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# The Discourses of Health Professionals on the Tuberculosis Patient in Mozambique: Reproduction and Resistance

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## Abstract

Tuberculosis is one of the diseases that kills most in developing countries, especially in Mozambique, where there is a shortage of hospitals and health professionals and where the knowledge about the disease is centralized in the health professional and the patient is only the subject with the disease without the right to question or decide about you. Under these conditions of production, in the treatment process, speeches are produced, which signify and symbolize and classify the patient. The study aimed to understand how the discourse of tuberculosis is constituted in the current medical discourse. This is a qualitative study and uses the theoretical framework of French-speaking discourse analysis. The narratives of the subjects enrolled in the study bring statements that lead us to consider that the exercise of power over the patient is effective through the specific, institutionalized, and legitimized knowledge within the hospital.

**Keywords:** tuberculosis, health system, discourse analysis, Mozambique

## 1. Introduction

Tuberculosis is a contagious disease and constitutes a global public health problem. Currently, 22 countries are heavily affected by the disease, accounting for about 80% of all cases, according to data from the World Health Organization [1]. To combat the disease, measures and strategies concerning TB treatment and ways of dealing with the patient have been conceived and disseminated by the World Health Organization (WHO), which advises countries to adhere to it.

The observation and problematization of the discourse regarding these measures and strategies, as well as the relationship between the professional health subject (doctor, nurse, “clinician”) and the subject of TB, led us to construct the assumption that such measures and strategies work as “discourses on” the illness and the sick, contributing to the establishment of the “truth discourses” [2] about the illness and the sick. From this assumption, we seek to understand how the tuberculosis patient is discursive in the current medical discourse.

Our theoretical and methodological foundation is based on the contributions coming from the philosophers Michel Foucault of Discourse Analysis of French matrix, a theoretical field that works not only with the structure but also with the language event.

## **2. Theoretical foundation**

In the Collège de France, in his lecture on the History of Thought Systems, Foucault developed, through his archeological and genealogical methods, critical reflections on how the relations between knowledge and power are historically intertwined. The French philosopher focused historically, above all, on the transition from the classical to modern times. The emphasis on this period, which marks the passage from the Enlightenment to the nineteenth century, represented the period of the rise of Science which, under the positivist and empiricist methodological presuppositions, imposed itself institutionally as a producer of truths. Knowledge must now be provable in order to be recognized, and it must possess an object that can be observed, tested, and analyzed [3–5].

At the end of the nineteenth century, we can mark the birth of modern medicine by the increase in value of medical knowledge, known as “biopolitical strategy” [4]. According to theorists, with the advent of capitalism, medicine gains a new status, as the body is seen as a force of production. Knowledge is, therefore, a domain where the subject is necessarily situated and dependent, and in this sense, for example, the knowledge of clinical medicine defines for the subject of medical discourse all the functions of observation, interrogation, deciphering, recording, and decision [3].

In the book *Birth of the Clinic*, Foucault [4] conducted an archeological study of Western medical knowledge, seeking to understand the anatomical-clinical rationality that permeated the consolidation of medical knowledge in modernity, where the main investigative object is the disease or sick person [4].

The philosopher describes the modifications and evolution of classical medicine until the formation of modern medicine. In the medicine of the species, the diseases were classified in species and considered entities without any connection with the body. A disease would happen if and when one of its qualities had affinities with the human body. With the emergence of disease classification medicine, medical practice was carried out according to the visible characteristics of the disease, based on a perception.

Foucault's [4] studies allow us to see how medical knowledge supports a more refined control of the individual in the new political rationality that is configured, from the nineteenth century, with the main objective being the subjection of the human being. Instituted as knowledge, medicine, through its discourse, gives a configuration to its practice, constituting the so-called “subject-of-illness” [6], which, in turn, assures the hegemony of medical knowledge. From modernity, then, there is a proliferation of fields of truth about what is the human body, which is focused on the most diverse emerging knowledge: medicine, biology, anthropology, social sciences, economics, demography, psychiatry, law, psychology, hygiene, politics, and others. In this context, the body undergoes two transforming displacements of its disposition in the field of discourses. On the one hand, it was from modernity that the body obtained depth status to be discursively searched, defined, explored, so that the tridimensionality of bodies becomes validated as a context that can be epistemically subject to research [7].

It should be noted that in the light of Nietzsche studies, Foucault [4] states that truth cannot be understood as unique, fixed, and stable, but as truths that are

constantly constructed and postulated moments, in given places. So if there are choices, the truth can no longer be one. Every speech is seen functioning as regimes of truth. Truth is, in a circular way, linked to systems of power, which produce and support it, and is also related to the effects of power that it induces and reproduces. We emphasize that the relations that are established between the subjects and the discourses are always inevitably relations of power that circulate and are disseminated within their meshes and plots.

As highlighted, we are also based on the contributions of the Discourse Analysis of pecheuxtiana matrix. Thus, we understand discourse as the effect of meanings between sociohistorically determined interlocutors [8–10]. We also point out, based on Pêcheux [10], that we understand that the subject is spoken by both the ideology and the unconscious. We remember that the discourse is crossed by other discourses, by external voices that constitute it.

Another important concept is that of conditions of production, which comprise the subjects, the situation, and the memory. In the restricted context, it involves the circumstances of the enunciation and the immediate context, and, therefore, in a broad sense, includes the sociohistorical and ideological context [11].

The notion of ideological formation, in turn, serves to characterize an element susceptible of intervening as a force of confrontation with other forces in the ideological conjuncture characteristic of a social formation at a given moment. Each ideological formation constitutes a complex set of attitudes and representations that are neither individual nor universal but relate more or less directly to class positions in conflict with one another [8, 9].

### **3. Methodological aspects: some notes about the constitution of the corpus**

Our corpus consists of cutouts of semistructured interviews conducted in 2014, with 15 health professionals who, at that time, occupied the position of “coordinator” and “clinical” subjects, directly responsible for patient observation in the drug consumption process for the cure of tuberculosis (TB). These professionals were part of the National Tuberculosis Control Program (PNCT) in Mozambique, Africa.

It should be mentioned that the interviews were granted after completing all the bureaucratic steps required by the National Bioethics Commission of Mozambique. The interviews enabled us to construct a vast archive, understood here as field of pertinent and appropriate documents on a given issue [8].

It is pertinent to point out that the notion of discursive clipping was formulated by Orlandi [12] to distinguish the gesture of the linguist, which segments the phrase, from the gesture of the discourse analyst who, by cutting a discursive sequence, also cuts an inseparable portion of language and situation. We can then understand what the author proposes: cut as a discursive unit [8].

Another important point to emphasize is that the methodological emphasis is constituted in the relation between *interdiscourse* and *intradiscourse*. The *intradiscourse* refers to the linearity of saying; it is the thread of speech, according to Pêcheux [10]. The *interdiscourse*, in turn, refers to the complex network of discursive formations in which all say is inserted. We recall *interdiscourse* as a region of encounters and confrontations of meanings [13]. Observation and analysis of *interdiscourse* allow us to understand the functioning of discourse, the senses (re)formulated by the subjects and their relation to ideology.

It should also be noted that in the period corresponding to the second half of 2014, we analyzed the raw material, that is, all the interviews we performed and the production conditions in which they were produced. From this material, we

selected numerous discursive sequences of reference, SDR [14], which constituted the cutbacks. Some (five) of them were chosen for further analysis, which will be presented.

We cannot fail to mention that we use the indecision paradigm, as proposed by Ginzburg [15], to search for the linguistic-discursive clues that have been examined by us, allowing us to delineate the discursive regularities of the subject's discourse, the discursive formations in, and their respective ideological formations.

Finally, we emphasize that in our analyses, we try to cross the opacity of the text, seeking to make explicit how the symbolic object produces senses, considering that the meaning can always be other.

Continuing, let us focus and venture through the paths of discourse.

## **4. Discursive analyses seeking to look beyond evidence of meaning**

### **4.1 Clipping #1**

“The patient with suspected TB is observed in a normal consultation, he is asked for the Koch Bacillus (BK) exam, when the BK is positive the patient is accompanied to the PNCT sector. After starting treatment in the intensive phase, this patient is followed daily or depending on where he/she is accompanied directly to the place of the health unit until the end of the treatment” (Subject Coordinator and Clinical).

### **4.2 Clipping #2**

“We have our volunteers who help us in the community. They are looking for coughing patients and delivering sprinklers. Bring it here and submit it for analysis in the laboratory” (Clinical Subject).

### **4.3 Clipping #3**

“(...) they diagnose the patient, umm ... he asked for the bacilloscopy in the screening, the patient is what he is, and the clinician directs the PNCT sector” (Subject Coordinator).

Initially, we observed that the subjects affected by the bacillus are not identified by name, surname, cognomen, surname, or initials. They are referred to as “the patient,” which allows us to think about the enrollment of health professionals in discursive formations in which stigmatizations about the disease are prevalent, for example, TB would be associated with poor behaviors such as prostitution, alcohol consumption and other drugs, lack of hygiene, and poverty [16, 17].

The medical speech strongly marks the three clippings above. We recall, based on Foucault [4], that this discourse has the power to “fabricate” the disease and its treatment and also to silence the voice of the subject who lives the experience of TB. Under these conditions of production, it can be thought of as authoritarian discourse.

The discursive sequences: the patient is observed, he/she is asked, and he/she is accompanied to the laboratory. We submit the analysis to the laboratory and ask for the bacilloscopy. It indicates that the health professionals occupy the position of subjects with specific knowledge, which would assure them places hierarchically superior, in relation to the subjects affected by TB. Based on institutionally recognized and socially valued positions (coordinator, clinician), specific knowledge produces meaningful effects of “speeches of truth” [2, 3], being imagined and treated by patients who suffer from TB as speeches irrefutable, almost definitive, as we show in our doctoral thesis [17].



We wish to emphasize the aspect of medical tutelage, which, if on the one hand, gives supposed assistance, in the form of care, examinations, prescriptions, examination requisitions, on the other hand, demands obedience, understood as “natural,” in a society where there is a division between those who rule and those who obey, as is the case with Mozambican women. Medical discourse enjoys both the prerogative of including or excluding those who would be under its tutelage and of charging and reinforcing obedience on the part of the subject who, under these conditions of production, becomes susceptible of being “subject-of-illness.” The actions of observing, asking, accompanying, submitting, and analyzing, under these conditions of production, allow us to think that health professionals are inscribed in discursive formations that place the patient in the position of subject that must obey and submit to what is proposed or offered. The quote below corroborates our argument. The movement toward a relationship of domination on the part of the therapist on the patient is more common in the clinical practice of traditional bias, directly linked to the pedagogical medical discourse, which the therapist intends to have as knowledge and the patient submits to the clinical treatment, or this nightmare establishes well-defined relations of domination with well-defined and unchanging hierarchical roles in principles [18].

What we have discussed above refers to Foucault [3], especially his analyses and discussions about power knowledge. The philosopher shows us that power is not exercised without knowing, just as it is not possible that knowledge does not engender power; one produces the other. The philosopher also postulates that power functions and is exercised in a network, that is, it is never specifically located in this or that place, here or there. Power, as thought by the author, is relational in character, being exercised and not possessed [3].

Continuing, we would like to focus on the discursive sequence of clipping number 1, which refers to the recommendation of clinical tests to the subjects supposedly infected: you are asked for the Koch Bacillus (BK). The examination, here thought as a power device, allows qualifying, evidencing, controlling, and dictating what should or can be done by the sick subject. As Foucault [5] teaches us, the examination is at the center of the processes that constitute the individual as an effect and object of power.

In order to increase the present analysis, we highlight the criticisms of the French philosopher, author of *Microphysics of Power* [3] and “*Vigiar e Punir*” [5], the disease and patient are thought and treated as objects that deserve only the subjection of medication and the patient is not seen as someone capable of making decision or interfering in the treatment process [4]. In the space of the clinic, where bodies and glances intersect, the knowledge of suffering—allotted in the subjectivity of symptoms—is inserted in a reductive and objectifying discourse. Under the sovereign power of the empirical eye of medical science, one has the space of open experience, only to the evidence of visible contents. What creates the possibility of a clinical experience is precisely the application of a look at the disease that gives it objectivity. There is always in the sick body a concrete a priori, which can be unveiled, in Foucault’s words: clinical experience—from the concrete individual to the language of rationality—was taken as a simple, looking under the body [19].

Patient and disease control is not the exclusive exercise of health professionals, but it also covers the family institution, as we will show in the next section.

#### 4.4 Clipping #4

“We involve family members; the family members control the patient. First, if the clinical picture of the patient is not serious, we make a pact with the family and inform them about the care they take with the patient and help them to provide it and this motivates the patient to take the medication until the end” (Subject Coordinator).

We observe that the pedagogical and disciplinary action extends to those who occupy the positions of subject “members of the family,” who would be responsible for the patient. In this case, the family may constitute an “extension” of hospital power to the patient. According to Gonzales [20], for effective TB control, the participation and flexibility of the medical and family teams is necessary, in the follow-up of the patients, and supervision can be done at home or even in the workplace. Mobilized and authorized by hospital teams, relatives can also exercise control over the patient, who almost always enters into discursive formations marked by submission and belief in medical discourse.

The discursive sequence emphasized brings linguistic-discursive indications that allow us to say that, in this case, the subject-patient position is subject to the dictates of hospital and family institutions: we make a pact with the family. The signifier “pact” instigates us to think of a reproductive scheme, that is, the family reproduces medical discourses and actions, from a discursive memory. The family, conceived as an institution, inscribes itself in discursive formations that make it believe that its function is to help to make docile, useful, disciplined, to cure TB patients.

In these conditions of production, we can say that both sick subjects and family members occupy the place of “good subject,” performing their roles in the form of “freely consented” [10]. We point out that in this modality, that of “good subject,” the interdiscourse determines the discursive formation with which the subject identifies himself/herself and this subject blindly suffers this determination [10].

#### **4.5 Clipping #5**

“(...) TB is still a neglected disease unfortunately people only realize that the disease is already taking care of it when it is already at an advanced stage. And I think we still need to spread the word about TB a lot. We need to encourage people that the little cough he has, the first thing he should think about is exactly TB, and that this treatment that is given to the patient really works and he heals, but for that he should follow up and one of the strategies is the Short-Term Observed Direction Treatment Strategy that has given optimum results, people take the medicine as it should be” (Subject Coordinator).

When we look at this clipping, we are going to stick to the discursive sequence “people only realize that the disease is already taking care of it when it is already at an advanced stage.” In our view, the realization of the disease when it is in an advanced state can be interpreted as a gesture of resistance from the subject-patient to accept that he is suffering from tuberculosis. As pointed out, the signifier tuberculosis refers to networks of meanings according to which being affected by the disease means “being poor,” “prostitute,” “convict,” among other senses. Resisting disease and the condition of the patient seems to be a resource that is worth the subject not to submit to institutional discourses.

It is pertinent to point out that Foucault’s notion that power is found in social relations, in the form of relations of force, presupposes resistance to every form and exercise of power. If there is a relation of power, there is a possibility of resistance, Foucault teaches us. The perception of oneself as subject-of-illness causes changes in the daily life, in a particular way, and in the life and history of the subject, in a wide way. While he perceives himself as “normal man,” he feels inserted in society, being able to work, study, produce, and act. Feeling in good health is feeling more than normal, that is, not only adapted to the environment and the requirements, but also normative, capable of following new norms of life [21].

On the other hand, “feeling bad” breaks with the normativity, requiring diagnosis, clinical, laboratory, and other tests that can translate its meaning (s).

Admitting “feeling bad” brings pain and psychic suffering to the subject: “Why did this happen to me so soon?” leading him, in some cases, to deny the disease [20]. The subject-doctor position is the verdict, and its supposed knowledge lies in the promise of healing and/or postponing death.

Our arguments can be based on the contributions of Pêcheux [10] regarding the “bad subject.” We can say that the subject, in a certain way, is *counteridentified* with the predetermined dictates by the health services where prescriptive functions are exercised: one of the first things to think about is exactly in tuberculosis and he should follow up.

The discourse of the “bad subject” is that in which the subject of enunciation turns against the universal subject, through the taking of a position which, in this case, consists of a separation that reflects distancing, doubt, questioning, contestation, or revolt in relation to what the universal subject gives to think. In this case, then, the bad subject is counteridentified by the discursive formation imposed on him by “interdiscourse” as an external determination of his subjective interiority, which produces philosophical and political forms of discourse-against (i.e., “counter-discourse”) [10].

Whether it occupies the position of the subject that fully identifies itself with the discursive formation in which one becomes aware, or occupies the position of the one who is counteridentified, the subject continues to be discoursed as “the patient,” the “tuberculous,” “the one who must obey and follow” what is recommended to him (imposed) by the medical discourse, whose specific knowledge, prestige, and condition of irrefutability assure him legitimacy and power.

According to our hypothesis, this discursivization contributes to the construction of a discursive memory whose senses can negatively affect the identity of the subject. It should be remembered that the senses become enunciable and readable by the action of discursive memory [14].

Knowing that the term identity carries multiple meanings, we emphasize that here we use it in the sense of identification, because we understand that identities can function as points of identification and attachment.

According to Hall [22], we can cite three types of identities: the Enlightenment, the Sociological, and the Postmodern. In the first, identity is centered, unified, and endowed with reason. It consists of an inner core that is born with the subject and in it develops, although it remains essentially the same (identical) throughout its existence. In the second, the subjects and the cultural world in which they live are treated as unified and predictable. However, gradually, the subject, thought as having a unique and stable identity, is perceived as fragmented, composed not of a single but of several identities, sometimes contradictory and incoherent. Finally, in the third, the subject does not have a fixed or permanent identity, being conceived as a mobile celebration, formed and transformed continuously. It is an identity marked by heterogeneity and dispersion.

From these considerations, we understand that identities are always fragmented and fractured; they are never singular but multiply constructed along discourses, practices, and positions that can cross and be antagonistic. They are subject to a radical historicization, constantly being in the process of change and transformation [22].

We would like to emphasize that, given the fluidity of the identities emphasized by Hall [21] and the notion of discourse adopted here, that is, that all say is constitutively crossed by the discourse of the other, we will use the term identity in the sense of identification.

To understand oneself as subject-patient of tuberculosis, makes the subject mainly occupy the place of being sick the one of the needs help from others, allows him to produce predominantly stereotyped senses, seeing himself as incapacitate to act upon himself about the disease [10, 22].



## 5. Final considerations: a few brief considerations

Medical discourse, in particular the discourse of health professionals of those working with patients with TB, has different forms of control over the patient. One of the ways in which the exercise of power is effective is through specific, institutionalized, and legitimized knowledge. This knowledge circulating in the discourses on disease and the patient contribute to the formation of an interdiscourse in which the sick subject is spoken, interpreted, and watched but never listened to. These discourses focus only on what is visible, apparent, and “rational” in disease.

We observed a reproductive pattern, that is, health professionals reproduce in their speeches words and forms not only of control of medical discourse but also of organs such as the WHO. Families, on the other hand, are called to collaborate with the treatment, reproducing words and devices of vigilance about the patient.

Being discursive as “sick,” “tuberculous,” “carrier of disease” can contribute to the constitution of a discursive memory where stereotyped and negative senses predominate about the disease. When updated, in the words of the subjects, they can reverse these senses, negatively influencing the constitution of their identity, once the senses produced become circulating and accepted, not only by the patients and professionals but also by the family and community as such.

Reflecting on the discourses on tuberculosis, the sick and the constitution of their identity can contribute to the resignification of meanings and positions to be assumed by the subjects who could move from the subject-from-disease to the subject-from-healthy.

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