Ciência & Saúde Coletiva
cienciaesaudecoletiva.com.br
ISSN 1413-8123. v.29, n.7
DOI: 10.1590/1413-81232024297.03692024EN

Care resignification in the pandemic context

Daniella Teixeira Dantas Gouget (https://orcid.org/0000-0002-6540-2313) [1]
Tatiana Wargas de Faria Baptista (https://orcid.org/0000-0002-3445-2027) [1]

Abstract *This essay discusses the care process of health professionals in the context of COVID-19 from the perspectives of psychoanalysis, under the prism of Donald Winnicott's transitional space, and of collective health, under the prism of the practical wisdom of José Ricardo Ayres, the micropolitics of live work in action by Emmerson Merhy, and prudent care by Ruben Mattos. It suggests elaborating a care perspective to propose a possible resignification of illness in a pandemic, where health is marked with calamity, health catastrophe, and suffering and anguish, whether in the body or subjectively. In this way, understanding the manifestation of care by health professionals in a pandemic context brought about with narcissistic and heroic meanings and feelings of impotence and helplessness contributes to elaborating a creative conception of care. We conclude that the perspective of expanded care favors the creative possibility of new productions of meaning and support for professionals, resignifying their life experiences through love, creativity, practical wisdom, prudent care, live work in action, and motor imaginary.*

Key words *Care, Anguish, Health Professionals and COVID-19*

[1] Programa de Pós-Graduação em Saúde da Criança e da Mulher, Instituto Fernandes Figueira, Fundação Oswaldo Cruz. Av. Rui Barbosa 716, Flamengo. 22250-020 Rio de Janeiro RJ Brasil. danigouget@gmail.com

Introduction

With the unexpected advent of COVID-19 in 2020, the sense of time passing was accelerated, accompanied by an acute rise in SARS-CoV-2 viral infections, with deaths and the health system's collapse. Health professionals complained that they could not cope with the process of illness that the pandemic was establishing in the body and subjectivity, which only reinforced that the pandemic comprised another record of illness beyond the body. It became clear that the subject becomes ill and complains not only through the biological body.

Contemporary malaise and its variations of clinical narratives are revealed through a surplus that causes a loss of meaning in psychic experience, manifesting itself in the records of the body, actions, and feelings[1]. The pandemic has influenced this malaise, affecting singularities, mental health, and the economy – causing inequalities, helplessness, and discouragement[2]. From this viewpoint, Birman[2] associates the pandemic with a catastrophe.

The lack of effectively guaranteed immunity against the invisible villain of the pandemic (the virus) has affected preserving the human body's integrity. Virus mutability was considered a possible invincibility. The experience became fraught with suffering for everyone who went through it, especially those who took on care – with overlapping tasks and shifts, due to the reduced number of professionals working (with the increasingly rapid spread of COVID-19). Health professionals described a progressive experience of unusual feelings, such as impotence and helplessness, in the face of all the pressure and expectations embedded in the pandemic setting, as if they were summoned to take on the role of the Salvation Army. In an attempt to respond to a context marked by uncertainty, professionals often resorted to alternatives such as self-medication to pursue increased waking time, and over-streamlined tasks, giving up time for breaks and rest.

Suffering arose through anguish at the unknown, where a relationship was identified between the feeling of anguish and the need for support (holding)[3], which, according to Winnicott[3], translates the feeling of stability and predictability in the environment, enabling the subject to feel safe and welcomed in their life context.

Anguish often paralyzes the subject in their symbolic capacity and can operate as a defense. It can also open up a subjective resignification of meaning through the care perspective, which requires creativity to bring about change. Figueiredo[4] (p.117) affirms, "[...] there is always tailoring in the making of meaning". We, therefore, understand the need to give way to the word, looking for a creative possibility and an elaboration of all this experience. Those who fall ill and suffer are, primarily, subjects and not just bodies. Therefore, speech should be privileged, as Figueiredo[5] (p.43) points out, "[...] as a possibility of making another dimension of the complaint that singularizes the request for help". However, how could this experience be put into words if there was a lack of knowledge and recognition of what was happening? How could we find support, recognition, and availability in the presence if the most defended control measure were physical distancing? We were living in a time of multiple illnesses, where the caregiver was also sick – whether from the virus or the threat of emptiness and anguish caused by seclusion. For this reason, care was a necessary response to the meaning of life continuity.

Under a new period, the current one, with the possibility of understanding and resignifying when looking back, we question what reflection on care would have been possible then. The elaboration of new meanings for the perspective of care is translated in this essay through the possible reflection and direction for the experience of malaise produced throughout the COVID-19 pandemic.

This essay aims to discuss the care process of health professionals in the context of COVID-19 from the perspectives of psychoanalysis, under the prism of Donald Winnicott's transitional space[3], and collective health, under the prisms of José Ricardo Ayres' practical wisdom[6,7], Emmerson Merhy's micropolitics of live work in action[8,9], and Ruben Mattos' prudent care[10]. For the discussion, we sought, from clinical practice, as a psychologist in a public health unit, during the pandemic period (in particular, from 2020 to 2022), to recapture memories of that time and place them in critical analysis, streamlining the argument and pointing to theory-practice integration in the process of redefining care.

From the perspective of a theoretical essay inspired by Larrosa[11], this reflection on the pandemic time is an opportunity to think about and for the present, bringing the practice that affects health workers and the authors of this text as an opportunity to look critically at their experience. The dialogue with the mobilized authors will enable a creative reflection on care during COVID-19.

The pandemic context and pandemic illness

An 'Epidemiological Transition'[12] movement has been in the making since the mid-twentieth century. It involves a reduction in number of deaths from infectious and parasitic diseases and higher deaths from chronic noncommunicable diseases[12]. However, not all countries have had a linear and complete epidemiological transition[13]. Countries with peripheral social formations, such as Brazil, are characterized by vulnerability and social inequality, resulting in the coexistence of mortality from chronic diseases and infectious and parasitic diseases. This reality reflects immense fragility to subjects, social contact networks, consumption capacity, maintenance of health services, and the production of autonomy[13].

With the advent of COVID-19, the problems faced in extreme social inequality were exacerbated, and others were added, such as psychological and social symptoms besides viral infection. The pandemic imposed a break in the subject's stability in their daily life routine, with the incidence of a lack of meaning, as there was a break in the subjects' continuity of meanings. However, it is vital always to keep the process of 'making sense' active, enabling the articulation and symbolization of the various expressive forms[4] – because, as Figueiredo points out, "when meaning crystallizes or is received or taken in a crystallized way, the process is interrupted, and creativity is stifled"[4] (p.116). This crystallization haunted many subjects throughout the pandemic through the fear that the threat of the virus represented a closure of meaning: fear, dread, flight, avoidance, and death.

Meaning is always the result of a social construction and depends on availability[14]. This path promotes understanding the new context and a possible dialog for the constitution of possibilities for new meanings. However, how do we construct new meanings?

COVID-19 represented a reality that asserted itself through an intangible virus, whose power was previously unknown and immeasurable. In this circumstance, a new coherent reorganization of perceptions and affections still needed to be built, facilitating the action of care and the constitution of meaning.

As Contemporary Society is established by a rupture of meaning from the imposition for subjects to act on immediacy and a culture of urgency[15], we can infer that the pandemic was inserted into a setting already characterized as a crisis. The pandemic has announced itself by updating this moment of crisis, and without the possibility of any recognition and the opportunity to construct meaning, it has had the effect of consecutive anguish of symbolic loss and social disaffiliation[15].

Anxiety is understood as a malaise[16] that represents a lack of hope and prospects, which aligns with what we are currently witnessing, where the lack of meaning and a coherent chain of signifiers has caused a deficit in the prospects of when all the persistent suffering generated by COVID-19 will end. The suffering started and continues with anguish, unemployment, and the elevated number of deaths caused, representing symbolic, material, and affective losses, respectively – still active mourning processes. The pandemic was a biographical challenge, affecting the body's material, symbolic, and imaginary aspects[17].

Everyone repeated the same chorus: "*It will pass*", perhaps to create an illusion of collective chorus and temporariness and brevity; however, the lack of understanding of when this suffering would pass only seemed to reflect in more anguish. Also, the uncertainty about the future only increased, producing even more hopelessness.

A crisis of values was at work, associated with the technological and scientific advance of knowledge. Without a chain of signifiers to handle the production of knowledge needed to respond in a meaningful way to everything experienced, a health catastrophe was established and was a trauma – an experience that takes us unexpectedly, invades us, and sends us into psychic helplessness[2]. The global crisis spread along with the virus, corresponding to a multidimensional crisis. We understood that this crisis was – and still is – a crisis of connection between the dimensions of intrapsychic, interpsychic, and material realities, as a psychosocial crisis of the intermediary[18]. The connection between subjects was shaken through physical distancing or veiled emotions with the use of masks. The community, the social, intersubjective exchanges, and the possibilities of contact became subject to the need for protection and physical distancing. Suffering was trivialized in a context of low governance and investment by hospitals in public health services[15], favoring experiences of helplessness and distrust in the future[2]. As much as the possibility of social contact was maintained virtually, the absence of permanent face-to-face links, with the lack of representation of the subject's availability to the other, harmed the construction of incentives for possible solidary and affectionate encounters, which affected intersubjective, compassionate exchanges and care practice.

With the new variations of the virus and the displays of its dizzying capacity for contagion, suffering escalated with the outbreak of symptoms, illnesses, absences, losses, and (even) deaths. Chronic illness shapes the subject's identity by their illness[19]. However, in the case of pandemic illness, the question is how the subjects were shaped if they lacked a sense of their illness. With the accelerated unfolding of the disease in the pandemic, we could ask ourselves how sufferers preserved their identity beyond the physical symptoms.

The reflective path to a creative care

The proposal to reflect on the perspective of the subject's clinic and expanded care makes it possible to consider the subjectively constructed context, including a willingness to look and listen, beyond the objective construction of the patient with their illness[6,20]. Extended care allows the subject to unfold their potential beyond recognizing their limitations and identifying the possibility of new encounters of meaning. It thus favors the possibility of making sense. Through this openness, the opportunity arises for 'reflective practice' and the construction of projects with other subjects in collaboration to transform the world[21]. Bonds and intersubjectivity could stimulate the practice of reflexive clinical practice[20], a place from which we could position ourselves to think about a care perspective for coping with and sustaining individual and collective illness during the pandemic.

Support, named by Winnicott as the 'holding function'[3], stands out during care as a function that enables the subject to support themselves, find stability, and establish themselves subjectively, which implies a guarantee of the continuity of life and favors the strengthening of identity, hope, and the production of meaning.

We are clearly moving towards a time when we focus on more than just objective biomedical issues. Other types of issues arise, such as fear, anguish, and anxiety, confirming the relevance of care. In this context, we realize that the sick subjects are not only those infected by the pandemic virus but also all those who have been involved in some way with caring (for others or themselves in quarantine). What often goes unnoticed by caregivers is that the need to do everything possible, save, and face reality with all their might tends to diminish the defenses of the person they are trying to care for. Also, the constant failures in the social receptive devices tend to reproduce further the absence of meaning[22], which we constantly witnessed in the clinic, where health professionals risked getting sick, suffering, and losing. Without the space and conditions, they often did not have access to the reflective process necessary for the care and receptive process.

Working in hospital care for people being treated for acute and chronic illnesses during the pandemic drew us closer to the intense anguish of health professionals, invaded by pandemic-related issues (such as pressure for presence, courage, and efficiency), which affected their bodies and subjectivities. This anguish caused them intense bouts of anxiety, which manifested daily in the interactive dynamics they established. These professionals had to escalate their care time due to the increased demand and working hours, which meant they had to deal directly with the anguish of patients and their families and withstand all the pressure of external productivity and internal support. In our meetings with health professionals at the hospital during the pandemic, we constantly observed some recurring situations:

- Some of them went directly to the psychologist at the health unit or informed her that they had signed up for one of the many virtual psychological listening services on offer. In these cases, we could witness an active search for a mental health worker and the health professional's recognition of their limitations and need for support and elaboration;

- It was common to meet agitated professionals in their work, seeking to fit into a constant logic of productivity, which seemed to express a probable escape route from the possibility of reflection and coping with reality;

- We could also meet health professionals in secluded places, in isolation, attempting to hide their feelings of sadness and frustration, as if they were trying, through tears, to release all their pent-up affection. Tears were most often described as suffocating;

- Some of them still denied reality, trying to claim that everything was fine, that nothing had changed, repeating the mantra that life went on as usual.

Some of the subjects who participated in these experiences fit into more than one of these stages, configuring the anguish and imprecision brought by the pandemic context and the limitation of meaning available from a care protocol perspective.

The discourses of health professionals generally questioned personal strength in intensity and durability. They expressed the fear of becoming

ill, insecurity about the future, and the need also to be cared for.

It became clear that these health professionals never considered the possibility of quitting their jobs. They often identified their limitations, revealing fear and insecurity, but did not give up. They constantly stressed the need to cope and maintain superhuman strength, as if they could take on the role of superheroes in such a frustrating setting (with the breakdown of meaning) defined by the COVID-19 pandemic.

Superpowers were multiplied by increasing working hours (with disrupted sleep and rest), negotiating for personal protective equipment through informal ties, and attempting to alleviate pain through intermediary strategies between doctors and patients.

Regarding the willingness of health professionals to cope during COVID-19, we find in Dejours *et al.*[23] the strategy of collective defense, which is defined as being a device built collectively, based on a consensus, producing cohesion and through which the subjects/workers support themselves, seeking to transform their perception of the reality that makes them suffer[23]. Acting as a resistance to Reality, the collective defensive strategy protects the subject against the suffering from working conditions. On the other hand, it can also be a trap, represented by aggressiveness, passivity, and even alienation, a failure to recognize one's suffering and the suffering of others, which can end up generating even more suffering.

Also, some individual defense strategies can lead to cynicism, dissimulation, rationalization, passivity, and even individualism[24]. One of these defense strategies is the emergence of 'superheroism' as a reflection of a narcissistic trap. In this way, the health professional defended himself against the lack of meaning that emerged in his practice through his function's precarious effectiveness during the pandemic, alienating himself from the others whom he cared for and assuming the solitary experience of the exaltation of his function's potential (illusion). A strong narcissism surfaced[25] as a defense against becoming ill. Under the creativity of another perspective and represented through care, love became a potential creative resource against any form of illness.

Although the suffering produced in the pandemic may characterize a suffering unique to the subject – health professional – care agent, when entering a neoliberal productivist logic (which implies the demand for productivity and alienating consumption), the subject tends to appropriate a defense, which can be collective, under the imagination of superhero to placate precariousness and inefficiency, generally supplanted by the SUS reality. By trying to avoid possible frustration at the experience of heroism, the subject can also generate new frustration because the superhero imagination does not represent reality. However, imagination can fertilize reality by following the path of hope, bringing a new possibility besides frustration, that of creative production[26]. There are no possible projects or hopes without imagination.

Imagination enables us to know, learn, be affected, and be enchanted[27]. Imagination fosters sensitivity and promotes care. We should transform anguish positively into an affirmation of living, creating new social and political symbols of possible mediations[1], which is how we understand imagination and the creative possibilities for strengthening it.

Following this understanding and associating it with the notion of transitional space[3] – an area of commitment and cultural experience, a potential space between internal reality and external life – we reflect on the viability of a link between the imagination of heroism and reality, promoting the possibility of producing creative meaning for the care perspective, where understanding the imagination of heroism would favor the production of meaning about the care perspective in reality. We believe that this production of meaning also involves the possibility of health professionals finding sources of pleasure. Dejours *et al.*[23] affirm that organizational and work demands are sources of suffering for subjects but also of pleasure. Pleasure emerges through appreciation and recognition at work[23], which is related to the issue of heroism. Thus, by living and integrating work and pleasure, health professionals can (re-)create and (re-)imagine themselves, making sense of and resignifying their care experiences.

Work, Care, and Creativity

Regarding the relationship between work and care, we draw attention to the need to develop work committed to life[19]. Through clinical practice, we saw daily that health professionals were committed to their care activities. Care provides work with a perspective of technical flexibility and comprehensiveness[19]. These professionals made their techniques more flexible to position themselves comprehensively and with the aptitude to meet the needs and demands imposed by the new context.

Reflecting on care, we come to the importance of exercising prudent care, as proposed by Mattos[10], which values the consequences/effects of the care action, contributing to a decent life for the professionals[10], based on conscious, responsible, and sensible care action. Care thus emerges as favoring professional commitment to a dignified life[10,19]. The care implied and committed to the other during the pandemic reflected on the caregiver as possibly providing him with a compromised life of meaning, decency, and dignity. The recognition, thus translated, of this potential gives care a creative meaning.

Health work is dependent on live work in action[8], which, as expressed by Mehry[8], indicates work realized while performed, producing care – which contributes to the configuration of its existence through relational dynamics presence, constituting the cartography of the micropolitics of live work in action – a productive walk that builds bonds in health action. Most of the time, health professionals perform their care function in their presence, hindering their physical distance from their work, as was required of many other functions during the pandemic. Their role in presence has gained notoriety and escalated during this time because, besides physical care, it represented the possibility, for the other subject, of proximity with emotional, affective, and social care – which tended to reinforce the personal pressure of health professionals to hold the position of a savior.

From the perspective of micropolitics, live work in action considers the bonding process as a creative work promoter, where creativity and autonomy enable the emergence of technical and social practice, facilitating the production of a new care product – a technical, social, and affective practice[9]. Bonds, creativity, and affection paved the way for another meaning for care during the pandemic. Regarding the meaning of affectivity, we identified its notoriety through the symbolic dimension in health practices[14].

Thus, dimensioned care is established beyond the biomedical paradigm (which reduces the patient subject to their sick body), representing expanded care focused on the subject's clinic. Canguilhem[28] (p.79) affirms, "Even from a physical viewpoint, man is not limited to his body. [...] Thus, we must seek beyond the body to judge what is normal or pathological for that same body". Moreover, with contemporaneity, a rupture has occurred in our understanding of historical continuity, and subjectivity could not anticipate what emerges as danger[1] – and this is what we have seen actualized with COVID-19, by emptying the body's psychic security vis-à-vis to the world/nature.

Creativity at work has become necessary. It is integrated into the continuity of being and is considered necessary for the subject to feel alive, expressing their true self[3]. The capacity for creativity would allow the subject to adapt to reality, with its demands, challenges, and experiences of suffering, thus promoting the continuity of being. This possibility of continuity is a possible meaning for care, enabling the flow of life – stimulating hope for what appears as catastrophe.

Health workers should be able to add something of themselves to their work[29,30], showing their ability to interpret reality and use their creativity to overcome the barriers of the challenge set by reality. From this perspective, practical wisdom emerges as a learning capacity that values speaking and listening. This capacity enables creative intelligence[7] – a cunning, creative, and effective know-how with a corporeal dimension acquired through experience. This intelligence emerged as the inventive tool of the hero workers' practice during COVID-19. A tool invested with human emancipation powers, where each worker could somewhat manage their subjectivity in becoming aware of how to act in each situation, became an instrument of narrative and creative action.

Practical wisdom has an intangible dimension that is essential for the production of care[30]. This wisdom enables workers to construct and mobilize about their suffering and that of others from a symbolic exchange with the social field, where the meaning of personal identity can then be elaborated. In this symbolic exchange, workers recognize and strengthen themselves as professional and subjectivity and agent and patient of yet another creative possibility of the action of care.

The potential of motor imaginary

From the perspective of the study developed in this essay, we perceive the coexistence of two poles of possibilities: deceptive imaginary (which we interpret as the defense strategies developed during the pandemic, primarily through heroism) and motor imaginary (which we understand from the care strategy)[26]. Understanding that the pandemic context was established like deceptive imaginary, its possibilities for creativity and practical wisdom could be strengthened by recognizing and valuing motor imaginary, operating as a

transitional space[26]. The transitional space acts as an intermediary space between the internal and external worlds, a potential space where creativity develops, and reflective activity becomes possible[26]. This flow favors the construction of meaning from a care perspective, guiding life, which is destined beyond the pandemic time, where embracing the pain of others creates new pulse circuits[17]. Regarding caring, we understand with Sá[14] (p.202) that this "is the only way to give the life we lead and the world in which we live meaning and value". Care, thus, includes a meaning of itself to resignify the pandemic, subjectivity, work, and life continuity.

Conclusion

Elaborating a possible care perspective in the face of a psychosocial crisis brought on by COVID-19 makes it easier for the subject to find continence and meaning in their experiences, thus resignifying their entire care and life experience during this time. Love, creativity, imagination, creative intelligence, practical wisdom, prudent care, live work in action, and motor imaginary represent, in this setting, possible meanings for understanding the care perspective, favoring change within COVID-19 – from a symbolic code that can be made sense of. Thus, creativity, the positive use of anguish, and the possibility of doing something different in the name of life will enable the subject (health professional) to overcome the suffering – which paralyzes them – and find meaning in their existence – which permeates the practice of care and its very meaning. As Fonseca and Sá[31] (p.299) emphasize, "[...] health work has an intangible dimension that is much greater and much more definitive for the quality of the care produced than what can be measured or apprehended by formal indicators".

Strengthening processes that value the subject's access to their subjectivities, such as recognizing what makes them suffer and what pleases them, works as an antidote to suffering[32]. Therefore, studies on the variables that underpin suffering in the pandemic setting are vital to helping health professionals, at first, identify these variables, favoring reflection on possible care practices. In this movement, health professionals can find autonomy in their practice and be guided along the path of unveiling their meaning of work, enriching their language registers[1] – while overcoming the imaginary of conformism that characterizes public health organizations[15].

Through a creative perspective of care, it becomes possible to revive language's symbolic function, emptied by fear, anguish, and anxiety – pandemic symptoms – thus setting the possibility of a reflective place for the subject. Studying care resignifications during the pandemic is crucial since the context facilitates the reproduction of malaise.

The unconscious alliances between subjects can generate care, enabling the constitution of subjectivity based on collective processes[15]. Therefore, we can collaborate in reframing the care perspective based on practices that focus on attention, listening, dialogue, mediation, bonds, and support in the face of suffering, allowing us to reflect on paradigms, address losses and changes, and, thus, produce new meanings.

In this configuration, care can find new meaning possibilities and be resignified, as has happened at other times, with biomedical care (centered on the body of the sick subject) and expanded care (valuing other dimensions, such as affection, speech, and desire) perspectives.

A possible resignification took shape at the onset of the COVID-19 situation, with the figure of the superhero appearing (still) to placate the void of absence, loss, and overload. Understanding how the COVID-19 setting was revealed, through how care was shown in clinical practice from the onset of the pandemic context facilitates work on understanding a care perspective that can promote more significant support and understanding of the circumstances of illness experienced during COVID-19. This perspective points to the realization of reflexive care practices with creative, dialogical, and meaning-producing actions. We, therefore, envision the possibility of building more collective spaces to support suffering, such as reflection groups – with investments in the production of care, research, and disciplinary exchanges. The SUS building project based on discussions that consider the relationship between theory and practice inseparable[32] promotes a dialogue that facilitates the reflection underscored by Cecílio[32] (p.281) on "how not to do more of the same thing". Doing things differently to find new meaning possibilities or at least redefining meanings opens up new possibilities for resignification and public health actions to provide care to cope with illness and, thus, support for the suffering subject. We are encouraged and strengthened by moving away from the perspective of health and illness to look for new life-meaning possibilities[3], even if the context is one of catastrophe and chaos.

Collaborations

DTD Gouget prepared the study's initial argument, discussion, and drafting. TWF Baptista contributed to the analysis and discussion of the argument. Both worked together on the critical review of the manuscript.

References

1. Birman J. Excesso e ruptura de sentido na subjetividade hipermoderna. *Cad Psicanal* 2004; 26(17):175-195.
2. Birman J. *O trauma na pandemia do Coronavírus – suas dimensões políticas, sociais, econômicas, ecológicas, culturais, éticas e científicas*. 3ª ed. Rio de Janeiro: Civilização Brasileira; 2021.
3. Winnicott DW. *O brincar e a realidade*. Rio de Janeiro: Imago; 1971.
4. Figueiredo LC. *As diversas faces do cuidar: novos ensaios de psicanálise contemporânea*. São Paulo: Escuta; 2009.
5. Figueiredo AC. *Vastas confusões e atendimentos imperfeitos: a clínica psicanalítica no ambulatório público*. 3ª ed. Rio de Janeiro: Relume-Dumará; 1997.
6. Ayres JRCM. O cuidado, os modos de ser (do) humano e as práticas de saúde. *Saude Soc* 2004; 13(3):16-29.
7. Ayres JRCM. Cuidado: tecnologia ou sabedoria prática? *Interface (Botucatu)* 2000; 4(6):117-120.
8. Merhy EE. *Saúde: a cartografia do trabalho vivo*. São Paulo: Hucitec; 2007.
9. Merhy EE, Feuerwerker LCM. Novo olhar sobre as tecnologias de saúde: uma necessidade contemporânea. In: Mandarino ACS, Gomberg E. *Leituras de novas tecnologias e saúde*. Salvador: UFS, UFBA; 2009.
10. Mattos RA. Cuidado Prudente para uma vida decente. In: Mattos RA, Pinheiro R. *Cuidado, as Fronteiras da Integralidade*. Rio de Janeiro: CEPESC, IMS/UERJ, ABRASCO; 2013.
11. Larrosa J. A operação ensaio: sobre o ensaiar e o ensaiar-se no pensamento, na escrita e na vida. *Educ Realidade* 2004; 1(29):27-43.
12. Omram A. The epidemiologic transition: a theory of the epidemiology of population change. *Milbank Memorial Fund Quarterly* 1971; 49(4):509-538.
13. Sabroza PC. *Concepções de saúde e doença*. Rio de Janeiro: ENSP; 2004.
14. Sá MC. Por uma abordagem clínica psicossociológica de pesquisa e intervenção em saúde coletiva. In: Azevedo CS, Sá MC. *Subjetividade, Gestão e Cuidado em Saúde*. Rio de Janeiro: Editora Fiocruz/ENSP; 2013.
15. Sá MC, Azevedo CS. Trabalho, Sofrimento e Crise nos Hospitais de Emergência do Rio de Janeiro. In: Ugá MA, Sá MC, Martins M, Braga Neto FC, organizadores. *A gestão do SUS no âmbito estadual: o caso do Rio de Janeiro*. Rio de Janeiro: Fiocruz; 2010.
16. Bauman Z. *Vida para Consumo: A transformação de pessoas em mercadoria*. Trad. Carlos Alberto Medeiros. Rio de janeiro: Jorge Zahar; 2008.
17. Gaudenzi P. Cenários brasileiros da Saúde Mental em tempos de Covid-19: uma reflexão. *Interface (Botucatu)* 2021; 25 (Supl. 1):e200330.
18. Kaes R. *O grupo e o sujeito do grupo: elementos para uma teoria psicanalítica do grupo*. São Paulo: Casa do Psicólogo; 1997.
19. Alves CA. Cuidado e cronicidade: Um encontro necessário. In: Alves CA. *Tessituras do cuidado: As condições crônicas de saúde na infância e adolescência*. Rio de Janeiro: Fiocruz; 2016.
20. Campos GWS. A Clínica do Sujeito: por uma clínica reformulada e ampliada. In: Campos GWS. *Saúde Paidéia*. São Paulo: Hucitec; 2002.

21. Onocko-Campos R. Humano demasiado humano: uma abordagem do mal-estar na instituição hospitalar. In: Onocko-Campos R. *Psicanálise & Saúde Coletiva. Interfaces*. São Paulo: Hucitec; 2012.
22. Figueiredo LC. A metapsicologia do cuidado. *Psyche* 2007; 11(21):13-30.
23. Dejours C, Abodoucheli E, Jayet C. *Psicodinâmica do trabalho: contribuições da escola dejouriana à análise da relação prazer, sofrimento e trabalho*. São Paulo: Atlas; 1994.
24. Mendes AM. *Psicodinâmica do trabalho*. São Paulo: Casa do Psicólogo; 2007.
25. Freud S. Sobre o Narcisismo: Uma introdução. In: Freud S. *Edição Standard Brasileira das Obras Psicológicas Completas de Sigmund Freud*. Rio de Janeiro: Imago; 1996.
26. Azevedo CS. A dimensão imaginária e intersubjetiva das organizações de saúde: implicações para o trabalho gerencial e para a mudança organizacional. Cien Saude Colet 2010; 15(Supl. 1):977-986.
27. Diniz D, Gebara I. *Esperança Feminista*. Rio de Janeiro: Rosa dos tempos; 2022.
28. Canguilhem G. *O normal e o patológico*. 6ª ed. Rio de Janeiro: Forense Universitária; 2009.
29. Fonseca MLG. Inteligência Prática e o exercício do cuidado na enfermaria oncológica. In: Fonseca MLG. *Da prescrição à criação: Inteligência prática, produção de cuidado e invisibilidade no trabalho de uma equipe de enfermagem em oncologia* [tese]. Rio de Janeiro: ENSP; 2014.
30. Dejours C. Inteligência Prática e Sabedoria Prática: Duas Dimensões Desconhecidas do Trabalho Real. In: Lancman S, Sznelwar LI. *Chistophe Dejours: Da Psicopatologia à Psicodinâmica do Trabalho*. Rio de Janeiro, Brasília: Fiocruz, Paralelo 15; 2008.
31. Fonseca MLG, Sá MC. A insustentável leveza do trabalho em saúde: excessos e invisibilidade no trabalho da enfermagem em oncologia. *Saude Debate* 2015; 39(n. esp.):298-306.
32. Cecílio LCO. Escolhas para inovarmos na produção do cuidado, das práticas e do conhecimento: como não fazermos "mais do mesmo"? *Rev Saude Soc* 2012; 21(2):280-289.

Article submitted 05/05/2023
Approved 01/02/2024
Final version submitted 04/03/2024

Chief editors: Maria Cecília de Souza Minayo, Romeu Gomes, Antônio Augusto Moura da Silva