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Art and humanization of health practices in a primary care unit

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This study seeks to reflect on a philosophical basis in relation to an artbased humanization project that was developed by the professionals at a primary healthcare unit. The “reception” at this service refers to the sector dedicated to receiving people who are looking for attendance but without an appointment previously scheduled. In order to restore the meaning of “welcoming”, as disseminated through the National Humanization Program, these professionals created a project that aimed to modify the ambiance of the waiting room so as to promote symbolic transformation of that space such that this could enable qualification of the interactions that take place there. Investigation of this phenomenon demonstrated that art had properties capable of involve individuals in an experience that could promote creation of new meanings for the waiting room.

Keywords: Humanization. Art. Primary health care. Waiting room.

Introduction

According to the National Humanization Policy[1] (NHP), embracement in the field of healthcare refers to construction of interpersonal interactions based on attentive listening, with ethical commitment and interest in acknowledgement of the other person. Embracement should not be restricted to a sector of the healthcare service composed by certain professionals who are allocated to the task of receiving people in need of care. Its concept is related to a certain attitude and ethical stance that should be used by all those who work in that environment.

Within primary healthcare (PHC), which is responsible for ensuring access to the healthcare system, reception becomes especially important. When arriving at the service, individuals may be in a situation of vulnerability and the way in which they are welcomed influences the type of relationship established with the team. However, in attempting to give responses to the often large numbers of people looking for assistance, professionals may end up unconsciously mechanizing the way in which they listen to and attend these individuals, in an automated behavioral process that is distant from the logic of embracement advocated through the NHP.

While the limitations on actions relating to the quantitative aspects of reception are recognized, taking into consideration the difficulties implicated in decreasing the demand and/or increasing the numbers of professionals at the service, it is important to develop strategies capable of promoting qualitative changes to the interactions established in these locations.

Amongst the NHP recommendations, professionals at primary care services are encouraged to take ownership of the work process, through identifying critical bottlenecks and proposing feasible alternatives so as to overcome them. From empowerment of the team, it is possible that innovative and transformative initiatives may emerge within healthcare practices. This process was identified at one primary healthcare unit (PHU), which used art as a tool for restoring the meaning of reception.

This path is unusual in environments like PHUs, which are so greatly marked by technical and scientific factors. However, philosophers such as the German Hans-

Georg Gadamer (1900-2002) have already shown how science came to dominate the way of thinking in modern societies, through "taking charge" of any explanation relating to phenomena within people's realities[2]. This has become even more evident in fields such as healthcare. Meanwhile, art was relegated to the field of fiction.

At the same time that art achieved autonomy, it became restricted to the imaginary and the unreal. Today, there are specific locations for art to be produced, which have become displaced from everyday life. For artistic experience, it has become necessary to find museums, theaters or concerts, for example. However, in this world colonized by scientific reasoning, integration of art with everyday life can configure an escape route from technicism and the substantively instrumental logic of the sciences, thereby bringing openings for human dimensions differing from those seized by technological sciences.

In relation to everyday healthcare practices, for example, issues relating to health, suffering or even the end of life, which often go unnoticed, can be placed in a new light. Matters relating to the sense of existence can (and often should) be evoked during care actions. Having the skill of knowing how to identify and address these issues is related to humanization. In this context, art can have a fundamental role.

The therapeutic effects of art have been recognized for many centuries, but it has only been over recent decades that systematic scientific studies have been developed with the main aim of comprehending the effects of art on patient health. However, with regard to studying the relationship between art and humanization, the scientific literature is still sparse. One possible explanation for this could be the difficulty of examining these matters through the systematization proposed by the scientific method, and especially through studies guided by quantitative analyses. For this reason, it may be necessary to resort to other theoretical and methodological approaches, and to other knowledge that makes it possible to build a comprehensive picture that might also guide other types of study, whether scientific or not.

With the aim of contributing in this direction, the present study had the objective of reflecting on the potential of art in relation to humanization processes

within healthcare services. The origin of this study was an experience of using art in a project to improve the reception and ambience of a PHU in the city of São Paulo.

Regarding construction of the reflection.

Among the authors of this essay, one belonged to the PHU team whose experience, which took place in 2010-2011, served as the starting point for the reflections to be developed. This author was an active participant in the process and subsequently dedicated time to studying it, in a project that developed to be a master's dissertation. This consisted of a qualitative study, based both on participant observation and on in-depth interviews with the other participants of the project.

However, this paper is not a presentation of all of the architecture of this study, or the set of results. Instead, it brings into discussion an aspect of the study that was certainly part of the investigative process, but is highlighted here as an approximation of a more abstract and conceptual nature. In the manner in which this essay is structured, only a relationship with the origin of that experience is retained. The aim in the present discussion is fundamentally to provide a comprehensive-interpretative picture. This type of depiction has been shown to be very productive for illuminating experiences, and we envisage that it may be useful for opening up new investigative routes and new proposals for action towards the humanization of healthcare practices in a general manner.

As indicated in the first paragraphs of the article, the fundamental philosophical inspiration was Gadamer's philosophical hermeneutics[2], from a double perspective: on the one hand, because this provides a critical reference to the technical-scientific reduction of western reasoning, which has a strong impact on healthcare services today; and on the other hand, because within the comprehensive-interpretive movement of hermeneutics, this indicates the forms of intelligibility of the process studied and the search for validity of the propositions. To develop the comprehensive-interpretive circle that is to be established between the singular project that has specifically been conducted and studied, and the meaning of art in

relation to the general meaning of humanization, a variety of thinkers will be brought in. From their different niches, interests and fundamentals, they enable fuller comprehension of significant relationships between instrumental reasoning, esthetic experience and ethical horizons.

Reception Project

The Family Health Strategy (FHS) was created with the objective of reorganizing PHC in Brazil. It determines the distribution of territory in geographically delimited areas and attributes responsibility for taking care of people who live there (totaling a maximum of 4000 people) to a multi-professional healthcare team composed of at least a doctor, a nurse, nursing technicians and community health agents.

The Brazilian healthcare system used to focus on development of the tertiary care level, represented by large hospitals. Starting in the 1990s, investments started to be made with greater emphasis on PHC, with the intention of reorienting the care model so as to enable comprehensive healthcare actions that would be sensitive to the sociocultural context of each population group. Family health teams are allocated to institutions located near to the population, with the aim of facilitating access and serving as first reference for caring for the most frequent forms of illness, and for health promotion in a general manner[3].

Teixeira[4] took the view that encounters between professionals and users may often generate tension and disagreements. In fact, the dimensions of the FHS, in which it was determined that family health teams should be responsible for large populations, often under conditions of extreme vulnerability, causes difficulty in adequately receiving these populations, given the diversity and complexity of the demands placed on PHC.

In mid-July 2010, significant attrition was noticed among the professionals at the PHU studied here (from now on called PHUX), a family health unit located on the western periphery of the city of São Paulo. This attrition was noticed and discussed by the team, and it was attributed to the impossibility of responding adequately to the

growing demand from users who were seeking urgent services, while maintaining a welcoming attitude and respecting the principle of universal and equitable accessibility to comprehensive healthcare. An internal discussion on these difficulties lead to a reform project of the PHU's reception area, which will be named here "embracement project".

At meetings, the existing reception model was placed in debate. At that time, the term reception was attributed to the sector in charge of emergency care. In this sector, there was a physician and a nurse on duty who were responsible for providing care to patients who needed immediate attention and did not have a scheduled appointment. When users arrived at the front desk of the PHU reporting some health issue, they were then sent to the "reception sector". Teixeira[3] had already envisaged that the practical solutions known within PHC for the issue of reception involved combination of some organizational arrangements within the healthcare service (reception, screening and access), which could undergo shifts (access, entrance and emergency care) and go as far as becoming emptied of meaning, such that it might be reduced to a new name for the old activity of screening or emergency care.

This distortion of the concept of embracement, which instead of being understood as an attitude of inclusion, ideally to be used by any professional within the service, in relation to a given PHU sector, had already been on the agenda of previous discussions. Sometimes, the name "embracement sector" was modified to "day care", with the intention of reminding the professionals that embracement is not a synonym of reception, so that it cannot be attributed to a specific sector and should be everyone's responsibility.

After ascertaining the "reception" flow characteristics, the factors that were possibly making it difficult to adopt welcoming attitudes were surveyed by the team. It was asked whether the attrition among the workers resulted from the organization of the healthcare system, which, within the logic of regionalization, envisages making the service unit responsible for a territory that is often extensive and vulnerable. It was concluded that, in the light of the excessive demand, the workers may have been

adopting a defensive posture. This, together with users' anxiety, would have resulted in difficult encounters.

Although changing the dimensions of the area served and increasing the number of care professionals employed would be desirable, it was understood that this would not be achievable over the short term. Nevertheless, it would at least be immediately possible to transform the environment in which professionals and users met when these users sought services. It was unanimously recognized that the reception area and waiting room were always physical and interaction spaces that were little valued in the service.

Silva et al.[5] pointed out that:

> "Rooms that only have the apparent function of allowing people to wait there provide proof of the emptiness of meaning in spaces that are fertile for healthcare interventions. Rigidly linking the name of waiting room to this place is to announce that this is a space free from pleasure or novelties, and thus to consolidate boredom".

The embracement project was therefore an attempt to involve professionals within different categories in a concrete movement towards transforming the environment, which already started with the expectation of constructing new symbols for restoring embracement as an attitude in the reception sector of the PHUX. The waiting room could have new meaning and be seen differently as a location with the possibility of better encounters between users and the health team.

From discussions, it was considered strategic to invest in transforming the waiting room into something more similar to a living room, which is a location that promotes reception in its deepest meaning.

Through dissemination of the debate regarding embracement at PHUX, many professionals began to voluntarily attend meetings, with the expectation of contributing towards reformulation of the physical space of the service's reception. The group was composed initially of one physician, ten health agents, one dentist and one nurse. Taking up the challenge of transforming the waiting room into a more

welcoming environment, many suggestions were made: some more simple, such as providing tea and biscuits for users; other more complex, such as painting walls and seats. Knowing that ownership of the environment was encouraged through the NHP[1], it was decided to put its recommendations to the group:

> "When using the ambience concept for the architecture of healthcare spaces, a qualitative advance in the debate regarding humanization of meeting spaces within SUS is achieved. It goes beyond simple and formal technical composition of environments, to begin to consider the situations in which they are built, as a result of the time experienced by a group of people with their cultural values and social relationships." (p.5)

According to the NHP, ambience within healthcare refers to the treatment given to the physical space, taking this to be a social, professional and interpersonal relationship space, which needs to be collectively built to provide welcoming, problem-solving and human attention. The points made through the NHP were essential for reinforcing the group's ideas, given the group's concerns about modifying the standard PHU structure, which followed the recommendations of the city authorities of São Paulo, as do all other local public health services, and gave political support to justify movement towards collective appropriation of this space.

With management support, the proposal to reformulate the physical structure of the waiting room was taken to the managing council, where it obtained formal consent.

The project was implemented in three phases. In the first phase, new decoration proposals for this environment were made. There was participation from employees, users (who received paper and coloring pencils to draw projects while waiting to be seen in the waiting room) and teenagers from the neighborhood (who were invited through the intermediation of school educators to go to the PHU, take photos and create their projects).

In the second phase, the three best projects chosen by the group (taking into consideration beauty, creativity and feasibility) were placed in the waiting room for users and employees to vote on. The project that received the most votes was one that had been developed by the daughter of a community health agent (CHA), who suggested that the waiting room walls should be painted with doors and windows, simulating the architecture of a house. The project with the second largest number of votes was from a CHA who had attended a one-year interior design course, and imagined the main wall of the PHU painted lilac, with a drawing of a tree, under which there would be a message written. The group decided that the project with the second largest number of votes would be more feasible to implement, since it did not depend on great technical skills. Some ideas proposed in other projects were also used: creation of a more colorful children's play area, with children's handprints on the walls (which had been conceptualized by an administrative assistant and a dentist) and drawings of birds going out through the window (conceptualized by a teenager from the neighborhood).

In the third phase, which took place on Saturday, August 21, 2010, a task force of volunteer workers was mobilized to make the transformations to the waiting room.

Participation in and humanization of the ambience

To examine this experience, the PHUX structure before the reception project will firstly be recalled. It is worth mentioning that the concern within SUS for ensuring the architectural quality of services was regulated through ordinance number 1884 (MS, 1994)[6], which provided norms directed towards state and municipal departments, to enable support for the development of instruments that would assist in examination and approval of physical projects for public or private healthcare establishments. This ordinance established criteria for drawing up physical and physical-functional projects for healthcare establishments, taking into account matters aspects such as: dimensions, building installations, internal and external circulation, environmental comfort and safety conditions, among others.

The building structure of the PHUX has characteristics developed in accordance with the norms of the National Health Surveillance Agency (ANVISA)[7], which were not targeted in the transformation project and will not be described in the present study.

The characteristics of the waiting room environment, consistent with the recommendations from the city authorities of São Paulo, can be stated as follows: walls painted white; a board containing information regarding the functioning of the unit (opening hours and number of employees), municipal programs (flu and tuberculosis vaccination), ombudsman telephone number; benches and chairs available in the main lobby and in the hallways outside the consultation offices; television tuned into the municipal authority's channel; and a reception desk at the entrance.

The primary planning of the PHUX ambience basically took into consideration protocoled operational factors. The physical attributes necessary for ensuring efficiency from a functional point of view are an essential requirement for healthcare services. However, humanization of the environment is also related to matters of other orders that are not exclusively technical and instrumental. The characteristics of the physical space that address psychoaffective issues and contribute towards interactions between individuals and their surroundings that are more positive need to be taken into consideration:

> What makes an environment "humanized" are the attributes that give it scale and characteristics compatible with the physiological, psychological and morphological dimensions that the individual carries, thereby assuring some capacity that this environment has for interacting in a beneficial way that is pleasing to users.[8] (p.68)

Toledo affirmed that, in general, it is in these spaces[a] "that we become aware of our weaknesses, impotencies and solitude in relation to the disease. It is also in these spaces that we can find the courage, solidarity and hope necessary for the healing process"[9] (p.445). This author added that certain physical aspects of the environment,

a) In this case, Toledo mentions the hospital environment more specifically. However, as can be observed, his reflections also make sense for primary care services.

not related only to functional efficiency or beauty, would have an impact on individuals' wellbeing, whether they were users or professionals, and also on the local work process:

> We therefore believe that humanization of the hospital building results from a project process that is not limited to the beauty of its outline, its functionality or its mastery of constructive matters. Together with these issues, it creates spaces that not only promote recovery of health and ensure the physical and psychological wellbeing of users of the hospital building, whether patients, accompanying persons or employees, but also can stimulate incorporation of new procedures within medical practices.[9] (p.442)

Which would be the ambience properties that could influence interactions and practices that occur in healthcare services? To answer this question, it is necessary to return to the waiting room investigated here. It is possible to infer that the scenario was primarily of technical nature, i.e. centered on the functional aspects of the unit, with little reference to subjective matters and thus related to the purposes and intentions of the team of professionals engaged in the activities performed there. This nature would reinforce the idea, both among users and among employees circulating there, that the care provided in the service would be limited to being instrumental in scope.

Ayres[10] pondered whether constitution of effective care could be understood from two dialectically related polarities within the reasoning that guides the interests that move healthcare actions, i.e. technical efficacy and practical success. Technical efficacy refers to the instrumental dimension of the action, which aims to reach a certain purpose, such as decreasing the risk of cardiovascular disease by means of prescribing medications to control arterial pressure. On the other hand, practical success refers to the practical sense of healthcare actions. For example: what the symbolic, relational and material implications would an individual experience upon adhering to treatment, taking into consideration the meaning of the disease in his life?

To achieve technical efficacy, it is possible to draw up a strategy for action using instrumental rationality, with the aim of reaching a predefined goal. On the other hand, understanding practical success does not depend only on application of technical-scientific knowledge. Its construction would be achieved through intersubjective exchanges starting from the dialogue established between individuals.

One of the criticisms of the contemporary healthcare model that has been made relates precisely to the reductionist approach that solely objectifies attainment of normalization of organic dysfunctions, without considering the practical and existential senses of healthcare actions. According to Ayres, humanization of healthcare practices can be synthesized as an active search for synergies between practical success and technical efficacy in healthcare practices.

Individuals' understanding of the care that will be provided for them is based on the experience that they have, starting from the moment when they enters the service. The scenario surrounding them promotes a set of perceptions that back up their interpretations. Therefore, would it not be precisely the symbols (resulting from the sum of the physical and esthetic properties mentioned, and which are built from this scenario) that form the factors that significantly influence the interactions occurring there?

On the path of art

It is interesting to analyze the way in which humanization went on permeating the movement of the embracement project. The process began through observing the difference between the concept disseminated through the NHP and the practices at the service that were receiving this name. Following this, meetings between employees to pinpoint the problems and propose solutions constituted participative management, which is another principle advocated through the NHP. Another interesting factor was the use of the NHP booklet to support transformation of the waiting room as an appropriation measure by the service to favor a humanized ambience. It is possible to conclude that while the NHP is the prerogative of SUS, it provided an important

theoretical-practical framework that backed up creation of the reception project and putting it into operation. This then led to the path towards art.

Art was brought in as a strategy for transforming the meaning of embracement probably as a result of how the professionals identified with this theme. Intuitively, since at that time the group had not yet addressed conceptual theorization of the theme, it was felt that the employees and users' creative expression would aid in formulation of a new ambience and also in musical and theatrical manifestations in the waiting room. However, there is now a need to reflect on conceptual fundaments that allow comprehension of this intuitive idea and its success and, as far as possible, to expand and deepen it in other spaces and contexts.

For this, we began to reflect on the process of transformation of the waiting room. The way in which the healthcare professionals of PHUX became directly involved with the actions to reformulate the environment differs from the way in which an ambience project would be carried out by external professionals. According to Medeiros, "the meaning of work may be of both instrumental and symbolic nature; the first would be about the monetary and quantitative values and the second would be the moral, qualitative and subjective values"[11] (p.32). Bajoit and Franssen[12] classified instrumental meaning as a way of earning a living and symbolic or expressive meaning as the individual's social and personal achievements. Of course, the instrumental dimension of healthcare professionals' work is not the same as the one present in "similar" work carried out by workmen, for example, but even so, there is an instrumental sense to it.

Evelyn[13] pointed out that modern society is characterized by the growing need for individuals to have to use work as an exclusive means for earning a living, which removes from them the dimension of human creation. This duality in labor activities was also highlighted by Lefebvre[14], who mentioned the ethic and political guidance of making work progress in such a way that it does not dissociate these two dimensions:

> "The quantitative aspect (of work) comprises economic growth (technical improvements and increases in material production

> calculated in tons of wheat, steel, etc.). The qualitative aspect is social development (intensity of social life; activities of organizations that replace political action with social action through democracy and surpass this; and production of 'spiritual' work). These two aspects do not inevitably march together, at the same pace"[14] (p. 120)

Frigotto[15] affirmed that bourgeois society made work a mere instrument and economic means, thus removing human achievement from it, in cultural, poetic and playful terms. This would give rise to a lack of meaning in working, thereby only attributing an alienating dimension to it.

In the experience at PHUX, it was interesting to observe that the movement made by health professionals was impregnated with complex meanings that were not restricted to the purpose of transforming the material and reaching a predetermined form (relative to the ambience project chosen). Moreover, the objectives of the embracement project were not initially laid out. These meanings took shape over the course of the activity:

> "I think this movement is a landmark in our work here at the PHU because we are trying to change several concepts, so that we change the way we work and the way we see the issues in our work. This (the action of transforming the PHU) is the materialization of what we are thinking". (Statement from an employee at PHUX, captured on a video that was made to record the transformation of the waiting room).

What seems to have enhanced this interpenetration between the instrumental and symbolic dimensions of the (apparently) simple task of improving the ambience of a waiting room was the *art* element. The act of "hands-on work" and modifying the physical structure of the PHU could be considered to be an artistic activity, contrary to mere execution of a technical task. In other words, and making analogy with crafts: it is possible to attribute different values to the same piece of sculpture produced by

hand by a group of craftsmen, if produced by technicians with manual skills. This occurs because craftwork is a type of artistic production:

> "Besides being a productive activity, it is also closely related to who produces the work. Craftsmen who produce such projects imprint their technical history and cultural repertoire (...). Artifacts thus express actions and relationships with their producers. In other words, they are webs of interactions composed of producers, who give meanings to their objects that exceed their utilitarian use." [16] (p.49-50)

In the case of manual activities, the artistic process occurs when "social relationships between product and producer focus on objects, thereby vesting artifacts with meanings beyond their technical nature or usage value"[16] (p. 50). In our case, the interweaving between producer (healthcare professional) and product (waiting room) was shown in the following statement:

> "I believe it is renovation. We are renovating. So it is a transformation (of the waiting room) and in each transformation, a renovation." (Statement from an employee at PHUX, captured on a video that was made to record the transformation of the waiting room).

As advocated by Davies[17], the final product of the work of art may be indiscernible from mere real things. What gives it an artistic nature is its "extrinsic properties, i.e. the properties that correlate between works of art and individuals, objects and institutions. These properties place the work in its causal, historical and social context" (p. 97).

Among the symbolic references correlated by the participants in the PHUX ambience renovation process with the act of transformation, the *beauty* of the movement was mentioned. This aspect deserves full attention.

Judgment on *beauty* is, at the same time, individual and universal. It does not manifest a mere personal preference (although it makes reference to this), but rather, has an intersubjective basis. According to Hermann[18]:

> Esthetic experience cannot be understood through scientific or exclusively rational criteria, nor can it be subsumed by one human faculty in isolation. It is precisely this possibility within esthetics that evades purely rational reflection, thereby conferring new forms of relationships with ethics. (p. 26)"

Judgment of beauty would therefore seem to have a form of validity that exceeds mere subjectivity. In this regard, this author points out:

> The attempts to break the existing barriers against sensitive experience create the conditions for ideas about good living to also start to consider merging sensitivity and spirituality. In this manner, a process in which imagination, feelings and even passion can give access to knowledge is started. (...) The esthetic experience involves abandoning concepts to give way to imaginative strength and sensitivity.[18] (p. 28)

Interpretation of the waiting room transformation surpassed rational evaluation and was supported in esthetic experience, as shown in this other statement from an employee:

> "I worked somewhere else for such a long time of my life and I have never seen a movement as beautiful as this. Honestly, this is a very special day in my life, with all this movement, all this transformation. We know that for as long as we live, we never stop transforming. It is very beautiful." (Statement from an employee at PHUX, captured on a video that was made to record the transformation of the waiting room).

The engagement of this employee in the ambience reformulation activities evoked the experimentation of beauty, not as a glimpse of an esthetically pleasing form (also because this manifestation was recorded before the work ended and its results were seen), but as a judgment on the ethical value. The movement that resulted from the union of professionals investing time, energy and attention to produce concrete expression of an idea elaborated collectively found its connection and expression in the form of esthetic emotion. According to Hermann, “although beauty is different from good, esthetic ideas connect with ideas produced for practical reasons”[15].

Art as a resource for humanization

Having investigated the artistic properties conferred on the transformation process, the final product from the ambience reconstruction work and its symbolic implications for the humanization proposal that motivated the entire action remain to be considered. For the professionals, the new waiting room ambience could modify user perceptions in relation to the intentions of healthcare actions:

> “People will see that we are concerned not only about taking medication and papers to their homes, but also about improving the environment to which they come.” (Statement from an employee at PHUX, captured on a video that was made to record the transformation of the waiting room).

The new waiting room was vested with intentions, beliefs and emotions. The final product was not just an imitation with decorative purpose. It represented certain issues that could accentuate the possibilities of this location as a meeting space. Art acted as a means towards knowledge, thus presenting other ways of regarding the waiting room.

It was also possible to identify the workers' communion around a shared cause. Art, with its potential to promote esthetic experience, would be capable of establishing connections between the singular and the shared, thus enhancing the feelings of union and belonging. The quote from the employee above is a perception resulting from simultaneous esthetic and ethical judgment regarding the movement. Beauty, which according to Schiller[19], would represent conciliation between reason and sensitivity, would be an indicator that this experience went on impregnating senses for those experiencing it: senses that humanize the experience of being healthcare professionals within that space and that, as was hoped, could result in humanization of the relationship with users.

It is worth mentioning the matter of the feasibility of implementing equivalent projects within other scenarios, since this experience resulted from voluntary group planning among healthcare professionals. Caution is needed in relying on this experience as a model, given that spontaneity was a fundamental element for the relevance of the results.

Just as occurs with street art, which is marked by transience, the walls of the waiting room were then repainted white. Simultaneously - and it is not intended here to suggest that there was any cause-and-effect relationship - an adjustment was made to the attendance flow of the unit, which led to a significant increase in the number of users in the waiting room. To accommodate this new dynamic, it was necessary to rearrangement the furniture layout (the chairs were placed in rows in front of the television) and also to adjust the reception and user referral processes. The significant volume of work resulting from these transformations caused a certain degree of exhaustion among the workers. This situation was placed on the agenda of a technical meeting at the beginning of 2014. "It is time to paint the wall in the waiting room", said a physician. Would these healthcare professionals once again place their faith in art, as represented by the action of painting a wall in the waiting room, as a resource for transforming practices so as to favor humanization?

Final remarks

The main balance from this reflection points towards the potential for art to give new meaning to healthcare work processes and towards reconstructing these processes as humanized practices. In addition to more traditional resources, guided by rational logic, such as training done to "sensitize" employees with regard to the importance of incorporating new attitudes in their relationships with users, art was revealed to be a resource capable of involving subjects through their experiences.

Through the notion of humanization, reestablishment of human dignity, which has often been compromised in interactions within the scope of healthcare, is advocated. Reductionist care practices guided exclusively by technical-scientific logic and automatism, resulting from a certain form of organization of work processed would be factors contributing towards disqualification of relationships between subjects. In this context, art was shown to be powerful for enhancing the horizons of views that had been restricted to a certain order and for favoring restoration of other channels providing perceptions of the world.

Artistic experiences are characterized by "seeing the world again", thus imbuing it with other meanings created from elaboration of memories, feelings and reflections raised by art. Senses are built from these experiences, in such a way that subjectivity elements appear as resources for enriching comprehension, which may result in production of relationships with greater commitment.

In the case that served as the basis for this reflective essay, art seemed to be the path that led to the objective and subjective transformations that created new symbols for the waiting room, thereby reflecting and instructing changes in intentions and attitudes regarding the meaning of work, and reconciling its instrumental and symbolic senses.

Art is capable of combining the instrumental dimension of actions (which aims to achieve a certain purpose) with the meaning of the action (which is built from its symbolic implications). Perhaps a more systematic and deeper exploration of relationships between ethics and esthetics and between good and beautiful can also

contribute towards new ways of correlating technical efficacy and practical success from healthcare actions, thereby bringing new impulses for healthcare humanization.

Collaborators

The authors worked together in all the steps of the paper's production.

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