

# The everyday life of people living with the chronic condition of diabetes mellitus\*

A VIDA COTIDIANA DE QUEM VIVENCIA A CONDIÇÃO CRÔNICA DO DIABETES MELLITUS

LA VIDA COTIDIANA DE QUIEN VIVENCIA LA CONDICIÓN CRÓNICA DE LA DIABETES MELLITUS

Ana Paula Silva de Faria<sup>1</sup>, Roseney Bellato<sup>2</sup>

## ABSTRACT

The objective of this study was to understand the experience of a person with diabetes mellitus and how that person deals with adversity in everyday life. Data collection was performed by means of a Focal Life History questionnaire and by observing health care professionals. Data analysis was based on the comprehensive approach, which permitted understanding the everyday life as a scenario for those living with the experience of falling ill and searching for care, considering that this experience is unique and personal. It is impossible to create health care practices that disregard the everyday life and health situation of the person. Furthermore, it is impossible to propose such practice without the active participation of the person affected by those decisions and conducts.

## KEY WORDS

Diabetes mellitus.  
Chronic disease.  
Delivery of health care.

## RESUMO

Este estudo objetivou compreender a experiência de adoecimento de uma pessoa em condição crônica do diabetes mellitus e a maneira como esta enfrenta as adversidades no seu cotidiano, cujo corpus de dados foi obtido através da História de Vida Focal e da observação de práticas profissionais de atenção. A análise dos dados foi embasada na abordagem compreensiva, que nos permitiu entender o cotidiano como o grande cenário para quem vivencia a experiência de adoecimento e a busca por cuidados, sendo que o modo como cada pessoa a vivencia é única e individual. Assim, não é possível construir práticas profissionais cuidativas que desconsiderem a situação cotidiana de vida e saúde da pessoa a ser cuidada. Como também não é possível propor tais práticas sem que haja a participação ativa da pessoa sobre a qual irão incidir as decisões e condutas aí tomadas.

## DESCRIPTORES

Diabetes mellitus.  
Doença crônica.  
Assistência à saúde.

## RESUMEN

Este estudio objetivó comprender la experiencia de enfermarse de una persona en condición crónica de diabetes mellitus y la manera como esta enfrenta las adversidades en su cotidiano, cuyo corpus de datos fue obtenido a través de la Historia de Vida Focal y de la observación de prácticas profesionales de atención. El análisis de los datos tuvo como fundamento el abordaje comprensivo, que nos permitió entender lo cotidiano como el gran escenario para quien vivencia la experiencia de enfermarse y de buscar cuidados, siendo que el modo como cada persona la vivencia es única e individual. Así, no es posible construir prácticas profesionales de cuidado no consideren la situación cotidiana de vida y salud de la persona a ser cuidada. Como también no es posible proponer esas prácticas sin la participación activa de la persona sobre la cual irán incidir las decisiones y conductas allí tomadas.

## DESCRIPTORES

Diabetes mellitas.  
Enfermedad crónica.  
Prestación de atención de salud.

\* Extracted from the thesis "A experiência de adoecimento e a busca por cuidado empreendida pela pessoa com Diabetes mellitus", Nursing Graduate Program at Federal University of Mato Grosso, 2007. <sup>1</sup> M.Sc. in Nursing. Assistant Professor at Nursing Department. Federal University of Mato Grosso, Rondonópolis Campus. Member of the Research Group on Nursing, Health and Citizenship. Professor of the Undergraduate Nursing Course at Cândido Rondon University Center. Cuiabá, MT, Brazil. apaula.faria@gmail.com <sup>2</sup> Ph.D. in Nursing. Adjunct Professor at College of Nursing at Federal University of Mato Grosso, Cuiabá Campus. Coordinator of the Research Group on Nursing, Health and Citizenship. Cuiabá, MT, Brazil. roseney@terra.com.br

## INTRODUCTION

This study addresses the experiences of falling ill and the search for care for diabetes mellitus according to the logic of those who experience it, allowing for reflections about the multiple dimensions of this experience. This will contribute to new forms of acknowledging and providing care to the needs of people who experience this condition.

We have observed that diabetes mellitus care has been mostly prescriptive until now, standardized and centered on the disease and not on the experience of falling ill for patients with this condition. This is the case because the care provided to the patients is strongly centered on the medication acquisition and availability, orientation for lifestyle changes and undergoing Diabetes mellitus monitoring and control exams<sup>(1)</sup>.

Actions to control and monitor diabetes mellitus have been mostly performed during the medical appointment by requesting laboratory exams and monitoring the clinical situation. Professionals have understood such actions, as a whole, as a synonym of care delivery to the needs of people with diabetes mellitus, as well as their families, maintaining and reproducing reductionist actions that are focused on monitoring, control and vertical information transmission. They do not realize, however, that several of the difficulties these people experience in their daily routines result from healthcare actions that make no sense to them, since they are performed in a mandatory way, regardless of their reality.

The experience of falling ill to diabetes mellitus is intermingled with the patients' daily routine, and that is where the senses and meanings of this experience are built. In addition, forms of living and managing this chronic condition are (re)created in this scenario, permeated by a spontaneous willingness to live, always with a collective bent, which reorders time and space, allowing the patients to face their fate and the fear of mortality<sup>(2)</sup>. The daily experience and the experience of falling ill within it present several possibilities; therefore, universalisms of any order, imposed by healthcare professionals, are not adequate to this experience.

According to these assumptions, and with the analysis of the corpus of data obtained in our study, we could apprehend the many forms of coping with the chronic condition of diabetes mellitus patients built into their daily routine and experienced with great intensity. Although health professionals do not usually perceive and/or problematize the difficulties patients face and the possible solutions they find in the practices developed with these patients, they are factors that will allow patients to face this condition as well as possible.

## OBJECTIVES

The purpose of this study is to understand the experience of falling ill of people with the chronic condition of diabetes mellitus, as well as how they face the adversities deriving from this condition in their daily routine.

## METHOD

This is a qualitative study, based on the Case Study model<sup>(3)</sup>, which allowed us to use several methodological approaches to apprehend the logic of people with diabetes mellitus in relation to their experience of falling ill. Furthermore, the study focused on their search for care to solve their healthcare problems. The study subject was Pedro, an alias for a person from Sorriso/MT, Brazil, admitted at a public hospital in the city of Cuiabá/MT due to complications associated with diabetes mellitus, including: systemic hypertension, kidney disease to be defined and necrosis of the right hallux, which resulted in its amputation.

The apprehension of Pedro's experience of falling ill and his search for care happened according to the Focal Life Story (FLS), made feasible by the In-Depth Interview (IDI) as a resource for the process of remembering the situations the patient faced in his daily routine. The FLS directed our focus towards the senses and meanings present in the narrative of this experience, and fourteen meetings were necessary to clarify and further the situations experienced.

The narratives were recorded and later fully transcribed. Later, a comprehensive corpus of field journal data and observational notes of the situations experienced during the meetings were added. These meetings occurred in January and February/2007, mostly within the households of Pedro's relatives in Cuiabá/MT, where he stayed during his treatment in that city.

The understanding of this experience of falling ill in its multiple senses was possible due to the use of sensitive reasoning<sup>(4)</sup>, both during the several meetings with Pedro and later, when the resulting data were organized and analyzed, as the researchers assumed a position of regarding the feelings, knowledge and senses implied in this experience. Thereby, more than simply trying to understand the causes and effects of the chronic condition of diabetes mellitus, we tried to comprehend what this daily routine is like, in which one tries to survive the healthcare professionals' prescriptive and mandatory actions to monitor and control the disease and the patient; as well as the forms of living with the disease and the (re)creation of norms for living and caring for one's health.

The experience of falling ill to diabetes mellitus is intermingled with the patients' daily routine, and that is where the senses and meanings of this experience are built.

The perspective that guided us through the whole period in which the meetings were held was one of attention, in order to contemplate the patient's daily routine as a whole, as well as to understand how those who experience the disease and its care perceive it. However, paying attention to the daily routine means that one should pay attention to the description of these experiences and how the process of living with the disease is organized, as they are translated by small gestures, banal events, the expression of emotions present in the subjects' tone when they narrate a given episode. Therefore, all those *small nothings*<sup>(2)</sup> that make daily routine seem worthless were highly regarded, as opposed to the attitude of healthcare professionals who do not know how people face the adversities when they have to experience events of falling ill and seek care.

This study complied with the ethical requirements of Resolution 196/CNS/96, which deals with research involving human beings. In addition, the research project, which this study is part of, was approved by the Review Board of Hospital Universitário Júlio Muller, file #235/CEP - HUJM/2005.

## RESULTS AND DISCUSSION

In order to understand Pedro's experience of falling ill and search for care, first, it was necessary to understand his routine. This daily routine is perceived as insignificant and banal, marked by a cyclical time of repetitions and permanencies<sup>(5)</sup>, in which his way of living and dealing with the chronic condition of diabetes mellitus happens at full intensity.

This life is constituted by fears, uncertainties, by the double game between mechanisms of acceptance, transgression, escapism and passive resistance to the fate the chronic condition imposes on the patient<sup>(2,6)</sup>. Such mechanisms surpass the daily routine of people who, like Mr. Pedro, try to survive the many impositions and determinations the disease forces upon them, which are in turn reinforced by the prescriptive and mandatory actions of healthcare professionals who do not understand the difficulties and challenges patients face. Such challenges are intensified when the patients experience the phases in which the disease becomes more acute, causing a constant state of attention and stress.

This is the daily life, in which the ways of living are based, supported by the feeling of ambiguity; and where one feels the limits and mortality. This life is stressed by a willingness to live and the need to enjoying the here and now, capable of transgressing healthcare professionals' orders as a way of living this moment<sup>(6)</sup>. Therefore, the way in which each person experiences his or her process of falling ill is unique and deeply personal<sup>(7)</sup>.

The disease is part of Pedro's life. Hence, there is no way of providing care to his real needs without understand-

ing the context of his life, as well as the many other repercussions of diabetes mellitus in his daily life, which is obstructed by financial and personal problems, among others. This makes him see his disease as *a problem* because, in his words, *diabetes is a problem [...] A very complicated problem*.

Exhaustive reading of his narrative revealed that his daily routine is obstructed by the disease, especially by the daily small deaths represented by countless daily losses<sup>(6)</sup> in relation to his previous way of living. The disease was discovered over 15 years ago, when his body had no signs or symptoms of diabetes mellitus, and his life had fewer limitations and restrictions. As Pedro started to experience the manifestations of the disease more intensely, it became the center of his existence.

[...] I used to work, but now I can't work anymore because I'm sick. My legs are sick [...] so I can't do that now. Until I get better again, how am I going to carry weight? If I do, my legs will swell again (saddened tone).

From that moment on, Pedro took on new rules for his life<sup>(8)</sup>, making the choices that were possible due to how he perceived the manifestation of the disease in his body, resulting in the limitations and restrictions of his daily activities. Besides, self-esteem is lowered in this process, especially due to the difficulties to provide for his own sustenance. Therefore, the experience of falling ill is built in this continuous process of possibilities and limitations throughout life, bringing along the knowledge built upon concrete facts from his daily routine in relation to feeling healthy and sick<sup>(8-10)</sup>.

However, when the acute phases of the disease became more frequent, Pedro started to perceive diabetes mellitus as a problem. For him, although the disease lies more and more intensely within his body, it is not part of his life. It is something that came from outside to change his life in a negative way, i.e. the disease changed his life for worse<sup>(11)</sup>. Therefore, we see that, for him, being sick becomes a contingency of the physical manifestations of the disease. As he experiences an increased frequency and lengthening of the acute phases, which require a stricter control of his lifestyle habits, he tends to see this disease in a more negative way.

In addition, he feels that the restrictions and limitations are like a punishment or *orders* to be followed, as what rules his life nowadays is a *fate* that has no concrete meanings in his experience of falling ill. There is a latent, ever-present resentment due to this perception of the disease and the need for control and monitoring, expressed among *things we want to do but cannot do because of the diabetes*, according to Pedro.

In this process of remembering his experience, a valuable contribution of the FLS approach, Pedro evaluated the choices made throughout his life when he was younger and healthy, powerfully shown at this moment of aggravated

disease. In this process, he could also make predictions about his life and his chronic condition. And, away from the ideal models of well-being, we perceived that the structure of the daily life of people with diabetes mellitus is based on feelings, practices and attitudes that often coexist in conflict with the many prescriptions and controls dictated by healthcare professionals<sup>(9,11-13)</sup>.

In this context of life, healthcare is added to the financial difficulties experienced by the patient and therefore intensified. He states [...] a health problem. Then we use the money we have to eat.

In addition to the increased expenses with food, Pedro has a distorted understanding of this care routine, seeing it as a punishment and/or an *order* to be followed, as seen in his narrative.

Eating is... he gave me a list. I kept that list so that I could live with it. So I could survive with it. [...] yeah, but I had to drop it... eating a single loaf of bread? (teary eyes) [...] It... it's a problem, isn't it? (teary eyes with a crying voice).

We could understand that he does not associate healthcare with his diet, nor diet with an essential step for treating and controlling the evolution of diabetes mellitus. The practices and discourse of healthcare professionals constantly reinforce the need to change one's eating habits, but they do not consider how difficult it is for the person to understand that such attention to diet is associated with the treatment of diabetes mellitus and healthcare. In his perception, the restrictions placed on his diet, exposed on the *list* he was given, force him to *survive* instead of living longer and better. This clearly shows that the logics underlying professional practices differ from the daily routine of a person with diabetes mellitus.

Changes in diet habits do not seem to be a negotiation between the person with diabetes mellitus and the healthcare professionals. Instead, they are seen as an order. Pedro says that he *was forced to drop it*, showing his difficulty to accept such an *order*. It should be considered, therefore, that *living with diabetes mellitus requires changes in the daily routine and also in the values, in whatever they consider relevant in their lives*<sup>(11)</sup>. Perhaps, if diet restrictions were understood as being important for their health, maybe they could be felt as less painful.

This ambiguity between *having information about* and *really understanding* seems to be a central issue in the many restrictions and limitations, which the person with diabetes mellitus is submitted to. It could lead to situations of transgressions, double games or theatrics, seen as ways of resisting to the domineering practices and to things that are strongly instituted and regulated<sup>(6,9)</sup>. These situations may be considered as forms of coping through a silent resistance, since such restrictions and limitations are not part of a collective dialogue or the encounter of the caregivers, the professional and the person with diabetes mellitus<sup>(7,14)</sup>.

It can be seen that these coping strategies really permeate Pedro, according to his narratives. Even though we developed a relationship of bonding and trust, every time we asked him about his diet, he told us what he should eat instead of what he actually ate, strengthening this double game as a way of avoiding judgment and demands from healthcare professionals. Therefore, *the diabetic patient says what the professional wants to hear, using subterfuge, games and cunning, since he feels distant from the institutional routine*<sup>(15)</sup>. Therefore, the space that should be used for care is deemed ineffective, becoming a space for the reproduction of practices that do not allow these people to voice their opinion, overlooking their knowledge built from their own experience of falling ill and from the health management they need to develop in their daily routine.

Even though professional healthcare practices focused on diabetes mellitus regulate and institute, in an obligatory and persistent way, what Pedro should eat, resistance arises in his daily routine as masks and double games, through which he shows how distortedly this attention to diet is perceived, resulting in his difficulty to relate it with his disease. Perhaps the person with diabetes mellitus shows the desire to eat forbidden food due to this kind of situations, and [...] *these desires make them suffer, repress, salivate, forget, transgress, lie, deny, admit, feel pleasure, control and feel guilt*<sup>(15)</sup>.

In Pedro's specific situation, there is also a paradox between what he can eat nowadays and what he was able to eat before leaving the Northeast of the country, with cultural and economic issues arising from this fact. These can be understood according to his own perspective, mentioning that his financial situation was very difficult when he lived in the Northeast, lacking money to provide for his own household. As such, eating was restricted to whatever he could acquire with the meager resources at his disposal, but there was no diet restriction. In his words,

I can't eat flour. I can't (saddened voice) eat it. That's what I liked best, you know... now... because I'm from the Northeast, and I really liked flour. Yeah, but I was forced to stop eating it [...].

Nowadays, even with better living conditions, there are several restrictions, even to the point of interfering in his culture as a Northeastern person, which causes him great grief.

Some people say, *let's have a barbecue*, and they come over and invite me. And I don't go, because I'm not going to eat salted meat [...] Then I stop, because I won't. I stop and do it [...] I have to prepare it because someone else comes to my house to do it, they do it with salt, the way they like it, right? And we can't just get there...and do it [...].

Pedro does not associate the limitations and restrictions of his current lifestyle with the care routines for his health. By not associating this care with the construction of life norms that make sense to him<sup>(8-9)</sup>, he attributes his transgression to his friends, to meetings with Northeastern com-



rades, which, however, does not lessen his suffering and guilt. This feeling of guilt stems from the professional approach that starts with how these people receive the diagnosis and how their treatment progresses<sup>(10,15)</sup>.

However, a conflicting situation is present once more, because, at the same time as there is a desire to partake in such meetings, Pedro is faced with the words *order* and *cannot*, which prevent him from enjoying these moments of company and socialization: [...] *I have to say that, like, we can't do that. There's a lot of people who ignore those orders and then they feel sick because of that, right?*

Even though there is a feeling that reinforces the need to be together, to share time around the table, with the pleasure implied in living collectively and characterizing the socialization provided by the group<sup>(6,9)</sup>, the pleasure of communion around the table is taken away from the person with diabetes mellitus, since even their *piece of bread* is literally forbidden.

Conflicts like these are experienced on a daily basis by Pedro, and go far beyond the control that was reportedly incorporated in his life. Therefore, he needs to establish his own rules in this experience of falling ill, developing other coping mechanisms beyond the imperative aspects of diet control, since eating is not only a source of nourishment, but there is also a strong social aspect to it. It should be considered that one communes with others around the table, i.e., the pleasure derived from eating is a part of living *with* and being *in* a collectivity. If one is denied these pleasures, the result is a hampered socialization.

At such times, the family tends to better understand these restrictions and somehow be a possible shelter for socialization. However, at the same time as the family is seen as a place of reference and support, a conflicting feeling of *being burdensome* can arise, like in the case of Pedro, changing the dynamics in his brother's family, as stated: *We feel kind of ashamed, feeling like we're burdening people, you know*. Thus, although organic solidarity can manifest within the family itself, there is also the embarrassment due to the several restrictions brought about by diabetes mellitus, causing feelings of inadequacy and retraction from family life<sup>(6,16)</sup>.

And, although Pedro sees diabetes mellitus as a *problem*, when he feels sick, he uses the knowledge built based on manifestations of the disease and the treatment experienced in his own body instead of the information acquired from the so-called *healthcare education* professionals offer. This learning was also due to the experiences shared with one of his cousins, who has also had diabetes mellitus for over 18 years. Even after 15 years with this disease, he keeps on stating that

diabetes is a problem [...] I don't know why I'm diabetic [...] I don't know what it is. [...] It's a problem, isn't it? It's too complicated for me, because, if it (glucose) goes too low, it makes us anxious, we sweat, we feel tired and can't walk [...].

Feeling ill is seen in signs and symptoms expressed by this body, becoming significant and entailing awareness of these manifestations<sup>(11)</sup>. We can understand that, sometimes, feeling sick becomes an important but negative source of learning, since, in this stage, there is a certain degree of loss of the body's functional capacity. Healthcare professionals, especially physicians, still neglect this acquired knowledge, even in the adverse situations experienced in the daily chronic condition. When Medicine took over the patient's body, it legitimized clinical knowledge, disdaining the knowledge of the diabetes mellitus patient, built on the experience of being ill, re-elaborating the production of feelings attributed to the process of living<sup>(9,11)</sup>.

We can also see that, as a result of practices that are still fragmented and centered on a situation healthcare professionals describe as a necessity, Pedro's conception of care arises as one that stems from the physician instead of himself, as he states:

I was always there with the doctor. I never stopped going there. [...] That's why I was taking care of those problems, because of the foot disease. [...] Whenever there's any problem in my foot, I'll go and see the doctor.

In this perspective, self-observation and self-care are subordinated to the healthcare professional's surveillance over his body.

The relationship between physician and *patient* is built, essentially, within the institutional spaces, through disciplinary actions focused on controlling the patient's routine, mediated by care that is essentially biomedical and centered on the professional<sup>(17)</sup>. The power of such a relationship legitimates and centers healthcare decisions in the physician's hands, excluding Pedro from having a say in his own therapeutic process. His responsibility and participation as an active subject are reduced, resulting in his denial as a self-caring person.

Professional healthcare practices focus on the diagnosis and proposition of therapeutic measures based on clinical knowledge, reading the patient's body in order to objectify the disease. This reasoning disregards the subjective aspects of those experiencing the chronic condition of diabetes mellitus<sup>(13)</sup>. Therefore, Pedro became another one of those *docile bodies*<sup>(17)</sup>, who are not included in healthcare planning and management in this space, which should be a reference for collective care construction.

The conception of self-care was built in a distorted way, especially regarding the use of insulin. Pedro reported that it was like a thermometer, marking the evolution of his disease, since it could not be controlled by the *pills* anymore. At the same time as insulin becomes ubiquitous, another stressful factor arises, represented by the difficulty faced with self-application. In turn, this made him depend on healthcare professionals at the beginning of treatment, as seen below:

[...] It was bad because I didn't know how to apply it. The guy at the healthcare station, he taught me. I'd go there and nobody wanted to do it for me. Do you understand? I had to go there every day to do it. It was really complicated. It was really difficult to get someone to apply it on me. Then I asked the guy to teach me how this injection should be applied. [...] I learned to do it because it was difficult for me to go there every day. And it was really a pain to get them to do it for me. It took too long [...].

Learning how to self-apply insulin was a response given due to the healthcare professionals' lack of sensitivity, as they did not perceive Pedro's real necessities, in his own search for autonomy. Therefore, it was an opportunity to avoid a place where neither care nor the solution for his health problems was offered, since it was not receptive to his needs.

By itself, insulin therapy is considered a stressful factor, due to the difficulties involved in handling the application technique. Even if the healthcare professionals consider this a simple technique, they would do well to remember their shakiness during the semiotics lessons at the start of their academic course, so that they can understand the feelings of those who need to develop these self-care skills<sup>(18)</sup>. The emotional factors related to the evolution of the disease should be added to this stress, as, in Pedro's example, his body has sustained serious injuries that seem to be independent of his treatment compliance.

Other people with diabetes mellitus probably face all these difficulties, since they also experience the stress in daily insulin use - however, these remain unseen by the healthcare staff. Group experiences could make it easier to collectively build alternatives to reduce the stress caused by these and other adversities in daily routine<sup>(16)</sup>. However, apprehending the reality of these people still is not part of healthcare professionals' practice, who focus on the intervention modes on the sick body, even though these are still named healthcare education practices.

Experiencing the chronic condition of diabetes mellitus presents several dimensions that go well beyond the insulin-related care routines and diet restrictions. Although Pedro constructs the senses and meanings of the disease based on daily coping with this condition, we can see that they are overall influenced by not incorporating or accepting the disease as a part of life. More than accepting it, he needs to feel capable of keeping on living according to the new rules that his life imposes<sup>(8)</sup>.

Although he experiences this coping and develops several forms of passive resistance towards instituted and regulating practices<sup>(6,9)</sup> that dictate lifestyle changes as a synonym of good health and aggravation control, this situation triggers feelings of frustration, grief and fear. In spite of the good healthcare practices professionals dictate, there is a chance that these will not be complied with, as they make no sense for the experience of falling ill that was constructed within the conflicting relationship between patient,

disease and healthcare professionals. Frequently, there is the perception of being made responsible, especially during the acute phases or complications of diabetes mellitus.

*Blaming the patient or blaming the victim* occurs because self-care is still understood as depending on individual disposition only. If it is absent, one is judged as incapable of controlling oneself, which is manifested by not complying with the prescribed diet, not doing physical activity or not using the medication as prescribed - far from what would be expected of the patient's behavior, since he does not work to improve his own health, indicating a *moral failure*<sup>(13)</sup>.

The distinct logic that coexists in care for diabetes mellitus, i.e. that of healthcare professionals and patients with this chronic condition, is still the focus of several studies. However, healthcare professionals are concerned with controlling and monitoring routines that could prevent or delay the onset of several and critical complications that could often result in death. For the patient, because of lack of knowledge, because the initial signs and symptoms of the disease are not clearly visible or even because complications come up, apparently regardless of treatment compliance, their concerns are focused on the practical restrictions the disease causes in their daily lives<sup>(13)</sup>.

To face these daily imperatives, Pedro developed mechanisms of escaping from the homogenizing practices, making use of double games, transgression and cunning<sup>(6)</sup>, which may even be manifested unconsciously. Therefore, the experience of the chronic condition is configured as a battlefield, where different practices and knowledge are intermingled to build the experience of falling ill, in a unique and individual way. And

in this sense, the daily routine must be understood as the alchemical laboratory of the minuscule creations that dot daily life, as a place to recreate oneself and maintain identity, which allows one to resist<sup>(6)</sup>.

In this process of living with the chronic condition of diabetes mellitus, health professionals add other obligations, supported by compliance with the *program*<sup>(1)</sup> and the actions that stem from it, creating protocols for care delivery to these problems, flattening the several dimensions of experiencing such a condition, limiting it to the monitoring and controlling aspects of the clinical treatment. People with diabetes mellitus eventually respond whatever the professionals expect to hear regarding their orientations of how treatment *should be done*, since little or no attention is given to *how I actually comply with this treatment and how I take care of my disease*.

The conception of resistance assumed herein is related to attitudes, gestures or actions, either small or large, that oppose, circumvent or avoid the instituted professional practices that attempt to mold the daily routine of diabetes mellitus patients. Therefore, it can be considered a relief from the obligations, i.e. it appears as a way of coping and accepting, or not, the disease as a part of life.

More than *straying away* from expectations, resistance to obligations is, therefore, a demonstration of an ability to survive the many limitations represented by living with diabetes mellitus, i.e. a form of seeking new rules to organize one's life, changes in habits and values, the necessity for continuous and prolonged treatment and control. It also represents a daily challenge for the person, so as not to lose his own identity and assume the identity of the disease, since professionals' focus and actions are directed towards it.

## FINAL CONSIDERATIONS

In our study, it could be seen that, overall, professional healthcare practices focused on diabetes mellitus do not apprehend the dimensions involved in experiencing the chronic condition diabetes, since these are focused on formal, prescriptive actions whose core includes changes in diet habits, daily physical exercise, attention to medication

and monitoring and controlling the body to detect possible complications.

By considering diabetes mellitus a chronic condition, we assume the need to reconsider how it influences and affects the life of the person and his family, causing deep changes in their health and routine. This perspective implies that professionals should reconsider how healthcare management and practices are organized and offered to the patients, either in the scope of basic healthcare or in other levels of care.

As such, we consider that the healthcare needs of people who experience the chronic condition of diabetes mellitus need to be apprehended and understood in the dimension of their daily routine, since this is the space in which they face the difficulties that stem from that condition. Also, such practices cannot be proposed without the active participation of the person who will receive the decisions and actions decided therein.

## REFERENCES

1. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Diabetes mellitus. Cadernos da Atenção Básica: Brasília; 2006.
2. Maffesoli M. O conhecimento comum: introdução à sociologia compreensiva. Porto Alegre: Sulina; 2007.
3. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 9ª ed. São Paulo: Hucitec; 2006.
4. Maffesoli M. Elogio da razão sensível. 3ª ed. Petrópolis: Vozes; 2005.
5. Bellato R, Campos EC. Insignificâncias essenciais: a busca pelo reencantamento no cotidiano hospitalar. Cuiabá: Ed. UFMT; 1999.
6. Maffesoli M. A conquista do presente. Natal: Argos; 2001.
7. Prado ML, Reibnitz KS, Gelbcke FL. Aprendendo a cuidar: a sensibilidade como elemento plasmático para formação da profissional crítico-criativa em enfermagem. Texto Contexto Enferm. 2006;15(2):296-302.
8. Souza SPS, Lima RAG. Condição crônica e normalidade: rumo ao movimento que amplia a potência de ser feliz. Rev Lat Am Enferm. 2007;15(1):156-64.
9. Rezende ALM, Ramos FRS, Patrício ZM. O fio das moiras: o afrontamento do destino no cotidiano da saúde. Florianópolis: Ed. UFSC; 1995.
10. Muñoz LA, Price Y, Gambini L, Stefanelli MC. Significados simbólicos dos pacientes com doenças crônicas. Rev Esc Enferm USP. 2003;37(4):77-84.
11. Silva DMGV. Narrativas do viver com diabetes mellitus: experiências pessoais e culturais. Florianópolis: Ed. UFSC; 2001.
12. Alves PC. A experiência da enfermidade: considerações gerais. Cad Saúde Pública. 1993; 9(3):263-71.
13. Barsaglini RA. Análise socioantropológica da vivência do diabetes: um estudo de caso. Interface Comun Saúde Educ. 2008;12(26):563-77.
14. Penna CMM, Pinho LMO. A contramão dos programas de educação em saúde: estratégias de diabéticos. Rev Bras Enferm. 2002;55(1):7-12.
15. Santana MG. O corpo do ser diabético: significados e subjetividades. Florianópolis: Ed. UFSC; 2000.
16. Madureira VSF, Waidman MAP, Ribeiro E, Stamm M. Relações familiares e cotidiano: a análise de quatro estudos à luz de Michel Maffesoli. Acta Sci Health Sci. 2002;24(3):831-42.
17. Foucault M. Microfísica do poder. 22ª ed. São Paulo: Graal; 2006.
18. Moreira RC, Cruz CFR, Valsecchi EASS, Marcon SS. Vivências em família das necessidades de cuidados referentes à insulino-terapia e prevenção do pé diabético. Rev Gaúcha Enferm. 2008;29(2):283-91.

### Funding

Funded by CNPq under register 402866/2005-3 - Ed 342005-BR163 2aEt/Public Notice MCT/CNPq/MS-SCTIE-DECIT 34/2005 – Influence area of BR 163 and developed by UFMT Collective Health Institute and FAEN/UFMT Research Groups GPESC and GEPLUS.