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Use of Dialysis, a Model of Identity Bifurcation for Patients Admitted to EMS-Cocody (Ivory Coast)

Agobe Ablakpa Jacob[1*], Koffi Koffi Gnamien Jean-Claude[2], Adjoumani Kobenan[3] and Ackoudoun-N'guessan Clement[4]

[1-3]Assistant Professor, Institute of Ethno-Sociology (IES) -UFR-SHS, Félix Houphouët-Boigny University Abidjan, Côte d'Ivoire

[4]Associate Professor, UFR Medical Sciences, Félix Houphouët-Boigny University Nephrologist-Registrar, Hemodialysis Department of the Yopougon-Abidjan Hospital and University Centre (CHU) Abidjan, Côte d'Ivoire

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***Corresponding author**
Agobe Ablakpa Jacob

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Abstract: It should be remembered that kidney failure is a frequent chronic disease. It is the result of the evolution of certain diseases, such as diabetes, hypertension, infections and congenital malformations, which destroy the kidneys. These no longé perform their purification function (Gombert B., 2014). This evolution can be mitigated by avoiding it or by addressing all the factors that can aggravate it. Moreover, the announcement of the disease to an individual constitutes a moment of fragility (...). So, the project of this communication is to analyze the process of identity reconstruction in the person with kidney failure in a socio-cultural environment. In concrete terms, it is a question of describing the long journey and acceptance of the disease on the one hand, and on the other hand, the resilience strategies developed by the patient. The conceptual framework used in this study is based on the principles of Dubar's (1992) theoretical approach. This leads to the result that the reconstruction of the patient's identity is problematic; first, the announcement of renal failure, which is a disruption that will occur over time for the patient and his family. Secondly, the patient's autonomy can only be achieved through the reconstruction of identity through personalized management of treatment and daily life actions. To this end, socio-professional care is all the more necessary.

Keywords: Renal insufficiency, Dialysis, Identity reconstruction, Identity fork.

INTRODUCTION

The diagnosis of a chronic disease is often a disruption that will last for the patient and his or her family.

The disease will require acute care in the early stages, followed by support leading to changes in the lifestyle of the patient and his or her family.

Autonomy can only be achieved through personalized management of the treatment and actions of daily life. Multi-professional care is essential. Indeed, paramedical personnel will be involved in care and therapeutic education. The intervention of an occupational therapist may be useful if it is necessary to adapt the housing to the patient's new situation. The intervention of professionals in the social sector is also essential to enable the person to remain in active life, at work, at school or university but also in relation to domestic tasks. Medical and social care is not always sufficient because of the gap between health and social services. However, the well-being of the person depends on these two aspects, which in reality form a whole, and on a real coordination of the actors concerned [1].

Demographic and epidemiological data have shown the very high weight of people suffering from chronic, often disabling, diseases in our society: it is estimated that in France 15 million people, or nearly 20% of the population, suffer from chronic diseases, sometimes several in the same person. Increased life expectancy and medical advances are tending to increase the number of people living with chronic diseases. A 2007 DREES survey of applicants for the Allowance for Disabled Adults shows that out of 100 people who applied for the AAH, 50% of the agreements under L. 821-1 and L. 821-2 of the CASF are given to people with one or more chronic diseases [2].

Recent studies have demonstrated the reconstruction of problematic identity forms. The first forms the majority of people with mental disorders. They aspire to re-enter the labour market and live a normal life. However, social workers perceive them as patients who cannot function normally. The second form of identity is reconstructed in a relationship of concordance between the perceptions of people with mental disorders and those of workers. The last form of identity is part of a conflictive relationship that affects only one person. The latter is perceived as a sick person, but this person is functioning and able to return to the labour market Leclerc Anick [3].

In Cote d'Ivoire, childcare facilities have been created to help parents who suddenly found themselves with kidney failure. In 2007, the Hemodialysis Department attached to the SAMU was created in place of the Hemodialysis Centre. The EMS was created by Decree No. 76-247 of 14 April 1976. It was established as a National Public Institution (EPN) of an administrative nature by Decree No. 84-746 of 30 May 1984. By this act, the EMS is endowed with legal personality and financial autonomy. Decision No. 257 of 4 April 1995 of the Ministry of Public Health and Social Affairs attached to it the Centres for Burns and Hemodialysis.

Decision No. 944/ MSHP/CAB/ of 19 June 2007 establishes a Public Hemodialysis Service attached to the EMS in place of the Hemodialysis Centre. In view of Decree No. 91-658 of October 1991, which determines the functions, organization and functioning of the EMS, the mission of the EMS Hemodialysis Service is to provide care for the therapy of chronic renal failure. The number of patients treated in the EMS hemodialysis department in the first half of 2012 was 116. The number of patients treated in the 2nd half of 2012 increased to 152. In the first half of 2012, the number of dialysis sessions performed in the EMS services in the first half of 2012 was 922. The number of dialysis sessions performed in the 2nd semester is 1201[4].

On the other hand, the number of patients treated in the Hemodialysis Service EMS in the 1st half of 2013 is 1209 Patients with 35 deaths recorded. During the first half of 2013 in the Hemodialysis Department recorded 1209 patients with a high proportion of men of 826 or 68.32% and a low rate of women with renal insufficiency with a proportion of 383 or 31.68%. These figures reflect that men are more exposed to the risk of kidney failure infections [4].

Renal insufficiency disease (RI) causes many victims with the number of deaths of men high at 26 or 74.28% and that of women at 9 or 25.72% for the 2nd quarter of 2012. If, we compare the result of the hemodialysis service in the 1st half of 2012 and that of 2013, we point out that the number of individuals with kidney failure has almost doubled. This also shows that the problem of kidney failure is crucial. There is a remarkable evolution of renal insufficiency disease with a high rate of dialysis services [4].

The management of patients undergoing hemodialysis creates an interaction between the patient entity and the care specialist entity. These two main entities build interdependencies and negotiate a lot about treatment. Patients learn a lot about their treatment and lifestyle from health specialists. The most experienced patients know more than the nurses who are new to the hemodialysis service at the EMS. Some patients are willing to participate in the work of nurses. They very often seek to understand what patients are going through. The borderline between health care providers and care providers is less clear than in other services [5].

Field visits to the EMS hemodialysis department have shown that there is a discrepancy between the individual perception of end-stage renal disease due to different pathologies and the collective perception of identical treatment. We find the same discrepancy between the invisibility of the disease outside the hemodialysis department and its visibility in the hemodialysis department. The question underlying this study is to know: How is the process of identity reconstruction of people with kidney failure carried out? The objective of this study is to analyze the process of identity reconstruction in the person with kidney failure in a socio-cultural environment. In concrete terms, this means: i) Describing the long journey and acceptance of the disease, ii) Describing the resilience strategies developed by the patient.

THEORETICAL AND METHODOLOGICAL APPROACH

The conceptual framework used in this investigation is the theoretical approach of Dubar [6]. It allows us to study identity reconstruction based on the interaction between the identity claimed by people with kidney disease and the identity attributed by individuals in their environment.

Methodologically, the study is based on a qualitative approach. Conducted from November 1 to November 12, 2018 with 13 individuals. With these, semi-structured interviews were organized to understand the long process and acceptance of the disease as well as the ideological productions that guide social behaviour in the couple. The choice of eligibility of the interviewees is the status of the actors. The preferred data collection technique is the principle of triangulation and saturation that is central to chronic disease management: data must be systematically cross-referenced, whether during the interview (returning to the same question through other channels), from one interview to another, and between different sources; Observation, interview and writing[7].

RESULTS

From announcement to awareness and acceptance of the disease

The definition of a chronic disease is not based solely on an etiological criterion because the same disease can have completely different consequences. Chronic diseases lead to disability, fatigue or asthenia; they impose therapeutic constraints and behavioural changes, such as the need to consider dialysis treatment at specified times (two sessions per week in the hemodialysis department of EMS-Cocody) or possible dietary adjustments; they also sometimes require adverse drug reactions. They have social consequences that can lead to isolation or exclusion. Because of their disabling consequences, these diseases give rise to the recognition of the disability or disabilities resulting from them [2]. This is what E.M. testifies to: "*I was violently shocked when the disease was announced. For me, life stopped*. ». Patients therefore experience trauma when the disease is announced.

Use of dialysis: A step towards acceptance of the disease

By looking at the life history of these chronic patients, we can see a more or less brutal break marked by the use of dialysis. Patients enter an unknown universe, which can be impressive, where the technique predominates. The generators define the layout of the unit, the pace of work and care, the pace of life of patients, the competence of nurses and patients, their relationships. But for most of the actors, whether they are cared for or cared for, the anguish generated by the technique gradually fades over the years and through learning [5]. This technical treatment is particular because of its heavy constraints and paradoxes. Dialysis treatment weighs heavily on the daily lives of patients. Because, the treatment indefinitely renewed, two sessions of dialysis at a rate of 4 hours per session. Dialysis treatment is palliative but relieving for the patient. It must be repeated over and over again until the person is transplanted [5]. In addition, there is also extensive medical monitoring (illustration).

Photograph of a patient in hemodialysis session at EMS-Cocody
Source: Agobe, Field Survey, 2014

Two paradoxes add to the constraints of treatment and complicate the experience of patients on hemodialysis: Renal failure is an invisible disease. They are seriously ill and do not appear to be ill but have the status of disabled people. Venous arterio-venous fistula is the only visible mark of the disease [5]; "*We have no symphonic signs for others to identify us*", as shown by the patient undergoing hemodialysis.

The etiology of the disease and the conditions for palliative treatment (dialysis) vary from one individual to another. However, they undergo the same collective treatment in the hemodialysis department. It is in this sense that Y.J. is comforted by these expressions: "Other diseases such as hypertension or diabetes are developed from one renal patient to another. In my opinion, the origin of the disease is different" The ideologies of the patients objectively explain the advantages and disadvantages of palliative treatment of renal failure.

Dialysis treatment is a significant event in the life of a person who must use it for survival. The announcement of the need for palliative treatment comes most often after the disease is announced but especially in the chronic stage. A period of illness that has given the patient time to become aware of the seriousness of his condition but to rebuild his identity and accept to live with the disease: this situation is in itself a painful experience for the patient. But the perception of palliative treatment initiates a different situation insofar as it marks a certain inevitability. It is sometimes the last resort to rebuild identity and develop the ability to live with the disease.

Renal insufficiency patients have a problematic and symbolic relationship with their bodies, while their families develop an ideology that explains the fear and despair of losing their suffering loved ones. However, patients refer to the practice of dialysis in two ways: on the one hand, the dialysis operation is a moment of "*Regeneration*". And on the other hand, dialysis is a painful moment because of its time constraints but a deprivation of activities; "*Dialysis is for me a moment of renewal of its renal function to function better or to evacuate waste from the body*", a statement collected from a patient.

Analysis of the relationship between dialysis patients and the patient, a form of reconstruction of the patient's identity

The disease being the point of action between dialysis patients and the patient creates an interdependent relationship between the entity of medical personnel and the entity of dialysis patients. The patient weakened by the disease is relieved by the medical staff who restore his confidence to come out of his pathological state but especially to rebuild his identity. As a result, patients as a whole find their relationship between themselves and the treating body "acceptable". These words of G.H., a renal patient in these terms: "*They are at our service, they understand the patient's condition. It is true that when I came on dialysis on the first day, it was not easy. I had not yet accepted the disease and I was often nervous towards those around me. But the medical staff understand this behaviour. They understood my suffering, today we have a good relationship. There are no problems between us. We expect well". I follow the instructions of the attending physicians. There is no problem between us...".* Renal failure changes the patient's lifestyle. The patient suffers from the constraints of renal failure. The only relief for the patient is hemodialysis.

Indeed, the practice of hemodialysis creates a permanent contact between the patients and the patient. Because each patient undergoing hemodialysis is entitled to at least two sessions of hemodialysis per week. Indeed, the fact of coming regularly for hemodialysis sessions builds a cordial relationship between the patients and the patient. Beyond the caregiver-caregiver relationship, there is another relationship of familiarity between the patients and the carer. This is explained by A.B., a patient he met at the EMS hemodialysis department, in these terms: "*There is a bond of familiarity created between me and the nursing staff. Everyone calls me "Dean*". I should go dialysis at Yopougon University Hospital because of the transportation costs I have to pay to get here. But given the attention that the medical staff pays to my personality, I prefer dialysis to EMS...".

In addition, the visiting hours of Health Specialists to their patients are variable. They depend on the days, the Hemodialysis Services, the severity of the cases, the psychological importance available to the patients at the beginning and/or the importance they will acquire during the dialysis sessions. When the nurse has successfully connected the patient to dialysis and does not have any particular concern for the rest of the dialysis session, his behaviour sometimes has the character of irritating his entourage. Some doctors and Caregivers in Public Hemodialysis Services are not renowned for their modesty. This is what K.M., a kidney patient, says in these words: "*In this Hemodialysis Department, I dialysis here, almost 8 years ago. But my brother, I inform you that out of the three Nephrologists doctors who have to follow us, there is only one doctor who comes regularly to visit us. This doctor listens to us attentively and does what we need according to the technical platform. The others, the day they are happy and they come, they barely take care of us. For me, they see us as the living dead...".*

Family management of the disease, legitimization of the patient's new status.

The person with chronic kidney disease who arrives on dialysis undergoes many changes in their life. These disruptions sometimes seriously affect the quality of life. There are often repercussions on emotional relationships, on the patient's social role, loss of work sometimes even a loss of autonomy. These disturbances lead to a change in the patient's image and self-esteem [8]. These personality disorders of the individual could also have an impact on the couple's health. By the health of the couple we mean a set of behaviours related to desire and satisfaction. It is also expressed by the pleasure of giving and the pleasure of receiving. Sexuality is essential to give and receive affection. It could also be a simple entertainment with only the search for pleasure. And it is also an affirmation of self, manhood, femininity and identity. For others, sexuality is a reproductive function only [8]. The management of renal insufficiency thus includes a medico-social aspect (medical care, equipment, environmental facilities, therapeutic education, support, disease follow-up) and a socio-economic aspect (assistance in maintaining socio-professional integration, assistance in maintaining the autonomy and identity of the sick individual).

In view of the above explanations, it is expected that the family unit will be an important step in the care and rehabilitation of the pending patient in dialysis. That is, the family must allow the patient to cover the costs of dialysis but also demonstrate a willingness to consent to help the patient rebuild her identity. After the interviews with the patients, the parents participate in the payment of medical expenses and dialysis sessions. These words from U.P. testify to this: "*Since I had this disease, I can no longer work. I am a farmer and when I try to work a little. I can't hold it. So I no longer have a source of income. It is my brothers who help me pay for my dialysis sessions and prescriptions...*". Of course, the choice of this opportunity is specific to each patient. It depends on the patient's abilities, wishes and well-being. However, it cannot be prevented from noting that the management according to dialysis patients cannot correspond to what one would have expected. Indeed, the meaning given to care according to the patients differs from one patient to another. As a result, patients as a whole define care as a relief. In addition, the interventions of the patients' parents would have no other purpose than to maintain the sustainability of the care of their relatives suffering from renal failure. However, psychological and relational limitations were mentioned by the patients. According to patients before the onset of the disease, they did not have major problems with their families. The relationships were acceptable.

In addition, during the onset of illness with the high cost of prescription fees, the relationship between patients and their relatives has changed. Patients report that they often negotiate financial assistance with their relative to cover medical expenses. Indeed, this relationship of dependence of patients on their relatives is experienced by patients as a situation of economic exhaustion. It is in this sense that D.F., a patient, testifies in these terms: "*I feel humbled. Before, I used to earn my own daytime bread. I was taking care of myself. This disease room made me handicapped. There's nothing more I can do. I live at the expense of my parents today. At home, I can no longer decide things either. You know when, you have nothing, we can't associate you with family decisions...*". This situation reflects the difficult reintegration of people suffering from kidney failure.

The dietetics of renal insufficiency, diet as a way of building identity

For people with kidney disease, everyone has different needs depending on their age, medical history and stage of kidney failure. Some nutrients such as protein, sodium, potassium (vegetables, fruit, chocolate) and phosphorus can either accelerate the progression of kidney disease before the end stage, worsen the symptoms of kidney failure or complicate its treatment. Diets adapted to each stage of the disease and each type of treatment are therefore necessary. The dietitian will work with the patient to plan the daily routine and try to slow the deterioration of kidney function. Dietetics can have consequences on the acceptance of the disease by relatives. When the kidneys can no longer do their job as regulators, it is necessary to monitor the type and amount of food consumed. According to the treatment providers, a diet will be recommended to meet the nutritional needs of the sick person: "*Undernutrition must be avoided and therefore balanced eating, which is sometimes difficult. Indeed, loss of appetite is frequent, with, in particular, a disgust for meat (this often improves with dialysis, controlling the accumulation of certain substances contained in food. Reduce symptoms such as fatigue, nausea, itching and bad taste in the mouth. Check blood sugar levels (glycemic control) if the patient is diabetic. Beverages: Most often, dialysis patients stop urinating. The absorbed liquids are therefore no longer eliminated, they accumulate in the body and can cause oedema and, in the event of a very large excess of liquid, acute oedema of the lungs. When the person no longer urinates at all, it is recommended to drink a very limited amount of liquid per day. Indeed, drinks are not the only contributions to be taken into account. Food also contains water in varying amounts, which should be taken into account (for example, a watermelon contains much more water than a banana).* ».

Renal insufficiency and biographical rupture, towards a bifurcation of identity

Sociological research on diseases chroniques† is largely due to the pioneering work done in this field by Anselm Strauss and Barney Glaser cited by Voegtli M [9]. In particular, these authors have developed a new approach by integrating social work in disease management into the analysis. This shift in the focus of analysis refers to how the actors "†négocient to live as normally as possible when they are confronted with the disease. Therefore, the focus is on the social and psychological (not medical) aspects of living with the disease chronique†"† Kathy Charmaz's [10] survey of 57 people with various chronic diseases and Michael Bury's survey of people with polyarthritis in Britain illustrate this shift in perspective. Charmaz(idem) cited by Voegtli M., idem) is interested in the loss of self, more precisely in the modification of the organization of significant attributes of the person (self-concept), which break down with the qualitative and quantitative transformation of social interactions related to the emergence of the disease. For Charmaz (idem), patients live a limited life in social isolation, gradually becoming burdens in a context where the values of independence and individualism are prevalent. In line with Goffman's analyses of the mechanisms for imposing and managing stigma (Goffman [11], cited by Voegtli M. (idem)), Charmaz considers that successive public mortifications undermine the foundations of self-concept, and that patients may decide to restrict their public appearances in order to avoid such devaluation experiences [10] The author's thesis is that of the deep break introduced by the disease, which provokes a fundamental questioning of the person's social identity. We are therefore more interested in what the disease does than in what the social actor does with it, by highlighting the upheavals it causes. As well, Michael Bury develops an analysis of the disruption, or biographical disruption, following the emergence of the disease. It shows that the process of bringing the disease to light causes a disruption of the structures of daily life and the forms of knowledge associated with it (Bury, [12], cited by Voegtli M., idem)). Three consecutive elements are used by the author to explain this. First, the actor must face a disruption of what were previously given assertions and behaviours ("†taken-for-granted assumptions and behaviours†"). This questioning by the author leads, secondly, to a rupture with the explanatory systems mobilized until then by the actor, which involves a fundamental questioning of his biography and the constituent attributes of his person (ibid.). Finally, the response to this upheaval is the mobilisation by the actor of the resources at his disposal. This conceptualization of the rupture related to chronic disease has been the subject of several readjustments and criticisms aimed at completing it. Three elements will be the focus of the author †: the course of the disease during the life cycle, the mobilization of resources according to the actor's career and, finally, the centrality that the disease acquires in this conception as an explanatory factor of an actor's social identity. These dimensions refer directly to the person's work to ensure coherence linked to the emergence of chronic disease.

The rupture as used by Bury for chronic disease analysis is limited in design to mid- to end-of-life [13, 14] cited by Voegtli M., idem). In this sense, it is not mobilized to report on experiences upstream in the actor's career. However, they can have a significant weight in the apprehension of the disease as a rupture. In their investigation of elderly London East End seniors, mainly from the working class, who had suffered, sometimes multiple times, from apoplectic attacks, Pound et al. insisted, for example, on the need to place the experience of the disease back in the career of acteur†: "† For many, the apoplectic attack did not imply recognition of a world of pain, suffering and death (Bury [22], cited by Voegtli M., idem) on the understanding that their age and position in the social space had familiarized them with such mondes†" Pound *et al.* [13]†: 500; Our translation; see also, in a more recent work [15, 16]. Under penalty of considering as a determining factor an event that could only be experienced as a "normal †crise †", the break introduced by the disease must therefore be understood taking into account all the events that occurred during an actor's career and his position in the social space. As we have pointed out with regard to retirement, these remarks must make us aware that the disease is not only imposed, but also experienced, and that the upheavals it can cause are to be linked to the question of how the actor mobilises the resources at his disposal.

As we have touched on, the apprehension and means of managing the event are not independent of the resources available according to the position occupied in the social space and the actor's biography [15, 13] cited by Voegtli M., op cit†). Bury had already mentioned the variability for resource mobilization actors. This refers to the need to take into account the position held by the actor in the social space, the social networks available and the degree of flexibility offered by the institutions in which he is inserted [12]. It is in fact the entire biography that must be taken into account. In the case of chronic disease, biography is in this perspective to be understood from a triple perspective, as noted by Corbin and Strauss [17], namely biographical time, conceptions of self (as an evolving component of identity) and the body. "†L he biographical adjustment becomes the central process by which sick people and their families take action to retain and/or regain a certain degree of control over their biographies made discontinuous by the disease.

This action allows them to integrate the disease and the changes it brings into their lives. The action allows them to give form and meaning to their biographies in response to the phases of the disease and all the contingencies it apporte†" [18]. If the chronic disease involves a biographical adjustment for the actor, it is therefore made according to the resources at his disposal or that he is able to create. Far from being limited to disease management, this adjustment implies a reorganization of the entirety of the actor's insertions.

DISCUSSION OF THE RESULTS

The literature on chronic diseases has highlighted the trap of considering the actor only as sick, whereas he can be inserted into many social sub-worlds. Isabelle Baszanger quoted by Voegtli M [19] clearly showed the complexity of this processus†: "†On is dealing with a process of social change. In this sense, it is necessary to go beyond the crisis, to think about continuity, duration, i.e. to think about a reorganisation in the crisis or other forms of organisation than those used précédemment†: for example an organisation (even a precarious one) that takes into account the potential alternation crisis/non-crisis. And, whatever the forms of recomposition of people's careers, to think that they encompass their insertion into systems other than medicine, the recomposition of other universes that are being made, dismantled and rebuilt... in interaction with actors other than doctors.

The disease situation must be studied in all places of life sociale†" [9,19]. In this sense, the author points out that chronic disease does not necessarily produce, during its successive manifestations, the same effects in terms of identity recomposition [13, 14]. In other words, the actor's career is made up of negotiated recompositions that affect all his insertions sociales† "†La negotiation, writes Baszanger, is one of the major means to achieve recomposition, i. e. to maintain a certain order social† These continuous negotiated recompositions must most often be initiated by the patient actor because he is at the intersection of the different spheres of social life. In each sphere reigns a set of rules and roles constantly constructed by the different actors involved. Each set is affected by the "disturbance" of the patient's insertions. Through negotiations, these ensembles† are recomposed and rebuilt" [9] cited by Voegtli M., idem†). This negotiation is carried out in a social structure that constrains the space of possible objectives and subjectivity. The inclusion of actors in multiple social sub-worlds [17] means that the work of negotiation is not limited to disease, but that it causes a recomposition of investments in these different strata and a work of coherence of the person. This is called the reconstruction of the patient's identity.

The psychological difficulties of dialysis patients are linked to the fact that their illness is fatal and makes restrictive care essential. The discovery and announcement of the disease therefore confronts the patient with his own death. The first moments of this discovery lead to social and psychological upheavals and constraints that lead the subject to reduce his daily activity. This leads him to detach himself from the world and no longer invest it, hence a withdrawal into himself, sometimes accentuated by social isolation [20]. That is why family and caregivers have a very important role to play. This theoretical observation reinforces the results of this study through Dubar's theory [6], which allowed us to highlight the reconstruction of identity based on the interaction between the identity claimed by people with kidney failure and the identity attributed by individuals in their environment.

On the other hand, some patients find dialysis to be socially beneficial, if they are people who were already socially isolated before, dialysis will allow them to establish links with other people, whether they are cared for or carers. Dialysis is often considered by patients as a "dead" time, lost, hence the importance of sometimes re-explaining the interest of dialysis, what it is used for [20]. The use of dialysis creates a certain familiarity between the patient weakened by the disease and the person treating him or her, but also with other patients. Consequently, the onset of the disease, as a traumatic event, can lead to a profound change in the perception of time. This analysis by Lefebvre confirms the disruption that kidney failure inflicts on the patient's life.

Indeed, the passing of time is what brings us all closer to the deadline of death. However, renal insufficiency is, more than any other person, confronted with this perspective, which is all the more inevitable because dialysis is only a palliative care, i.e. a care intended only to push back the limits between life and death. As D says. Cupa in the journal soins (October 1992) "the patient experiences the announcement of the dialysis and his entry into dialysis as a shock. It is a passage into another life, that of survival, because, from then on, without dialysis he cannot live, it is dialysis or death [20] ". In analysing this subject, it should be stressed that at the same time dialysis relieves the patient is a painful moment for the patient. Because dialysis could only delay death, which for the patient is in the near future. Moreover, it is necessary to consider the vital issue of this treatment as painful to say the least insofar as it puts the subject in a situation of absolute dependence, identical to that of the newborn child called neotenia, and therefore impotence. This feeling of dependence will be more or less well experienced depending on the subject's personal history. It is precisely because dialysis is a vital necessity that it is experienced as an absolute constraint [20]. While cancer patients can expect treatment to cure them for patients with renal insufficiency, hemodialysis is a palliative treatment that will never restore their kidney function. Treatment is not there to "*fight*" a disease (or delay the onset of its symptoms, as is the case with triple therapy) but to compensate for an acquired organic failure forever. Thus, patients forget the diagnosis of renal failure since they have already "*lost*" against this disease from the moment they started Dany *et al*. [21] cited by Desseix A [21].

In the analysis of chronic diseases, it is clear that placing the emphasis on breakpoints is not in itself sufficient to account for the career of the sick actor. A shift in the focus of analysis towards the work of coherence carried out by the actor, upstream and downstream of the point of bifurcation, seems to be better able to account both for the way in which the entry into illness takes place and the effects that it has on the person's recomposition (adjustment of inscriptions in different social sub worlds, investment in social roles, recomposition of sociability links). In this respect, the literature on AIDS patients is particularly suitable for designing the process of this work of coherence.

CONCLUSION

In total, this study is intended to contribute to the sociology of chronic disease. Indeed, its objective was to analyse the identity building process of patients with renal insufficiency. In concrete terms, it was a question of describing the long journey and acceptance of the disease as an element in constructing the individual's identity. And on the other hand, the resilience strategies that socially structure the position of dialysis patients to rebuild their new way of life. It should be noted that there is almost total heterogeneity in the way people with kidney disease view palliative treatment (dialysis) in their daily lives and in the way their families view disease and dialysis. This is reflected in the analysis of the different discourses of the actors interviewed. The rational factor makes it possible to play a positive role, insofar as it allows people suffering from kidney failure to feel more confident in their surroundings; by being assured of rebuilding a social identity, the relationship with those around them is immediately calmed down. The qualitative study of the discourse of people undergoing dialysis suggests a strong rationalisation of the themes addressed in the reconstruction of the identity of people suffering from kidney failure. The discourse of actors with insufficient renal capacity is most often confined to ideological references that easily reconstruct the new status of the actors but above all the legitimization of their relations with their surroundings.

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