

Invisible conversations: subjects spoken but unheard in gynecological visits

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Abstract *This is a qualitative study based on the theoretical-methodological assumptions of the Conversation Analysis (CA) that describes and analyzes face-to-face interactions between three nurses and seven users of primary health care services during the cytopathological test collection visits. The descriptions and analyses were based on excerpts from the audio-recorded interactions during the nursing visits and transcribed based on the CA conventions. Data microanalysis from an emic perspective allowed identifying interactional situations of (mis)alignment, (dis)affiliation, repairs, and sensitive issues, and lack of listening to specific topics by nurses while conducting visits. Thus, signs of suffering, malaise, or violence were not explored, and care was not enhanced. The study shows that the cytopathological test collection visit can be a space to listen to issues related to sexuality and investigate the presence of violence against women. The dissemination of these findings and this methodology among public health and nursing professionals may stimulate a reflection on their communicative abilities, contributing to improved quality of care in health services.*

Key words *Conversation Analysis, Face-to-face interaction, Violence, Women health, Public Health*

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Introduction

The doctor-patient or health-user professional relationship's theme is central to understanding the limits and potential of clinical practice, and the research findings in this field can be extended to other health professions, including nursing.

The gynecological nursing visit is or should be a dialogical meeting¹ or a network of conversations², allowing space for conversation between nursing professionals and health service users. Sensitive listening allows hearing what people say and how they speak, understanding what makes them suffer. However, health practices, including medical and nursing visits, are still profoundly affected and impregnated by the hegemonic, technocratic, biologicist, medicalizing, and even moralistic model³.

The colposcycological test (CT) occurs within the interactional space of the nursing visit, both potentially plural, and follows a protocol's guidance, which guides the formulation of questions and actions to be performed in the act. Strict abidance by the protocol bureaucratizes the conversations produced in the CT collection visits, as it is restricted to compliance with an institutional mandate in which procedures are organized in routines⁴.

Health professionals and patients view health problems differently even when they have a common social and cultural background. The former build on scientific rationality, and the latter seek to explain the disturbance that affects them at a given moment, besides using holistic health and disease concepts. Visits are conducted in a mix of daily language and technical jargon in which different languages are employed to express discomfort and translate symptoms and signs into diseases and prescriptions⁵.

The relationships between professionals and users in health services are usually formal, hierarchical, and tend to reproduce pre-defined patterns⁶. We can consider that one of these patterns is a gendered language, in which gender is understood as a set of norms and prescriptions guiding male and female conduct in society. Joan Scott⁷ affirms that gender is a hierarchy of power between men and women based on sexual binarism and compulsory heteronormativity. As gender socialization occurs in all areas of culture and operates in individuals since birth, health professionals tend to reproduce these stereotypes in social and professional interactions uncritically.

The ascendancy of professionals on patients makes it their prerogative to ask questions in the

conversations, choose the topic, select who will speak, start and end sequences of interactional actions, and reprimand inappropriate contributions. The asymmetry between the interactants, with a propensity to exercise power on the part of institutional representatives, also appears in the recurrent delays or even the suppressed answers to questions asked by patients who often do not feel authorized to tell health professionals the sufferings that afflict them⁸ or those reported and unheard.

Then, as Ayres¹ proposes, in the relationship between health professionals and users, we consider that it is necessary to escape from an unsubjectivizing objectification anchored in technology and embracing care, understood as a practical action mediated by the word of subjects who provide and receive care. Also, according to Ayres⁹, it is necessary to place the meaning and instrumental success of the techniques – in this case, the cytopathological test – at the service of the happiness projects for those demanding care, as this will make the relationship between health professionals, including nursing professionals and users, understood as care. Openness to the other through listening and dialogue is a reception, a fundamental resource for users' desire to emerge and become the guide of the proposed interventions.

One of the assumptions suggested when starting this work was that the nursing visit is a space where reports of sexuality and violence issues could emerge, as women feel free to narrate such events, as observed in other studies¹⁰.

This paper's objectives, which are nested in broader research on women care's gender equity¹¹, were to analyze conversations and identify reports indicating a complaint, a signal, or a request for help, including violent situations. The dissemination of these findings to professionals in the field of health can reflect their communicative skills, contributing to improved quality of care in health services.

Methodological path

This is a qualitative study based on the theoretical-methodological assumptions of Conversation Analysis or speech-in-interaction theory⁴, which analyzed naturalistic interactions¹² between nurses and users during the nursing visit focused on CT collection.

This paper selected conversations in which nurses' listening difficulties are observed, which is evident due to misalignment¹³ or disillusion¹³

between professionals and users, observations¹⁴, unshared laughter, and omission of answers to questions or complaints, configured by silence or change of subject. We also included conversations in which sensitive themes emerged and statements in which we see users indicating something that can be understood as the start of an account of violence, but which were not explored by the professionals.

The concept of (mis)alignment¹³ refers to an interactant's responsive action in the face of the action projected in the statement turn immediately before the response. (Dis)affiliation¹³ refers to how the interactant shows his stance concerning something said by his interlocutor, and there may be an agreement with what was said previously (interactional affiliation) or disagreement (interactional disaffiliation). Observation¹⁴ happens when, in an interaction, the participants are faced with problems in the production of a statement (their own or that of the other), in hearing or in understanding what was said. Therefore, breaking the "flow of conversation".

Delicate subjects are noted with a different orientation of the participants. It appears in the way the interactant produces his statement turn or corporate action¹⁵, that is, a gesture, a facial expression, a visible breathing movement, accompanied or not by a statement. Interaction orientation change is evidenced by hesitation, increased or decreased voice volume, statement production acceleration or deceleration, and term replacement or suppression¹⁶.

This research is based on visits' conversations from January to December 2016, in face-to-face meetings between three nurses working in PHC services in a city inland Rio Grande do Sul (RS) and 26 women who sought the services to perform CT. Seven women were selected in this study. Their accounts brought linguistic elements and content related to the theme. Based on what the participants of the conversation make relevant in their statement turns¹⁷, an emic perspective was adopted.

Data was generated by audio recording these interactions, transcribed reliably to how they were verbalized, based on the conventions used by the conversation analysts¹⁸. Transcripts include silences and pauses; they signal laughter, hesitation, sounds emitted in deep inspirations (*hhhh*), emission of truncated or incomplete words, co-constructed or overlapping statements, when one of the speakers starts his turn and the previous one has not yet completed his own, marked by the presence of brackets. The

CA registers the continuators commonly used in conversations (*aham*, *hum*, *mm*), maintains the absence of concordance, pluralization, and "r" in the verbs in the infinitive, sets the tone given to words or particles, using conventions to indicate the extension of syllables (::), decrease (°°) in the tone of voice, arrows to indicate ascending or descending intonation and the mark (<>) to indicate a phrase pronounced in a lower tone of voice¹⁹.

Nurses are referred to as E1, E2, and E3 and women as M1, M2, M3. In this paper, we analyze seven excerpts of interactions referring to nurses E2 and E3 in meetings with users M8, M9, M10, M13, M15, M16, and M23.

The UFRGS Research Ethics Committee approved this work, and the visits were recorded with the formal consent of all participants.

Noises, silences, and spoken and unheard subjects

Nurse-user interaction in the gynecological visit can be affected by women's difficulties in talking about intimate aspects of their lives and sexuality-related issues, including malaise, pain, and violence. This work evidenced accounts possibly related to sexuality and violence that ensued physical and emotional suffering. However, some of these revelations and complaints were not heard by the professionals who attended the women, and this analysis was about these situations.

Participants' interactive contributions in clinical meetings may express agreement or disagreement, alignment or misalignment, or even affiliation or disaffiliation concerning any interactional action by interlocutors. On the one hand, users can spend time justifying themselves or apologizing for not complying with some precept or norm. On the other, they can ignore nurses' proposals by producing silence, changing the subject, or even contesting or denying what was said by professionals in the previous statement turns. Similarly, professionals can use the same interactional resources in responses to statement turns produced by users¹⁴. However, nurses are in a position of greater power and authority vis-à-vis users in CT collection visits and institutional settings.

Misalignment and disaffiliation are observed in Excerpt 1, part of the conversation between E2 and M10, a 62-year-old user with a history of ten pregnancies. In line 1, the nurse asks a question that involves the user's current reproductive state:

Excerpt 1: “You’re not pregnant, are you?” (M10, 62 years, separated, nine children, and one spontaneous abortion).

- 1 E2: You’re not pregnant, are you Mrs. L?
 2 M10: *Hhhhh*
 3 E2: *Hahaha*
 4 M10: no, no, I can’t get pre[gnant] anymore
 5 E2: [how] long-
 6 M10: I removed the(.) hhh=
 7 E2: =you had surgery? =
 8 M10: =I did ahah

We observe that the format of the question of E2, in line 1 - “you’re not pregnant, are you” is restrictive in the sense that the preferred answer is negative. When asking the question in a negative format, E2 limits the user’s responsive action, imposing on her the interactional, and therefore social obligation, of having to provide explanations in case of inconsistency with the question’s preference. Instead of “yes” (an unpreferred answer) or “no” (a preferred answer), the user sighs intensively (*hhhh*), which shows that her answer is misaligned with the question. Misalignment occurs because the sigh is at odds with one of the rules that permeate social interactions in which, given the first action of a particular type (e.g., a question), the second action operates responsively to the first (e.g., one answer)¹⁴. In this case, one might think that the audible sigh exhibited a complaint and the nurse’s response is laughter.

Laughter and humor are situated; that is, they depend on the context and sharing of the world among the communicational framework participants. When there is no transparent interactional problem, laughter invites the interlocutor to laugh in response and works as an amalgam to build alliances between participants and create bonds of complicity. When only a party laughs, there is evidence of disaffiliation in the interaction. Considering the age and history of the user’s reproductive life, it is worth considering that both the nurse’s question and her way of dealing with the user’s response was not equitable, as she disregards the generational aspect of a woman who biologically could not be pregnant anymore, which was brought up by the very user (“I can’t get pregnant anymore”).

The sterilization procedure is brought into interaction by M10 as part of the accountability that she is producing in response to the nurse’s question. M10 refers to the procedure using the passive voice in the past tense, which suggests

that it occurred outside the scope of its agentivity²⁰. The user does not name what was taken from her (the uterus), which may indicate that she does not know the name of the organ or that pronouncing the organ’s name is problematic for her. In any case, she ends her statement turn by producing an audible sigh (*hhh*), which implies that she is addressing a sensitive topic and utters a complaint about what has happened to her (the removal of her uterus).

Another example of misalignment and disaffiliation can be found in Excerpt 2, in which M9 is uncomfortable with the physical aspect of his belly due to a surgical procedure. The excerpt starts with the user calling the nurse’s attention to her abdominal region through a request for information – “have you seen how my belly looks now?” referring to the “hole” left in the abdomen wall, which is within the nurse’s line of sight:

Excerpt 2: “The hell it’s all right” (M9, 40 years, single, three children).

- 1 M9: Have you seen how my belly looks now?
 2 (0.5)
 3 E2: No, but it’s all right
 4 M9: The hell it’s all right
 5 (.)
 6 M9: Look at this (0.6). He pierced here. Look,
 where the tube
 7 remained inside here. It left a hole.

The question asked by M9 requires an explanation, although it has a polar format, whose answer is “yes” or “no”²¹. When addressing the nurse’s question, M9 starts an interaction sequence that opens the possibility for her interlocutor to show solidarity with her. However, E2 misses the opportunity to exercise empathy, one of the reception’s premises. Instead, E2 seems to take the course of mitigation and produces an assessment of the mark on M9’s belly, initiated by an adversary sentence (no, but) and the quiet follow-on “it’s all right”, expressing acceptability to the procedure. M9 opposes the assessment produced by the nurse (“the hell it’s all right”), describes the procedure performed “by him”, the doctor, names the result obtained as “hole” and accuses him of medical malpractice.

The marks left or caused by surgical procedures due to pregnancies and deliveries seem to carve on women bodies’ ideal function in the symbolic female universe²². In gynecological visits, it is common for them to make the marks inscribed on their bodies relevant, as M9

did. However, M9 does not show the mark as an achievement, but a complaint of the iatrogeny produced by the doctor who attended her.

Again, Excerpt 3 is brought up, reflecting on (mis)alignment or (dis)affiliation in conversations between nurses and users, which starts with M16 seizing the visit's opportunity to clarify her concerns on a symptom of her concern. It is common for users to report symptoms in prevention-oriented spaces, such as CT collection, due to the difficulty of making appointments with a gynecologist in PHC or because they are often not heard in medical visits or are not taken seriously if they are heard²³:

Excerpt 3: "I'm kind of like this, you know. How can I say it?" (M16, 36 years, single, one child).

- 01 E3: Is everything [well?]
 02 M16: [a:h] I'm kind of like this, you know.
 How can I say it? (1.2)
 03 .) I...: (1.1)
 04 E3: °m:°
 05 M16: m: (.) I have been noting something
 different in me for two
 06 months now
 07 E3: mh↑m
 08 M16: Here's the thing °ai° I can't - I
 >mustn't<
 09 be ashamed, right [hh]
 10 E3: [no:] capable
 11 (.)
 12 M16: So, here's the thing
 13 E3: Aha
 14 M16: Here's our pussy, right=
 15 E3: =all right
 16 M16: there ri::ght on the side. I don't know if
 you already did it
 17 (0.6)
 18 E3: °m°
 19 M16: aha: (1.8) right on the side of the
 [cut]=
 20 E3: [m:]
 21 M16: =that we have [to]
 22 E3: [mhm]
 23 M16: That we have babies
 24 E3: Mhm
 25 M16: A small ball emerged
 26 (.)
 27 E3: Ok

Based on Excerpt 3, it can be seen that, in line 1, M16 takes E3's statement's turn not as a greeting but a question about her health status. In response, M16 expresses the perception of something abnormal in herself (line 5), to which the nurse responds with a continuator or, in the words of Schegloff⁴, a "go ahead". The complaint is prefaced by discontinued statement turns, hesitations, and expressions that operate to delay the approach of the topic (lines 2 and 3), which shows that M16 is having difficulty in exposing the problem that still becomes more explicit when the user brings up the afflicting feeling of shame ("Here's the thing. I can't, I mustn't be ashamed, right"). E3 validates M16's request for confirmation that it is unnecessary to feel ashamed ("no: capable"), an action that does not work as reassurance for M16 since she continues to delay the start of the statement turn. First, through a micropause and then via the expression of delaying the turn's start ("So, here's the thing").

M16 begins to explain, in a truncated way, the health problem that concerns her, referring to the part of the body where the problem is located and citing the name popularly used in Rio Grande do Sul for the female genital organ. M16 uses the expression "our" that operates as an inclusive way of expressing belonging. Thus, she works internationally to bring her interlocutor closer to her, sharing the female identity, because both are women. M16 invokes the anatomical position of an episiotomy and the previous experience of having a baby as a new possibility of sharing identity ("I don't know if you already did it"). This time, E3 is not affiliated with the proposal to share the experience mentioned by M16 since their interactional participation at that moment is minimal (lines 18, 20, 22, and 24). The description of the health problem, a source of concern for M16, occurs only on line 25, and it is something she refers to as a "ball" [which came out next to the episiotomy].

Excerpt 3 reveals several macrosocial phenomena in a micro dimension, namely, it is common for women (a) to be ashamed of exposing their bodies in CT visits and (b) women to have difficulties describing their gynecological health problems. The analysis of Excerpt 3 corroborates the argument that the substitution of the formal term for others of common, popular, or childish use as a way for women to deal with feelings of difficulty or shame is a recurring phenomenon

in women's health care visits²¹. The action of not verbalizing the name of the female genital organ and referring to the vagina through deictics (e.g., "down there") is another interactional strategy that women use to address feelings of embarrassment. This phenomenon can be ascertained in Excerpt 4, which begins with the nurse asking the user about allergy, something that the user claims to be occurring:

Excerpt 4: "I have an allergy in the (.)" (M13, 52 years, single, one child).

- 1 E2: Do you have an allergy?
 2 M13: I have an allergy.
 3 E2: Where
 4 (0.5)
 5 M13: Well, in the (.) but the doctor said it is from the heat.
 6 (0.8)
 7 E2: Right. Let's see if we can collect that.

Given M13's statement, E2 asks the user to specify the location of the allergy. After the nurse's request, we observe a pause that acts as a response delay and indicates that the interactant considers the question asked in the previous turn as problematic²⁴. This fact becomes even more notorious when M13 postpones through the word "well, in the", referring to the allergy site, only pointing to the location gesturally. The user refrains from pronouncing the name of the organ (vagina), adding the attribution made by the doctor to the discomfort caused by the allergy ("but the doctor said it is from the heat").

Excerpt 5 is an example of how users' complaints tend to remain unexplored to instigate the investigation of possible difficulties they may face in sexuality and conjugality. The excerpt starts with E3 questioning M23 about severe pain during collection, confirmed by the user. By inference, we see that E3 attributes the pain of M23 during the procedure to vaginal dryness and questions her about the duration of the discomfort:

Excerpt 5: "I also feel pain while having sex" (M23, 30 years, common law marriage, no children).

- 1 E3: Did you feel much pain? (1.7)
 3 M23: Yes, mhm (.)
 4 E3: >>why is it<<so dry? Was it always that dry (.)
 5 M23: Yes- I also feel pain while having sex (2.6)

- 6 E3: You have to buy a gel (.) the pharmacy sells gel, the vaginal lubricant. Ask there, (0.5) ↑it's very cheap (.) It helps, you know.
 7 M23: Mhm (.)
 8 E3: Because it's very dry there in the vaginal wall
 9 very dry
 10 (3.1)
 11 You can dress up

In response to E3's question, M23 introduces new information, namely, that "she also feels pain while having [sex]" (line 6). In the subsequent turn, instead of asking about possible causal attributions for pain in the user's sexual intercourse, which could include tiredness, gynecological infection, having sex without desire, or even the existence of conjugal violence, the nurse limits to offer a practical solution to the M23 complaint – the purchase of a lubricating gel. When offering the gel solution, M23 produces a minimal response, which suggests disaffiliation with the solution presented by E3 for her complaint of pain during sexual intercourse.

Besides the medicalization of sexuality through the indication of a lubricating gel, the dispensing of medications was broader, as can be seen in Excerpt 6, which begins with the user making a self-assessment referring to herself as "drained":

Excerpt 6: "I'm drained" (M8, 44 years, married, two children).

- 1 M8: So ↑I'm:: (1.1) how – how do you say it, I'm drained
 2 (0.6)
 3 E2: You're drained:
 4 (.)
 5 E2: But did you... has the doctor already prescribed so↑me: (.)
 6 treat[ment for you]
 7 M8: [°yes (.) °yes°]
 8 E2: All right
 9 (1.9)
 [suppressed lines]
 10 M8: =and I say I have to do something:: [to]=
 11 E2: [yes]
 12 M8: =help yes [(make the return)]
 13 E2: [yes: and the- yes: and the] doctor already gave you fluoxetine, right
 14 M8: Yes

Although the user's self-assessment can be described as derogatory, given the semantic field of the word "drained", M8 does not specify that she refers to her physical or emotional state. E2 repeats part of the M8 turn, more precisely, the section that brings about the self-assessment. Partial turn repetitions can realize several conversational actions^{25,26}. In the case of Excerpt 6, the turn repetition introduces a question (lines 5 and 6) regarding the resolution of the user's problem. The questioning starts adversely with a focus on the user's agentivity ("but did you"), and, after repair¹³, it becomes a confirmation request with the reallocation of agentivity to the M8 gynecologist ("has the doctor already prescribed some treatment for you"). The interactants tacitly treat the drug prescription's confirmation for the problem reported by the very user in the metaphorical form of "drained" as emotional. When mentioning the antidepressant in her statement turn, the nurse requests further confirmation that the doctor had provided treatment for M8's emotional distress.

The prescription of antidepressants in preventive visits, such as CT collections, attests to medicalization penetration in health promotion actions. Instead of promoting independence and self-care, the indiscriminate use of antidepressants in health practices and services triggers dependence and submission through medication to respond to issues in other spheres²⁷. Thus, economic, financial, emotional, and several types of abuse, such as sexual and domestic violence, can be pathologized, medicalized, and made invisible^{26,28}.

Excerpts 7 and 8 bring conversations in which women allude to situations suggestive of violence in domestic environments. Excerpt 7 starts with accounts of cesarean section complications (lines 1 to 4):

Excerpt 7: "I suffered a lot with my former husband" (M10, 62 years, separated, nine children and one spontaneous abortion).

- 1 M10: I only have nine, right *hh*
 2 E2: right:
 3 M10: And so (.) after her- after I had her
 4 I had a cesarean section, right, and I almost died (.) almost died
 5 E2: why?
 6 M10: Because, the thing is, I fell ill the: entire pregnancy
 7 (.) I suffered a lot with my (.) former husband

- 8 E2: yes
 9 M10: I suffered a lot with him
 10 E2: °aham°=
 11 M10: =he was very mean, right
 12 E2: aham::
 13 M10: So, in the entire pregnancy, I felt
 14 E2: Bad
 15 M10: Bad

Upon learning of the limited experience reported by M10, E2 asks the reason for the occurrence, requesting a justification or account²⁰. M10 attributes the fact to her poor health during pregnancy and, after a micropause, adds the suffering inflicted by the former husband. E2 attests to the receipt of information (yes, ahah, ahah), but it is disaffiliated to M10 in the sense of responding to the user, even after M10 qualifies her former husband as "mean" and ends the statement turn with the discourse marker "yes", often used as a means of seeking interlocutor affiliation²⁹. In contrast, the nurse joins the user when the topic of conversation shifts to the health status of M10 during pregnancy.

The fact that E2 refrains from asking for more information on M10's assessment of her former husband suggests that she chooses to ignore the situation of abuse or ill-treatment in M10's pregnancy and marital relationship, keeping the story ignored and untold. Excerpt 7 reinforces the assumption that visits for CT collection can be interactive environments conducive to the account of violence against women.

In the analysis of Excerpt 8, in the conversation between E3 and M15, a 19-year-old girl, who, when being placed on the stretcher, says she is scared of the collection procedure (excerpt is not shown). Then, the nurse shows she understands her feelings (lines 1 and 2), describes what she will do (lines 3 and 4), and asks M15 to warn her should she feel pain (lines 8 and 9):

Excerpt 8: "Who scared you this way" (M15, 19 years, common law marriage, two children).

- 1 E3: I know it is hard *hã hã hã*
 2 M15: °h°
 3 E3: In the first, I will introduce the speculum.
 4 . ok
 5 M15: ok. (.)
 6 E3: Come over here to this edge (.) there it is
 7 (0.5)
 8 If you feel anything, a very sharp pain
 9 You tell me, ok

- 10 (.)
- 11 E3: °this is a little° [normal]
- 12 M15: [I am scared hh]=
- 13 E3: =re: lax take a deep ↑breath
- 14 (0.7)
- 15 E3: >very smooth< you'll see it's nothing
much
- 16 (1.5)
- 17 E3: Who scared you like that
- 18 (0.5)
- 19 M15: ↑ai q- hh=
- 20 E3: =hhh
- 21 (10.9)
- 22 E3: It's not hurting much, is it?
- 23 (0.5)
- 24 M15: ai just a [little]
- 25 E3: [a little] discomfort (2.0)
- 26 (2.0)

The user again expresses fear (line 12), to which E3 responds by instructing her on how to control the feeling (“re: lax take a deep breath”), minimizing the fearful potential of the procedure (“you’ll see it’s nothing much”) and, at the same time, marking down the user’s complaint. After a pause, when asking M15 about the possibility that the fear had been caused by someone (“who scared you like that”), E3 shifts her attention to the intensity of the fear displayed by M15, who responds late and after a pause, and starts to elaborate a justification (“↑ ai q-”), but interrupts her statement and produces an audible sigh (line 19) that is repeated by the nurse, which seems to evidence a particular affiliation between the interactants. However, E3 missed an opportunity to encourage M15 to explain why she is visibly scared. Considering that M15 begins to elaborate the questioning made by E3 about who would have scared her, M15 could have likely revealed the cause of her fear had the nurse opened the possibility to talk more about the subject.

Reflecting on what occurs in the interaction in focus, it is worth noting the possibility that M15 may be in a post-traumatic stress state or that she has suffered sexual violence. In these situations, victims do not tolerate physical contact, which causes fear and revulsion^{30,31}. However, one cannot rule out that the gynecological examination itself, often performed without proper preparation or imposingly and abruptly, may have triggered pain and fear, which is also a case of institutional violence. Regardless of whether the rejection of the exam and the fear evidenced

by M15 are due to a situation of violence, domestic, or even institutional, the cause of such manifestations remains invisible since the user does not get to produce statements to describe it.

The invisibility of complaints and symptoms that could be indicating violence but that were not discussed could be because some problems are the responsibility of the services. Thus, the presence of signs and symptoms that refer to the female sexual system is heard and identified when indicating diseases such as cancer for which the service is a reference, while other conditions, such as violence, although they are a severe public health problem, remain invisible even when there are signs of their presence, disregarding the health sector’s responsibility³².

When the normative horizon is morphofunctionality and its risks, says Ayres⁹, directed as a traditional anamnesis, listening will identify an object of intervention, and aspects related to users’ existential situation will be secondary or even perceived as noises.

Historically, the biomedical model in Western society is anchored in science, technology, economic profit, and patriarchal institutions. This model operates in the logic of the segmentation of the human body perceived as a machine, viewing people as objects, and alienating professionals vis-à-vis the patient. We could add to this the hierarchical, bureaucratic, and authoritarian organization of work and standardized procedures³³.

The analyzed conversations indicate how much nursing was colonized by the hegemonic, technocratic, little dialogic, and hierarchical biomedical model. In this sense, subjects brought up by patients and considered irrelevant by doctors or nurses are not even heard. Complaints can be minimized or disregarded, and topics such as sexuality or violence remain invisible. Also, women’s medicalization has long been due to symptoms produced by domestic violence³⁴, besides overvalued technology, to the detriment of conversational interactions and dialogue.

Final considerations

This work has been the challenge of using a powerful yet little explored methodological resource in the health field – Conversation Analysis – to analyze conversations produced between professionals and users during the gynecological nursing visit. An unprecedented study showed that nurses do not always listen to women’s demands, either by making their stories visible or

showing empathy for their fears and difficulties. Reciprocal misalignments or interactional disaffiliations show that professionals are unaware of users' demands or that nurses' solutions are not satisfactory to users.

The study also showed that many situations evidence women care inequality in CT collection nursing visits, which emerged in the use of inappropriate questions and the interactional inability to assist users in difficulties with terms to address sexuality. Another aspect perceived through data microanalysis was the medicalization of prevention-oriented visits, contributing to women's chemical dependence without considering possible socioeconomic determinants. Finally, the research suggests that the CT collection visit

can promote the investigation of violence against women, and is, therefore, a receptive space for female issues transcending the biomedical sphere.

The research expanded the knowledge on how women are attended in the gynecological nursing visit and how the interactional resources appear in the conversations between them. The analyses of the interactions were not exhausted since the dialogues initiated in the visits were quite extensive, and other patterns and meanings could be sought. The dissemination of these findings and the power of analyzing conversational interactions with the collective health and nursing professionals can stimulate their reflection on the communicational aspects of clinical and care relationships.

Collaborations

All the authors worked on the paper. LZ Hesler collected data. DNP Andrade performed the linguistic analysis. SN Meneghel coordinated the project.

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Article submitted 28/10/2018

Approved 08/04/2019

Final version submitted 10/04/2019

Chief Editors: Romeu Gomes, Antônio Augusto Moura da Silva