to be found at an extreme point of certain organic conditions associated to this same aging (not exclusively, however there are, naturally, organic conditions which may require palliative care at any age).

The centrality of the family in palliative care

Within palliative care, the family of patients tends to take on a central role in the social processes underway. As noted by Ana Bernardo, 'the family constitutes a basic pillar in the care of terminal patients, to such an extent that without their active participation it would be difficult to achieve the proposed objectives. It is the family that can constitute the connecting link, the symbol of belonging and a reference of the individual. The family frequently shares the problems of the patients and thus becomes an active element in the therapeutic process. For this reason, the family needs and has the right to be informed of all aspects of the disease and particular situation of its patient, if the patients so permits. When the patient is dying, the family should be informed of the circumstances in which he is found (…)" (Bernardo, s/d).

Isabel Neto also highlights the central role of the family in the specific context of palliative care, referring to the necessity derived thereof, of the healthcare team working on the family dimension of the care: "The family frequently shares the problems of the patients; other time it presents specific needs (…). The family is simultaneously a provider and target of care. The professionals should always take this into account and systematically integrate family support in the provision of care to terminal patients" (Neto, 2004).

Discord in family relations in palliative care: a reality?

In this article, based on the result of research processes, we show that one cannot (or rather, one should not in any case) have an *irenic* perspective on the place of the family in palliative care. Indeed, a good part of the consulted literature on palliative care perceives the family along somewhat idealised lines, not conferring, in our opinion, sufficient centrality to discord and family conflict in the midst of this type of care. In this regard we intend to show, through empirical data and the respective theoretically informed interpretation, how the family is also the place of relations where discord and conflict are present, where these dynamics even become, in many cases, an element of major importance in the intervention of the professionals, with a view to solving or at least

mitigating many situations of tension which arise within the family context.

Framework of analysis: object and methodology

Objective

Our central objective was to identify and analyse situations of discord between the relevant actors (including members of the patient's family) around the possibility of the patient's hospital discharge, in the context of their hospital career of illness and within palliative care.

Methodology

Type of analysis and data collection instruments

The analysis conducted herein was carried out on data collected under the PTDC/CS-SOC/119621/2010 project, financed by the Foundation for Science and Technology (FCT); in particular the data obtained through twelve months of ethnographic observation carried out at two hospital internment units providing palliative care in Mainland Portugal. The ethnographic observation records were kept in "field logs", drawn up by two scholarship students contracted under the aforesaid project.

Sample

The data contained in the field logs were, in the first stage, subject to an exploratory Categorical Content Analysis, based on the following positive discrimination criteria: i) the existence of relevant family relations (i.e. with observable influence in the contexts of action in palliative care) of patients under palliative hospital internment; ii) the existence of discord between relevant actors (patient, family, professionals) in view of elements of uncertainty present in situations of palliative internment. With this procedure, 59 households were identified as being involved in situations with the intended features.

From this point onwards, the sample was constituted according to two analytical "axes", namely "critical moments" and "people". Therefore, not only people were selected, but also key-moments of interaction in palliative care, to the extent that these aspects proved analytically pertinent, thus configuring a "case". Indeed, as taught by Corbin and Strauss (1993), in qualitative sociology it is just as relevant to take

samples of situations as it is of people (sometimes, even more relevant). Hence, we define a "critical moment" as a situation where there is discord between the relevant actors in view of elements of uncertainty present in situations of palliative internment. The term "critical" comes precisely from the nature of these situations, mobilising the critical competence and skills of the actors, aimed at reducing the uncertainty inscribed in these very situations and involving different claims (sometimes implicit) of legitimacy. On the other hand, this procedure appears to be clearly justified by our intention to analyse, herein the *hospital careers of illness* of elderly people, in their relationships with family, and where these careers are only comprehensible as an articulated series of specific situations and respective experience lived by the actors under consideration.

Concerning the first axis, "critical moments", after analysis, we selected three types of situation: a) the initial entry and reception into palliative internment provided by healthcare professionals to the patients and their families; b) situations of discussion of the (im)possible hospital discharge of patients under palliative care; c) situations of discussions of end-of-life trajectories of patients and related aspects.

In the case under review we selected type b) situations for analysis, since these represent action scenarios where the autonomy of the families is particularly high in the context of the development of hospital careers of illness, as the family plays a fundamental role as a potential informal carer.

Concerning the second dimension of the "persons" sampling, we considered the following criteria:

Criteria of inclusion in the sample:

- Patient aged 65 years or above;
- Patient in a situation of internment in palliative care;
- Existence of information on relationships with the family considering pertinent topics;
- Existence of discord and/or family conflict regarding a possible hospital discharge.

Criteria of exclusion from the sample:

- Occurrence of dementia in the patient (confirmed by the healthcare team);
- Refusal to participate in the study.

Finally, from an initial total of 59 observed households, 9 cases were selected on an exploratory basis.

Data treatment: brief explanation of Greimas actantial analytical model

The treatment of the data obtained after sampling was carried out based on the semiotic work of Algirdas Greimas, in particular its Actantial Model (Greimas, 2007). A brief description of some of the central elements of the model is presented below.

The model seeks to interpret the action by decomposing it analytically. The central concept of this model is the *actant.* Actants are different entities (humans or other beings) that perform a significant role or duty in the development of the action. Greimas identifies six types of actants, which can be contextualised in the light of three axes of analysis of the action (see Annex 1). We thus have the axis of *wanting*, which articulates a subject and an object; an axis of *knowing* or *communication,* which articulates a sender and a receiver; an axis of *power*, which confronts helper and opponent elements. The subject is the person to whom an object (or purpose) is directed; the sender is the element that requires the connection between subject and object; the receiver is the element on behalf of whom the action is carried out; the helper assists in the accomplishment of the intended connection between subject and object; the opponent counters this same connection.

The classification process was carried out according to the following sequential process:

1. Identification of the key actants (more constant but observations and theoretically relevant);
2. First preparation, inductive, of standard grids around the key actants;
3. Deductive systematisation of the *n* possible situations taking into account the relevant elements of each situation and the key actants;
4. Return to the material/elimination of the possible but non-observed situations.

Actantial models of discord

Actantial Model 1–Discords around 'hospital discharge'
a. Patient as subject (i)

Sender		**Subject**		**Receiver**
Patient	→	*Leaving the hospital*		*Patient*
Helper	→	**Object**	←	**Opponent**
Professionals; health condition		*Patient*		*The family; family situation*

C1.
The patient is lucid, remains bedridden, calm, controlled and, according to the doctor, "Has an extremely strong personality!" She is very authoritarian with the nurse, but above all with her family. During the last visit, she argued with her daughter because she wanted to go home and she was in charge, leaving it quite clear that "I am in charge here!" her daughter is physically and psychologically exhausted and states that she does not have the right conditions to have her at home, although she has been caring for her mother for 12 years. With the team, the patient does not show an interest in going home. Her health situation is under control, not requiring analgesics. Her son-in-law does not want to present the team with the necessary documents for a new referral of the patient to the National Network of Integrated Continued Care (RNCCI), refusing to give the number of his bank account, required for the purpose of calculation of the costs of the care provided to his mother-in-law. The daughter is reluctant to take her mother home, because she fears that this return could finally destroy her marriage (…). The social worker indicated, as an alternative to internment in the RNCCI, her internment in an institutional Home or possible return to her former home, but the social worker does not currently know whether the daughter has investigated if there is a possibly vacancy at the Home previously indicated by the social worker. The team will propose to the family that the patient goes home at least for a few days (fulfilling the patient's wish), declaring her discharge is to test the reaction/capacity of acceptance by the family.

C2.
The patient shows an interest in returning home and is referred to the RNCCI. The wife is the carer, but is not at all receptive to the patient's discharge, because she claims that she is also sick and taking medication

to sleep. Furthermore, the wife only visits the patient when she has a lift from other people who are going to the hospital. Although the patient really wants to go home, the daughter claims that she cannot take him in because she lives in X, she does not even telephone to ask about her father, apart from which his grand-daughter does not have a steady job and is the mother of two children. The daughter and wife visited the patient last Saturday evening, through prior notice given on the previous evening, when the doctor took this opportunity to try to persuade the family to fulfil the patient's wish and take him home for the rest of the weekend. During the visit to the unit, the daughter had already said in an outraged fashion "I know that you are all here on holiday and want to send the patients home!", and the patient's entire family refused to take him home. Note was made of the existence of previous problems between the couple, and the social worker emphasised that, in contrast to families which are truly incapable of looking after the patients at home, this case involves a family which rejects the very idea and will not collaborate in anything.

Actantial Model 1–Discords around 'hospital discharge'
b. Patient as subject (ii)

Sender →		**Object** →		**Receiver**
Patient		*Leaving the hospital*		*Patient*
Helper →		**Subject** ←		**Opponent**
The family (son/daughter)		*Patient*		*Health condition; delay of home support; delay of response of the Network.*

C3.
The doctor used to explain and write down for her husband how the medication was administered, without ever understanding that he did not know how to read, which was only discovered when the patient was interned and the husband consistently asked what was written on the paper for the patient [his wife], since she was the one who looked after the medication even during periods of crisis of the disease. She is very emotionally debilitated, has little capacity to communicate. She feels sad and abandoned, her husband is very self-centred, and he often speaks of himself and says that he is worse than the patient. The patient repeatedly

confesses that she fears that her husband is going out with other women while she is interned. The team thinks that this discourse is related to issues of the past. The medical trainee joked with the patient telling her not to worry because no woman would want an old man like that anymore! The patient laughed. (…) [The patient] has only one son who lives in X and is now in Y to support his parents; he will stay until P and is preparing everything to take his mother home in a few days. He is very collaborative and receptive to taking his mother home, however, due to her state of cachexia, he says that he cannot even consider thinking about giving her a bath and the response of the home help service is taking some time to arrive. The social worker talked to him about the possibility of contracting private help, he answered that he could do this, but that he does not know anyone in his mother's village, so he said that he would talk to a cousin and ask her to help. Awaiting a vacancy at the RNCCI. The availability of the vacancy is taking time and the doctor believes that the patient will leave before there will be a vacancy in the network.

Actantial Model 1–Discords around 'hospital discharge'
c. Patient as subject (iii)

Sender →		**Object** →		**Receiver**
Patient		*Permanency in the hospital* ↑		*Patient*
Helper →		**Subject** ←		**Opponent**
Professionals; health condition		*Patient*		*The family*

C4.
The patient has a very present family, however he refuses to go home because he feels that he would be a burden on his children's lives. His son was transforming the office into a bedroom so as to be able to receive his father. The patient would only accept the option of going to the RNCCI, but his medical situation does not permit this. It should be emphasised that the patient expresses that he should die quickly, where this suffering of his is reinforced by the family's suffering. His children remain seated next to their father, reading, in silence. The patient scarcely says a word, either to the family or to the Palliative Care team. And shows a "defeatist" attitude, being very introspective. According to the doctor, "The patient has given up because he thinks that he is not doing anything at all here", having a full understanding of his situation because he directly questioned the team.

Actantial Model 2 –Discords around ‘hospital discharge’
d. Family as subject (i)

Sender →		**Object** →		**Receiver**
Familiar		*Permanence of the patient in the hospital* ↑		*Patient; familiar*
Helper →		**Subject** ←		**Opponent**
Health condition; improved health (or psychological) condition in internment; alleged lack of financial resources.		*Family*		*Team; definition of the clinical situation as “not palliative”; pressure of waiting lists on the number of beds*

C5.
The daughter cries a lot, she needs psychological supervision, she was furious with the team, said in oncology that at the Palliative Care Unit (UCP) they did not know how to treat her mother. Her symptoms are under control and she is waiting for a vacancy at the RNCCI. The team proposed that her mother should go home for a few days; she was not receptive and said at the day centre that everyone stayed at the UCP except her mother, who was discriminated against. According to the doctor, the patient’s condition has shown some deterioration over the last few days and her daughter was happy because this implies that they will not pressurise her to take her mother home.

C6.
Because they let the patient be admitted so that the carer could get some rest, her husband perceives this as an internment and no longer wants the patient to be discharged from the unit, refusing vacancies at other network units. The social worker says that the carer claimed that the patient did not sleep and screamed a lot at home, and needed help from the psychologist; nurse X says that at the unit this situation does not occur and the patient sleeps. The doctor says that the situation is more complex than it appears, that the patient is a woman who has spent a lifetime being forcibly at the disposal of others, that she was mistreated and that now she is making

them pay through her illness. This is a social situation, not a clinical situation, but is insufficient for palliative care. The doctor says that the patient shows a better general condition than the previous year, but that the patient pressurised the Regional Health Administration and they gave in but the patient is completely controlled and there are patients requiring palliative care who need her bed. Nurse X reiterates the belief that her husband will refuse the vacancy for a Long Duration and Maintenance Unit. The doctor suggests that a transfer should be requested immediately for the patient to be discharged. The social worker informs him that the husband has already been told to consider the accounts of the daily amounts payable in another unit of the network and he said that he did not have the money to pay this, the psychologist and the doctor say that he will not accept it.

Actantial Model 2 –Discords around 'hospital discharge'
e. Family as subject (ii)

Sender →		**Object** →		**Receiver**
Familiar		*Patient leaving the hospital* ↑		*Patient; familiar*
Helper →		**Subject** ←		**Opponent**
Closeness to the family; possible influence at the Homes in order to obtain a place.		*Family*		*Professionals; aggressive behaviour of the patient; exhaustion of the carer; health condition of the patient; location of the health units*

C7.
While still at home, even before being interned at the UCP, he hit his wife. He is in no condition to be discharged. He was referred to the RNCCI by the community, the CP team who terminated the referral, but they do not know if he will still be in a condition to go to the RNCCI when a vacancy appears. He lives with his wife and a single son who works all day. His wife was the main carer; she is exhausted, but would still like to take her husband home, although the team thinks this is impossible due to his current state and 'aggressiveness'. His wife is a popular poet, she writes 'very lovely poems' and is 'spectacular' (doctor). The patient is 'brutish'

in talking (doctor and nurse X), blackmails his children and wife when they come to visit, threatening that he will kill himself, that he would at home (…).

C8.
The nephew said that the location of the Medium Duration and Rehabilitation Units is a limitation to his uncle's transfer, since he also has an aunt, wife of the patient, with Alzheimer's, interned in a home, so the team should present a series of Medium Duration and Rehabilitation Units compatible with the aunt's location. The nephew's idea of taking the uncle to a Long Duration and Maintenance Unit is so that he can stay closer to the aunt. The team noted that these units do not accept patients with wounds, to which the nephew replied that he usually finds patients there with wounds. He said that they can pay the daily fee and if the unit agrees, the dressings, that the cost was not the problem. The doctor then said that she would wait five to ten days and if the situation continued the same they would request the transfer to be with his wife since "this is a minimum of humanity". As there was further deterioration, the patient will continue at the unit, but the nephew asked for his referral to the Long Duration and Maintenance Unit and says that he will talk to the unit and try to resolve the situation on his own, noting that family criteria are really downplayed in relation to medical criteria.

Actantial Model 2 –Discords around 'hospital discharge'
f. Family as subject (iii)

Sender →		**Object** →		**Receiver**
Familiar		*Patient leaving the hospital* ↑		*Patient; familiar*
Helper →		**Subject** ←		**Opponent**
Professionals; symptomatic control		*Family*		*The patient*

C9.
The patient was being supervised by the hospital's oncological service, came to a palliative care appointment urgently due to contact by the community team and was interned in medicine until a vacancy emerged in the UCP. She has […], heart failure and respiratory insufficiency, which are worsening. When she entered the UCP she was in uncontrolled pain, which is currently controlled by opioids that are systemically monitored,

because when the patient was interned in medicine she showed a ‘clinical picture of terror’. She is under control, she had insomnia last night. The psychologist has already intervened with this patient since the diagnosis in oncology. She has only one son who lives in X and works in Y. Although the patient says she does not want to go home, the team and the son are planning to take the patient home.

Key

(;)	non-necessary conjunction
(⟶)	Direction of the action or intention [from/to]
(C)	Case

Discussion

Through the data and concepts presented above, we observe that discord is part of the dynamics of interaction, present on a daily basis in various situations in the context of palliative care. This discord, on the other hand, is not distributed by chance in the different observed situations, where some seem to us to be more hazardous in their appearance: the initial reception in palliative internment, the situations of discussion of the (im)possible hospital discharge of palliative patients and the situations of discussion of the end-of-life trajectory of the patients and related aspects. Concentrating on the discussion of the possible (or not) hospital discharge of patients in palliative care, we also observe that discord not only tends to arise in specific situations, but also takes on a variety of configurations, as is revealed through the use of Greimas’ actantial model.

This data forces us to reflect on the great specifically social complexity confronting healthcare professionals–namely doctors, nurses and social workers, the objects of our study–in their daily professional lives. As can also be gathered from the use of Greimas’ actantial model, the healthcare professionals are directly involved in the definition and management of situations of discord, which will tend to increase, in our opinion, the difficulty experienced by these professionals in approaching this clearly relevant dimension of their daily work. In a connected and complementary form relative to the study of the involvement of professionals in situations of discord, we are also developing research work relative to the ways that professionals seek to soften the tensions and fabricate local agreements which mitigate these tensions, in order to promote the comfort of patients and their families in end-of-life processes. We consider these analytical

axes as relevant for the elucidation of the social complexity of the work of healthcare professionals in palliative care.

Conclusion

The analysis above illustrates the advantages derived from articulation, in the sociological research of health phenomena and, in particular, palliative care, between the perspective of pragmatic sociology and the analytical contributions developed by Barney Glaser and Anselm Strauss (who were, in turn, strongly influenced by the American schools of pragmatism and symbolic interactionism). In the case study, the identification of critical moments in end-of-life trajectories and the perscrutation of the plurality of perspectives and claims of legitimacy between the different participants in the context of the different situations identified in palliative care appears to bring some analytical clarification on extremely intricate professional daily lives, namely in dimensions of health practices which tend to be occluded in many studies of the area of health sciences. On the other hand, this same analysis enables comprehension, from other angles, the 'role' of the families of patients in palliative care, which is far from being limited to a linear, passive or even pacific involvement.

Furthermore, it should also be noted that the model of analytical treatment of data that was used, in addition to employing categorical content analysis, also introduced elements of Greimas' actantial analysis, thus recovering, at a methodological level, an element which arises as a reference in the actual foundations of pragmatic sociology and, at a theoretical-conceptual level, lending operationality to another basic concept of this theoretical framework: that of *situation*. The connection to the sociological analysis of the end of life, by Glaser and Strauss, also enables inscribing the situations in time, according to concepts such as end-of-life trajectory or personal and experiential career.

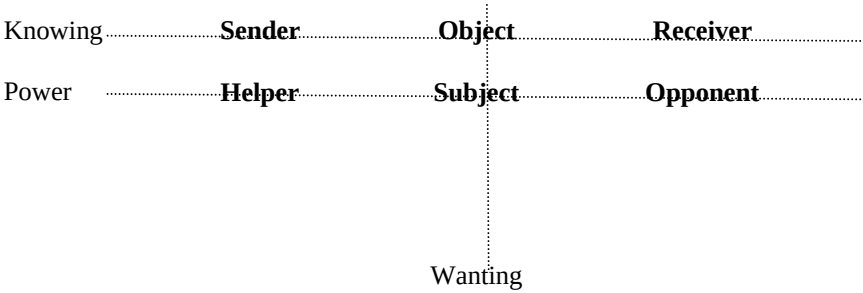
Notes

[1] CICS.NOVA/Interdisciplinary Coordination for Research and Innovation, Portalegre Polytechnic Institute

[2] Greimas began working with literary narratives.

[3] The illustrations presented herein are not exhaustive in relation to the actants identified in the tables, for each actantial model.

Appendix A: Schematic representation of Greimas actantial model (based on Greimas, 2007)



CHAPTER TWO[1]

THE PUBLIC EDUCATIONAL POLICIES FACING THE FIGURE OF THE FAIR: THE PRINCIPLES OF JUSTICE IN THE ACCELERATION OF SCHOOLING IN PORTUGAL[1]

JOSÉ MANUEL RESENDE[2] AND LUÍS GOUVEIA[3]

On the effects of schooling in Europe and Portugal: its implications between the twentieth century and in the transition to the new millennium

The Portuguese "school issue" presents interesting peculiarities when it is elevated to a scientific problem, namely, by the national historiography. This is mentioned by António Candeias (2001). According to this author, when analyzing the historical processes of literacy and education of European people, the Portuguese case is usually considered to be a peculiar case in comparison with what has happened with other European countries; that peculiarity is almost always pointed to by our historiography as one of the signs of the Portuguese "delay". And the signs of the delay are double.

On one hand, the literacy process in Portugal does not start in the same period as in parts of Europe influenced by the religious controversy pointed to historically and politically as the religious movement of the "Reformation and Counter-Reformation".

If it is true that, in their origin, the main quarrels converge in the religious issue, in the temporal course of the movement, its effects gain, in

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