

Care, lack of care and affection: a perspective for humanization in health

It is imperative to tackle care and humanization in health as strategic issues, to avoid them disappearing into oblivion or the intentional deletion of our memories.

In the transition from the 1990s to the 21st century in Brazil, the theme of humanization came to be considered strategic for health policy, giving rise to agendas related to knowledge, attitudes, and practices. An institutionalist aspect of the National Humanization Policy-HUMANIZASUS (PNH)¹ reminds us that humanity has its ambiguities but also a political architecture that, in its essence, incorporates blood and life, with exquisite vocabulary: care, participatory management, co-management, ambience, support, subjectivity, intersubjectivity, expanded and shared clinical practice, the role of users and workers, a community of practices, analyzers, transversality, interdisciplinarity, training and corollary measures. This rich vocabulary evokes a subject materially located in the asymmetries of power and conflicts inherent in health-work relationships. And the problems are at the same time the raw material and backbone for the exercise of the profession.

It is worth stressing that the opposite of humanization, namely dehumanization, may have repercussions in what remains unspoken about racism, ageism, sexism, and capacitism, which are expressions that evoke lack of care and violence, by expropriating and erasing the recognition of the other and their knowledge. The discourse of the hero, heroine, warrior, mission, sustains and is supported by images that dehumanize people in their relationships. They appeal to a place where someone can be protected from suffering, inequality, choice, the encounter that can take place because of color of skin, age, and the memories that it evokes.

The so-called empathy harks back to those idealizations that mask asymmetries. The maxim “put yourself in the other person’s shoes” ignores the fact that this other being talked about has color, pain, and class. And in the asymmetry of the bedside, the patients did not choose their place, they did not choose the disease, while professionals, researchers and managers initially chose to make this environment their workplace. By recovering the sense of being bewitched in and by relationships, Favret-Saada² reintroduces us to affection. It calls upon us to be affected by the pain of others and, at the same time, deconstruct the illusion that, by taking their place, we become supposedly equal. This operation denies otherness and difference and does not offer the other legitimate attention to care for their pain.

We cannot deny the differences, because by denying them, by caring, we can elicit lack of care. In decades of studies on the sociology and anthropology of care, Guimarães and Hirata³ deconstruct the universe of this concept as something natural, of the essence, or of an asset per se. Care can be translated into unimaginable dimensions in the circuits in which it operates, in the material relations of production, in inequalities between genders and, among women, according to the social markers that locate and rank them. In the same work³, the authors draw attention to the fact that, among the three possibilities of circuits of care, profession, obligation and help, it is in the latter that we find relationships based on trust and proximity, operating in family and community-based care. In times of pandemic, it always makes more sense to rescue these circuits, and the meaning of care as assistance in the peripheral areas, where the State offers stray bullets and empty plates; and care as a profession and obligation, in healthcare settings.

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