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Reflection Article/Essay

Discourse and micropower in the intervention with hospitalized elderly people with delirium: reflection on absent narratives

Discurso y micropoder en la intervención con personas mayores con delirium hospitalizadas: reflexión en torno a las narrativas ausentes

Discurso e micropoder na intervenção com idosos hospitalizados com delirio: reflexão sobre narrativas ausentes

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Abstract

In this essay, we analyze the interactions between elderly people (EP) hospitalized with delirium and the health team. To reflect on the construction of these interactions we rely on the philosopher Michel Foucault, in his presentation and book "Order of Discourse", where we consider how micro-power social relations can be presented in various contexts, landing the interaction described from the strategies and discourse exclusion tactics. It is emphasized mainly i) reason and insanity, identified in EP hospitalized with delirium, which may have a narrative from the neurocognitive disorder, presenting an experience of isolation; on the other hand ii) the health team is based on determining what is true from what is false, using its knowledge and tactics from the process of diagnosis and intervention, which cannot collect the experiences of EP with delirium. Finally, we propose a new construction of the phenomenon from agency realism that integrates the knowledge of the health team and the experience of the EP with delirium.

Keywords: Elderly People, Health Personnel, Hospitalization, Biopolitics, Interpersonal Relations, Discourse Exclusion, Agency Realism.

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Resumen

Este ensayo analiza ¿cómo son las interacciones entre las personas mayores (PM) hospitalizadas con delirium y el personal de salud? Para reflexionar en la construcción de estas interacciones, nos basamos en el filósofo Michel Foucault, en su presentación y libro del "Orden del Discurso", donde consideramos como las relaciones sociales de micropoder pueden presentarse en diversos contextos, dialogando la interacción descrita desde las estrategias y tácticas de exclusión del discurso. Enfocamos sobre i) la razón y la locura, al identificar en las PM hospitalizadas con delirium, una narrativa desde el trastorno neurocognitivo, presentando una experiencia de aislamiento y por otro lado ii) el personal de salud, que se basa en determinar lo verdadero de lo falso, utilizando su conocimientos y tácticas desde el proceso de diagnóstico e intervención, el cual no logra recoger las experiencias de las PM con delirium. Por último, proponemos desde el realismo agencial una nueva construcción del fenómeno, que integre el conocimiento del personal de salud y la experiencia de las PM con delirium.

Palabras-clave: Personas Mayores, Personal de Salud, Hospitalización, Biopoder, Relaciones Interpersonales, Exclusión del Discurso, Realismo Agencial.

Resumo

Este ensaio analisa as interações entre idosos hospitalizados com delirium e a equipe de saúde. Para refletir sobre a construção dessas interações, baseamo-nos no filósofo Michel Foucault, em sua apresentação e livro "Ordem do Discurso", em que considera como as relações sociais de micropoder podem ser apresentadas em diversos contextos, dialogando sobre a interação descrita a partir das estratégias e táticas de exclusão de discurso. Enfocamos principalmente i) razão e loucura, identificada em idosos hospitalizados com delirium, que podem ter uma narrativa oriunda do distúrbio neurocognitivo, apresentando uma experiência de isolamento; por outro lado ii) a equipe de saúde baseia-se em determinar o que é verdadeiro e o que é falso, valendo-se de seus saberes e táticas do processo de diagnóstico e intervenção, que não consegue captar as experiências de idosos com delirium. Por fim, propomos uma nova construção do fenômeno a partir do realismo da agência que integra o saber da equipe de saúde e a vivência do idoso com delirium.

Palavras-chave: Idosos, Pessoal de Saúde, Hospitalização, Biopoder, Relações Interpessoais, Exclusão Discursiva, Realismo de Agência.

Introduction

Older people (OP) have a higher risk of losing health due to the presentation of diseases, multiple associated pathologies, polypharmacy, and the possibility of presenting functional alterations. They make them more susceptible to hospitalizations in which it has been described that about 40% of hospitalized are over 65 years old (Mattinson, 2019). From this context, we will review the hospital experience of OP with delirium and the interaction with health personnel. To understand the problem of this essay, we will show the different actors in this relationship.

i) First, hospitalized OP who remain in different surgical and medical units of low, medium, and high complexity centers may present an acute and fluctuating neurocognitive hospital complication, known as delirium (hereinafter referred to as hospitalized OP with delirium). This condition generates important impacts such as increased hospitalization days, cognitive impairment, decreased functionality and independence, post-traumatic stress, and increased risk of mortality (Oh et al., 2017);

ii) Second, the *health personnel*, made up of doctors, nurses, paramedical technicians, kinesiologists, speech-language therapists, occupational therapists, psychologists, nutritionists, pharmaceutical chemists, who must provide the necessary care and attention for recovery, rehabilitation, and palliative care, and must also collaborate in activities to promote and protect health (González Wiedmaier et al., 2019).

In this essay, we will analyze the interaction aspects of the power relationships that are established between hospitalized OP with delirium and health personnel, considering this relationship from Foucault's perspective. It manifests power as "[...] *a vast technology that crosses the set of social relations; a machinery that produces effects of domination from a certain particular type of specific strategies and tactics*" (Foucault, 1980, p. 144). From this text, we will collect two concepts a) **social relationships**, in the everyday sense, and direct contact between the individuals that maintain links or interactions, which is reproduced in an atomized way materializing micropower, and b) the **specific strategies and tactics**. Considering the discourse as a common axis in both elements.

This leads us to ask in this essay: How are the daily interactions of micropower observed between health personnel and hospitalized OP with delirium? How can these interactions be transformed?

Epistemological Foundation/Theoretical Framework

The epistemological perspective that we link this reflection seeks to place the health intervention of OP with delirium in a critical and transformational perspective, ascribing to the feminist vision proposed by Barad, which intertwines ontology, methodology, epistemology, ethics, and politics, as part of the phenomenon to be studied and not above the phenomenon (Barad, 2007).

Thus, we will analyze aspects of the definition of subjects/power, their semiotic/material interactions (discursive and non-discursive), how they generate their knowledge, and the ethical and political implications of this intervention. To guide this analysis, we will explore a redefinition of relationships to generate intervention devices that are relevant and respectful of the needs of OP with delirium in the hospital setting.

From this perspective, we are going through the intervention device understanding, as Foucault points out, that power is present in different spaces and levels of our society, which means that it is present, consciously or unconsciously, in social relationships (Fair, 2010), where inherent relationships of power and domination of some agents over others are manifested, mobilizing micropower in daily relationships crossed by discourse, corporality, our norms and values (Guillen, 2004). This is how micropower

can be exercised in places such as hospitals, schools, and prisons, expressing in professional-patient, and teacher-student relationships, among others.

In this way, we will analyze the aspects of the interaction of speeches generated by OP with delirium and how they are listened to by health personnel, considering the strategies and tactics of deployment of this micropower, in which "[...] *the production of the speech is at the same time controlled, selected and redistributed by a certain number of procedures whose function is to conjure up their powers*" (Foucault, 1973, p. 14) generating an exclusion procedure. For this, we will use two concepts of exclusion of discourse, first of all, **the analysis between reason and madness**, where the discourse of madness loses validity at different levels of every day, social, political, and legal life, and its words "[...] are never collected or heard" (Foucault, 1973, p. 16). This perspective develops the idea of separation between individuals. Second, a form of exclusion that corresponds to **determining what is true from what is false**, which has had an evolution from the religious construction to the present in the search and will to know from the sciences. It has been built through the structuring of

> [...] observable, measurable, classifiable objects; a will to know that imposed on the knowing subject a certain position, a certain way of looking and a certain function…. that prescribed the technical level at which knowledge should be invested to be verifiable and useful (Foucault, 1973, p. 21).

This last system of exclusion is implemented in various institutional spaces, through daily practices such as the form of organization, learning, and construction of books, among others. Thus, the discourse from the perspective of truth is generated by authors, scientists, and professionals, which has veracity, for only being presented from that position.

From the perspective of praxis, Foucault shows another context of power generation, related to the "**Disciplines**", where he clearly expresses their organization, in which it is "[...] *defined by a scope of objects, a set of methods, a corpus of propositions considered true, a set of rules and definitions, of techniques and instruments*" (Foucault, 1973, p. 33). The disciplines for their construction require the elaboration of new statements and propositions, which must have a coherent and systematic character to the discipline that belongs, with certain theoretical and practical conditions, organizing their limits, expelling from them false or irrelevant propositions, in which "*Discipline is a principle of control of the production of discourse*" (Foucault, 1973, p. 38).

Therefore, the question that arises is: how does the discipline generate the asymmetry in the discourse? What is possible to explain through the rules, the generation of distant concepts for the individuals that do not integrate that discipline, through an inaccessible and intelligible language, and that is characterized because the regime of the production of truth is constituted through a network of devices and apparatuses that produce and regulate customs as well as habits and social practices. In this way, the disciplinary society seeks to maintain rules, procedures, and mechanisms of inclusion and exclusion (Giraldo Díaz, 2006).

This relationship requires a transformation process, where we will review the proposal of the feminist physicist Karen Barad, who expresses the importance of the construction of the phenomenon between the dyads (individual-object, doctor-patient),

understanding the phenomenon as a **performative reality**. That is, it is constituted by a set of agents that interact with each other, -the intra-action, manifesting the relevance of the relationship between the different actors and actresses, since they are not separable, nor independent, but part of the same phenomenon.

Development

As we mentioned previously, the agents of the micropower relationship that we will describe are the hospitalized OP with delirium and the health personnel.

To contextualize, we will first review the aspects of OP and their conditions, highlighting at the health level their greater risk of loss of health, making them more susceptible to hospitalizations, where it has been described that about 40% of hospitalized patients are over 65 years old (Mattinson, 2019).

In this way, our focus is that hospitalizations can generate various complications, one of them being delirium. It is defined as a neuropsychiatric disorder caused by a manifestation of acute brain dysfunction, which causes acute alteration of cognition, attention, and orientation, accompanied by alterations in perception, speech, emotion, memory, and psychomotor activity (Ospina et al., 2018). This complication varies according to the medical unit where they are located. In OP, a prevalence of close to 31% has been described in emergency units, 70% in surgical units associated with the complexity of the surgery, and up to 80% in the Intensive Care Unit (ICU) (Pandharipande et al., 2017). Within this process, the list of risk factors to trigger delirium should be mentioned, in which i) predisposing factors have been identified that being over 65 years of age, presenting geriatric syndromes (such as dementia, depression, risk of falls, malnutrition, polypharmacy, pressure injuries, sensory impairment) and pre-morbid states such as inactivity, poor functional status, social isolation, frailty. In turn, ii) precipitating factors, in which acute pathologies are considered, highlighting those of inflammatory origin, and environmental conditions: such as being in an ICU, sleep deprivation, use of movement restriction, physical restraint, and signal reduction sensory (Inouye et al., 2014).

During a hospitalization, OP experiences a lack of familiarity with the environment due to the daily rotations of the personnel who carry out their clinical procedures, which generates the feeling of always meeting someone new. At the physical and corporal level, many times people are subject to physical equipment necessary for physiological monitoring, and drug delivery, and if the patient presents changes in consciousness and agitation, preventive measures of containment and physical restriction will be implemented (Christus, 2017), preventing any activity from being carried out autonomously. This context may be unknown and unintelligible to the OP, which contributes to the presentation of delirium, in which feelings of fragility and loss of autonomy have been described by OP during hospitalization (Belluck, 2020).

Also, OP hospitalized with delirium have alterations in perception and speech, often with ideas of harm, distressing, uncomfortable, and sometimes terrifying, with hallucinations or persevering ideas, persecutory ideas (Belluck, 2020), in occasions directed towards the members of the health personnel. In this context, a relevant limitation suffered by OP with delirium is the ability to communicate and make themselves understood. On the one hand, their stories are not legible and

understandable to others (Darbyshire et al., 2016), and on the other, the health personnel notifies these reports as symptoms, using them from a technical point of view, for the determination of the diagnosis and treatment. Therefore, there is no listening to what the OP with delirium is experiencing, but rather, these stories are classified as a category of health measure (with delirium or without delirium), leaving these narratives below the threshold of scientific knowledge, so that the diagnostic health personnel diagnoses "the form", moving away from the content, conforming the dynamics of micropower (Ávila, 2006). These narratives are interpreted with stigma by the health personnel towards the OP, related to the principle of exclusion (reason/madness), expressing a separation (Foucault, 2005) between the staff and the OP hospitalized with delirium, as noted above, in the theoretical foundation.

Linked to this and due to the high technological development of recent decades, health teams are expected to apply techniques that achieve recovery or control of diseases, significantly increasing their techno-scientific skills. However, these advances have emphasized the technology of processes, seeking greater efficiency in the exploration of diagnoses and effective results. This dynamic has generated a distancing and rupture in the narrative interaction between patients and health personnel (Azeredo & Schraiber, 2016). Therefore, these advances have led health professionals to develop a specialized discourse, which is learned for years and that allows them to achieve a position among their peers. Likewise, the use of this speech can be difficult for patients to understand, being an aphasic of their hospital experience (aphasia is understood as a language alteration that can affect its understanding).

In this context of intervention, we will discuss how the delirium evaluation and intervention process is organized, and we will understand how health personnel collects the experiences of OP. The detection of delirium can be carried out with the implementation of evaluations, which can be applied by trained personnel, which include aspects described in the DSM-IV Diagnostic Manual, which are a) Acute change and fluctuating course of consciousness; b) Inattention; c) Disorganized thinking; d) Altered level of consciousness (American Psychiatric Association, 2013). When reviewing the delirium guidelines (Network for Investigation of Delirium: Unifying Scientists, 2018), its main focus is the detection of the presence or absence of certain behaviors. This follows the coherence of how neuropsychological evaluations that seek to identify and characterize have defined the cognitive/behavioral effects of brain pathologies, relating data to expected performance (Baum et al., 2017).

Regarding the cognitive assessments, it is important to mention that there is a standardized form of professional questions and expected answers from the patient, which allows diagnoses and interventions to be categorized, reflecting in this instrument an aspect of discipline and control. The implementation of these processes is necessary for daily work, and at the same time, they shape the biomedical discourse of health personnel, which is defined as "[...] *an area of objects, a set of methods, a corpus of propositions considered true, a set of rules and definitions, of techniques and instruments…*" (Foucault, 2005, p. 33). Thus, to integrate a discipline, health professionals make up their language, which allows: for classifying, diagnosing, treating, and establishing recovery expectations, in turn, this discourse allows for achieving a position and hierarchy within the same hospital community.

Thus, the members of the health personnel do not make adjustments or personalization the evaluations and interventions, but rather implement homogeneous processes in the OP with delirium. At the time of collecting information, only what is stipulated by the discipline is collected, without achieving a dialogue that allows knowing about the life history, interests, functionality, and previous roles, expectations, or fears of hospitalization, that is, the narratives of the patient, by not being considered, can generate distance in the relationship. This could be interpreted because the disciplines are organized "[...] *within their limits, each discipline recognizes true and false propositions; but it pushes all the teratology of knowledge to the other side of its margins*" (Foucault, 1973, p. 33).

Another relevant aspect, which occurs between health personnel and hospitalized OP with delirium, is non-pharmacological interventions that can reduce the incidence of delirium. These interventions are varied and are referred to as a package of actions (Tobar & Alvarez, 2020), directly associated with the relationship and interaction of health personnel with OP, where strategies are proposed that the personnel should facilitate as follows: i) create a personalized and familiar environment for each patient; ii) avoid the use of restraint and physical restraint; iii) facilitate communication and reorientation, which corresponds to the health personnel is present during the interventions, explaining the procedures that are going to be performed, listening to the needs of the patients, etc. iv) allow extended family visits; v) facilitate early mobilization, avoiding immobility; vi) use of glasses, hearing aids and dental plates (Oh et al., 2017). If we analyze these actions, they are related to the fact that the staff must initiate more direct contact and include the OP. We see this in acts such as greeting, explaining procedures, answering questions, and knowing part of their history to personalize their room; in addition to other actions that are related to the possibility that the OP can make contact with the context and the environment; exercise their autonomy. Unfortunately, the evidence shows that the implementation of these measures is poorly implemented in hospitals (Godfrey et al., 2019).

Discussion

In the following essay, we reflect on the daily interactions of OP with delirium and health personnel, and how despite technological advances and ethical development that make explicit the rights of patients (Moral & Montero, 2017), they can still replicate power relationships to the detriment of the health of the OP. In this way, we describe the atomized dyad of micropower at the hospital level, in which health personnel achieves dominance and power of discourse, through a disciplinary construction based on scientific-technological advances. Thus, this discourse is constructed within a structured educational system replicating the "[...] *political form of maintaining or modifying the adequacy of discourses, with the knowledge and powers that they imply*" (Foucault, 2005, p. 45). In this way, each of the evaluations, diagnoses, and procedures to be implemented by health personnel are organized, with clearly defined functions, contributing and materializing their protocols in the areas of knowledge (where the "truth" is linked to power), through the norm, order, and hierarchy (Osorio, 1984). This perspective can lead to an illusion of what health personnel expects from their patients, reflecting through clinical information, symptomatology, and techniques, an

image of high stigmatization of OP with delirium, which prevents the approach material and discursive of both actors.

From this position, power reaches the bodies, inserted in gestures, attitudes, speeches, and daily life (Sossa Rojas, 2011). From this perspective, we need to ask: **How can we transform this relationship?** Where the discourse of the discipline raises its limits, but also permeates the discursive and corporal materiality of the OP, so that knowledge is tangible, situated, and ductile to each interpersonal relationship.

Thus, we propose as a way out, the construction of a transformative phenomenon that questions dichotomous relationships, ascribing to the concept of "phenomena" understood as the construction of intra-actions of objects and observation agents (Plauborg, 2018), embodied in the iterative material-discursive exchanges of the actors (Tobias-Renstrøm & Køppe, 2020). Within the construction of the phenomenon lies the "intra-action" "[...] *between the subject-object, problematizing the natural separations… Limits are not our enemies; are necessary to make meanings* (Barad, 1996, p. 187).

The relationship between objects and observation agents is presented as neither separable nor independent, but rather we are part of the same nature that we want to understand (Bohr, 1987). In the case of the relationship of OP with delirium and health personnel, the latter are the ones who have the necessary knowledge to understand the materiality of delirium, from the physiological point of view, giving it clear limits from the clinical point of view. But also, it requires transformations in the interaction with the OP with delirium that allows them to permeate the historicity, the narrative, and the corporal experience of the OP, facilitating intra-action. This is going to demand modifications inside and outside the health personnel, highlighting the ethical and humanized value of each OP, as a subject with a history, roles, needs (Fisher, 2013), and current fears. Where its name, its narration, spatiality, and corporality take on such importance that it deserves to be heard, respected, and perceived.

In turn, the OP will expand their limits, where their experiences will gain meaning, being an experience that can be shared, recognizing the health personnel, as an interlocutor who provides guidance and confidence during hospitalization, which transfers them to the OP autonomy in the hospital context.

Another transformative aspect that agency realism recognizes is the identification of the context, where a-contextual variables will give inadequate results, making it necessary to change the "[...] *knowledge that rejects transcendental, universal and unifying master theories in favor of embodied and contextual understandings*" (Barad, 1996, p. 187) to understand a performative reality, in which "[...] *objective knowledge is situated knowledge*" (Barad, 1996, p. 180). Thus, people are part of the world-body space in its dynamic structuring.

From this point of view, the contextualization and personalization of the phenomenon are relevant in the intra-action. Therefore: knowledge, evaluations, and interventions come to life and are materialized in each OP, for example, the greeting name "Good morning, Don Manuel", or the cognitive interventions of Mrs. Cristina, a retired teacher, will be different from Mr. Cristóbal, an active gardener. Then the knowledge and discipline of the health personnel built over the years, with the intra-action of the historical and situational context of the OP will acquire materiality and consistency, transforming knowledge. In this way, the OP will be called to know and

relate to the situational context, in which the health personnel will facilitate the exploration and the link, changing the stigma of the passive role of the OP, for a dynamic, permeable, and transforming role.

In this perspective, agency realism presents us with a performative reality that considers individuals as material beings, where discursive practices are part of materiality and (re)configure the world through the determination of limits, properties, and meanings (Tobias-Renstrøm & Køppe, 2020). Thus, intra-action is a necessity and an ethical responsibility with the intra-active nature of the reality that we all share, which makes us constantly (Tobias-Renstrøm & Køppe, 2020). As Barad (2012, p. 215) says:

> In an important sense, in an impressively intimate sense, touching, feeling, is what matter does, or rather, what matter is: matter are condensations of responsiveness: each of "us" is constituted as responsible for the other, as being in contact with the other.

In this way, the relationship with the other, in the intra-action takes on an ethical value, and the contact situated with the other and the phenomenon emanating from this link must break with the vision of OP as an object that requires only measurement and physiological record for the achievement of clinical and health goals. However, questions arise about whether the health personnel will be able to build new relationships that allow the validation of the speeches and materialities of the OP, in their disciplinary context and the face of the demands of care?, or perhaps Will the OP be able to play an active role in relations with health personnel, given their history and experience of assistance? Or how do we transform the training processes of health personnel, so that they integrate the historical and relational processes of OP? Since, aspects that denote the humanization of care can be overlooked, in the care of hospitalized OP with delirium.

At the same time, we consider it valuable to develop research that generates scientific evidence about care models that recognize the value of intra-action, over purely disciplinary intervention.

Conclusions

The daily interactions between health personnel and hospitalized OP with delirium express micropower relationships, in which the dynamics of exclusion of the discourse of reason/madness and positioning of health personnel from the perspective of truth achieved by the construction of disciplinary theoretical-scientific knowledge are observed, which are implemented in strategies for the diagnosis and non-pharmacological management of delirium. Thus, the need for transformation that agency realism gives us light on how to build a relationship that requires contact with the other, to build an integrated, contextualized, and dynamic phenomenon around the narratives that respect the value of situated knowledge, as objective knowledge.

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