

Care process in the health field: ontology, hermeneutics and teleology

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The health care is a growing research field and has been addressed through new referential frameworks. Although it is an attribute essential to human survival, it did not receive enough analysis to build a sociology of care. The purpose of this essay is to map the production of knowledge about care, in order to develop a theoretical reflection on the subject. The literature shows an ontology of biomedical care, a hermeneutics of different approaches to care and the teleological challenge of caring in the contemporaneity. As conclusion, the technical-scientific basis of care gives few answers to the real demands of the people, demonstrating the need for a “social + logic” emancipatory approach of the care.

Keywords: Health care. Sociology. Biomedicine.

Introduction

The word “care” (in Portuguese, *cuidado*) originates, etymologically, from the Latin word *cogitatus*, which means meditated, thought of and reflected upon. As a noun in the Portuguese language, it gains the meanings of special attention, concern,

preoccupation, zeal, devotion dedicated to someone or something, the object of this devotion, duty, task, responsibility, toil, work, occupation¹. The meanings attributed to the word “care” speak about its social dimension, implicit in the interaction between subjects, in a relationship of help. However, many decades ago, the notion of care became more identified with professional actions in health care.

In this sense, although care is one of the necessary attributes to the survival of the human species² and is considered an expression of intense social support, the analyses that have focused on it have not been enough to constitute a sociology of care³. This occurred because care was conceived as a family responsibility, and it was taken for granted that the routine tasks belonged to women, in a singular behavior implicitly attributed to gender. As a result, care and its importance for social life have been undervalued by the human sciences and reduced by the natural sciences³.

Specialized care actions undertaken in the field of health have been discussed more attentively and are currently growing as a research area. Actions belonging to the biomedical model have been receiving more attention. In this model, the act of providing care means, primarily, diagnosing, treating and preventing diseases, and is based on knowledge developed in the technical–scientific field^{4,5}. Due to this, a critical reflection on its trajectory in the sphere of the clinic has been growing, as researchers and health professionals search for alternatives to meet the needs of the assisted subjects.

This essay discusses care based on the classic and on the contemporary literature about health care. It argues that the care actions in the clinic have assumed, in many cases, the status of a verticalized and protocolized intervention of a specialist who is the owner of knowledge, to the detriment of care as the human species’ tacit knowledge². The concept of care is discussed here from an ontological perspective that is based on a Heideggerian approach and views care as what makes multiple existences possible¹. A hermeneutic discussion is proposed with the aim of interpreting the signs and symbolic value implicit in the concept. Finally, a teleological contribution is provided, considering the purpose of exploration of the explanatory principle¹, in view of possibilities of dialog through a debate of ideas.

The ontology of biomedical care

The ontology of care has its roots in the broadening of the comprehension and observation of the causes of diseases, as well as in the expansion of the intervention on such causes. This has been produced by the scientific medical rationality⁶, aided by the objectivization of clinical knowledge and by technological development. However, the action of care in biomedicine has become effective independently of the subjectivity⁷ that is inherent in each individual in his/her process of becoming ill. In other words, there was, in the development of medical clinic, a gradual rejection of any subjective element implicit in suffering, in the search for a more productive and efficient technical knowledge to control diseases. Although this moment had a great historical relevance in the provision of care for ill individuals, as a consequence of this approach, what could not be observed by the methodological use of diagnostic assessment was disregarded. Subjectivity is seen here as more than an intrapsychic deterministic system; rather, it is dimensioned as a psychic production inseparable from the social and cultural contexts in which human action occurs⁷.

By determining that disease is a pathological fact and by moving it away from the existential sphere of the ill subject, scientific medicine, in its historical process, removed the content and substance of the process of becoming ill and recognized the disease only in its exteriority. Thus, scientific medicine excluded from suffering its dimension that provides meanings and self-knowledge for the one who suffers^{5,8-10}. According to Gonzales Rey⁷, this would be “to deny subjectivity”, that is, “to disregard the strength of the most genuine human production and submit ourselves to the realm of what is instrumental” (p.20).

Thus, the clinic became, predominantly, a place for the technical application of a type of care that is directly targeted at what was protocolled as a disease, because it is a deviation from the norm, a break in an expected balance⁸. The human being seen as an unregulated machine⁵ needs to be rectified and guided towards health, a hypothetical state of wellbeing to be achieved through the external intervention of a

qualified professional.

Evidently, this approach has received severe criticism^{5,8,10} and contemporary medicine has produced discussions from another clinical dimension in favor of respecting subjects' individuality and subjectivity⁴. However, our focus, here, is on the traditional clinic as defined by Foucault⁹, for we understand that such tradition influences what is currently defined and applied as care. Authors like Foucault⁹, Canguilhem⁸, Illich¹¹ and Boltanski¹² have analyzed the historical development of scientific thought aimed at the rational construction of medical knowledge. In many ways, such thought has influenced the production of a technically centered model of health care that persists in current times.

It is important to emphasize that we do not intend to make peremptory and dogmatic judgements that are bound to commit injustices, nor to ignore the entire counter-hegemonic production that has been built by different professionals, in many levels of the clinic that is performed in the health care services. However, it is necessary to approach existing actions that predominate in many contexts and are guided by a classic biomedical perspective⁵, so that we can advance in the debate and, perhaps, produce changes.

Barros¹³ argues that, after the adoption of the morphophysiological method in the biomedical clinic, the medical way of looking was reorganized. "The way of looking of any medicine 'practitioner' is replaced by the way of looking of the physician, supported and justified by an institution, which ensures him/her the power to decide, intervene, investigate and teach (the Hospital)" (p. 64). From an initial way of looking that classified disease processes, it became a calculating way of looking that is not satisfied with ascertaining what is evident, but extends its speculative capacity to risk calculation.

In 'The Birth of the Clinic', Michel Foucault⁹ described the development of modern medicine from the 18th century onwards in order to give visibility to the configuration of the model of care of clinical science, by means of an in-depth reorganization not only of medical knowledge, but mainly of the unfoldment of a new discourse emanated from a new experience of disease.

Foucault⁹ explains that, in the 19th century, scientific medicine enlarged its anatomical–pathological knowledge and added new elements to the model of understanding of diseases: chemistry and physiology. In this type of medicine, the clinic was no longer performed by being by the ill person's side day and night, taking notes of his/her symptoms: anatomists with freedom to conduct multiple sessions of anatomical investigation transformed it. As a result, it was necessary to reorganize the hospital field and create a new definition of the status of the ill person in society, instituting a medical domain of the singular knowledge of the ill individual.

When Canguilhem⁸ analyzes the development of the clinic, he conceives, firstly, the existence of someone who is ill and this person's request for help. With this, therapeutic knowledge emerges from the need of caring for someone. Its development is conducted by people searching for an ability to deal with what life offers them, and the experience of suffering lies in the center of the therapy. Subsequently, with the development of scientific medicine, whose basis is physio–pathological and anatomical–pathological, the clinic occupies the place of care and starts to be performed by the physician in the therapeutic process.

Foucault⁹ and Canguilhem⁸ highlight that the disease was objectified by dysfunction with the development of medical clinic and became the target and meaning of therapeutic action. The ill person, in turn, was relegated to the position of bearer of the disease, and his/her complaint served (and still serves, in some contexts) only as one more element, of lesser value, in the set of the diagnostic analysis. Care actions started to be guided by a search for the pathological factor, towards a type of assistance based on the idea that cure could be reached by the reestablishment of what was stipulated as normal, to the detriment of the creative and existential process implicit in the complaint brought by the ill person.

However, to Canguilhem⁸, the disease is not only the disappearance of a physiological order, a disorder. It is characterized as the emergence of a new vital order, another type of norm that arises from the history of each individual, in a restructuring process of the lived world. The ill person is not abnormal due to the absence of norms; rather, his/her abnormality is caused by an incapacity for being

normative, by losing the possibility of instituting different norms in adverse conditions. Being healthy is not the opposite of being ill; it is configured as being able to create new ways of living, a new normativeness, being productive, making choices, reestablishing the balance that is possible to him/her.

A sharp criticism against the biomedical model was made by Ivan Illich¹¹, with the development of his concept of structural iatrogenesis. The author denounced the colonization exercised by the ideological and political action of scientific medicine, its influence on the medicalization of society, and its power to limit the autonomy of individuals and traditional cultures as regards generating health, dealing with pain, illness, death and, specially, with diseases. Another important aspect approached by Illich¹¹ is the influence of the specialized language used by the physician to maintain his/her privileges and to ensure the professionalization of medicine. According to the author's ideas, the domination implicit in the construction of a specialized language, which excludes the patient from having access to its codes, gives the physician the power to say only what he/she considers necessary to obtain the patient's cooperation with his/her manipulation. Therefore, through the monopoly of language, it is possible to maintain the monopoly of care and disfavor the possibility of reducing alienation in the field of health.

The implication of the use of specialized language was also approached by Boltanski¹². The author showed that, sometimes, lack of understanding of technical language and the medical conduct of disclosing information in parts prevent the assisted person from creating his/her own mental imagery to favor a reflective relationship with his/her body and disease. This results in the construction, by the patient, of a representation of the discourse about the disease that the physician transmitted, to the detriment of his/her own cultural content. This knowledge adaptation, which is greater among people from social classes characterized by low income and low level of schooling, hinders the communication between health professional and ill person and condemns patients to a partial reconstruction, with misunderstood words, of what was said. People with higher economic and sociocultural resources, in turn, feel a shorter distance between what is said about the disease and

the interpretation of its meaning, and tend to communicate better, obtaining a more detailed explanation of their condition¹².

However, independently of the social condition of the person who searches for medical assistance and his/her capacity to understand the technical terms referring to the disease/treatment, an important issue still needs to be addressed: becoming ill means and impact more on the subjects' life than its biomechanical implications can reveal. The subjective aspects implicit in the process of becoming ill, no matter if they are present in the symptomatology or not, have not always been the object of attention of scientific medicine. A change in this situation occurred at the end of the 19th and beginning of the 20th century, as medical clinic faced an enigma difficult to be solved, related to the impossibility of dealing with illnesses whose causes escaped from diagnostic analysis.

The positivistic medical discourse found one of its limits in unreason and undertook a new investigative action to determine the causes of symptoms that manifested themselves in the somatic dimension, but did not originate in it. Freud, in his studies about hysteria, recognized physiological alterations according to excitability relations among parts of the nervous system and described that symptoms like convulsions, contractures, paralyse and sensitivity disturbances always appeared together with psychological alterations¹⁴. Psychoanalysis and other lines of psychological assistance had the merit of broadening the understanding of human suffering as, in the historical process of their theoretical foundations, they moved away from the biomedical, mechanicist and positivistic model when they developed a dynamic interpretation of disease and included social influences in its etiology¹⁵. However, it is necessary to highlight that the approaches of the psychological field were born in the midst of scientific medicine, and its actions of care, as part of the field of health, were influenced by the biomedical field. Their mode of assistance, with few exceptions, like those of Social Psychology¹⁶, Psychosocial Rehabilitation⁴ and other practices, is strongly characterized by an individualized clinical action based on the health-disease binomial and targeted at searching for the diagnosis and treatment of the mental disease. Many times, this mode of assistance is distant from actions that consider the

subject's social and cultural universe¹⁶.

Hermeneutics of contemporary care

When we search for the multiple and divergent meanings of care in a hermeneutic approach, we realize that recent studies about health care have produced knowledge in an encompassing, complex and diverse way. The approaches discussed in this essay were named based on previous studies that had already proposed some classifications: 'pragmatic approach to care'^{5,6,10,17-23}, 'extended clinic'⁴; 'managerial approach to care'^{24,25}; 'philosophical approach to care'^{21,26}; 'emancipatory approach to care'^{2,27-32}; 'political approach to care'³³; 'sociological approach to care'^{34,35} and 'cultural approach to care'^{36,37}.

The proposition called 'pragmatics of care' is related to the biomedical model of assistance, which is based on the logic of the contemporary scientific medical rationality^{6,28}. Its type of health care is characterized by a set of technical and technological procedures targeted at the treatment of the disease as the only and primary object of attention; concentration of knowledge and power on the physician and hospital; creation and validation of protocols that enhance procedures to produce higher safety, efficacy, speed and low cost; institution of guidelines based on a clinical method that is empirical and classificatory, and on physiological, anatomical and pathological reasoning; production of care actions deprived of a singularized attention to the assisted subject, with low quality in the professional-patient relationship^{4-6,10,17,19}.

Pragmatic actions tend to be oriented towards greater interventionism in general, a standardized treatment focusing on diseases according to an assessment of their risks, and less concern for singularities. As if biomedicine increasingly identifies patients who are homogeneous when compared to one another^{5,10,19}. Camargo Jr.⁵ argues that there has been a gradual depreciation of biomedicine as a form of care due to the fact that it has an iatrogenic inclination, despite or because of its technical strength, and its clinical perspective has been questioned due to its low efficiency to solve many health

problems. To a large extent, this happens because biomedicine focuses on the treatment of diseases, based on the production of scientific evidences that aim to assess the efficacy of procedures and their cost, in order to generalize them.

Another criticism that has been made to the pragmatic approach is related to the production of medicalization processes¹⁸ and social suffering²². Medicalization transforms the population's autonomous capacity to face a large part of the daily diseases and pains by creating an abusive consumption of the health care services, producing dependence and alienation¹⁸. In addition, it transforms questions coming from social inequality into individualized and medicalized understandings²².

Luz¹⁷ argues that it is through generalization and experimentation that the scientific method produces knowledge, which is reflected on the model of care practiced in different types of medical services. To the author, especially in the period between the end of the 20th century and the first decades of the 21st century, medical actions have become increasingly closer to the scientist who studies the disease, to the detriment of the practice of the therapist who treats the ill subject. This results in the prioritization of studies based on analytical laboratory experimentation to determine the evolution of the pathology, its etiology and the form of combat. Thus, a model of prescriptive care is developed, deriving from knowledge obtained without any relation to the patient.

The Extended and Shared Clinic considers the needs of the assisted subjects in a broader way, as it makes a counter-hegemonic proposal to the health care model of the biomedical clinic. Its difference is that it extends the object of knowledge and clinical intervention, including the subject and his/her context in it. The aim is to shift the focus from the disease to the concrete subject who has a disease. The implicit rationality in this model of clinic is that of caring for what is unpredictable and singular in each subject or collectivity⁴. To achieve this, the Extended and Shared Clinic proposes not to be limited exclusively to what the body can show through empirical observation, but to enable more fertile encounters with the assisted subject by allowing other themes, not only the disease, to be present. It invites the subject to jointly construct the decisions related to his/her own care, without avoiding any

challenge, either emotional, social, cultural or economic. It also renovates practices when it advocates the participation of a higher number of actors in care actions, including the multiprofessionality of teams, to develop singular therapeutic projects⁴.

The 'managerial approach to care' also proposes to invite the participation of several professionals in the sharing of responsibilities²⁴. At the same time it understands the importance, for the clinic, of a good relationship between caregiver and patient, it considers that it is difficult for this to happen spontaneously and generously, in view of the rigidity of formal organizations and their characteristic instrumental rationality, conflicts of interest, authority hierarchies and scarce resources. Health care management is defined by Cecílio²⁴ as the provision of health technologies according to each person's singular needs at different moments in life, aiming at wellbeing, safety and autonomy, so that this person can lead a productive and happy life.

Through the 'philosophical approach to care', Ayres²⁶ discusses the importance of reflecting on health care to understand the theoretical and epistemological bases of some current tendencies that have emerged across the world and the country as new discourses in the field of public health, such as: health promotion, health surveillance, family health, reduction in vulnerabilities, among others. To the author, the consolidation of these proposals and their consequent development would depend on radical transformations in the way we think about and promote health, especially its presuppositions and principles. Thus, he defends visiting philosophical aspects in an attempt to produce more expressive practical transformations, beyond the conceptual advances that have been achieved, contributing to the ongoing reconstruction of care practices.

The meaning of care already sanctioned by its use, according to Ayres²⁶, usually refers to a set of procedures technically oriented towards the success of a certain treatment. However, it is not on the meaning of a set of therapeutic measures or auxiliary care procedures that the author proposes to reflect, mainly because he considers it a construct that encompasses both a philosophical understanding and a practical attitude towards the meaning acquired by health actions in the different

situations in which a therapeutic process occurs.

In relation to the 'emancipatory approach to care', Barros² makes a sociological reading and discusses care and its social unfolding in three levels represented: in expression, as tacit knowledge; in the development of institutionalized focal actions, as the biomedical clinic; and in emancipatory care, with elements of the first two levels.

Care as tacit knowledge³⁸ results from a socialization process that started to be described as an attribute of the species, a personal practice that has been collectively constructed, the fruit of a long experience, coexistence and of a complex transmission, as it needs long-lasting interactions within a culture or tradition and is in the sphere of informal actions. When it is associated with the biomedical clinic and with focal and technical knowledge, care gains a reification contour – by viewing something abstract as a material or concrete thing – related to the symbols, values, practices and rules of modern western science, whose method predominantly recommends objectivization and, consequently reification or dehumanization. As an expression of knowledge that promotes autonomy, emancipatory care is produced as the third element, from tacit (socializing) and technical (reifying) knowledge, to build, simultaneously: attention, freedom of choice and decision-making, in relation to the legitimate rules resulting from social interaction, and to the legal rules that have been instituted and protocolled².

Thus, emancipatory care can be exemplified by the ideas originating from care that ground the proposition of some *Práticas Integrativas Complementares* (PIC – Complementary Integrative Practices)²⁷, in their dimension of Medical Rationalities^{6,28}. Here, the PIC are used as a possibility of developing emancipatory care, as they have, theoretically, characteristics like: conceiving, holistically, the process of becoming ill and individual care needs; targeting care at health and not at disease; reducing the distance between professional and patient; not being limited to the growing intensification of the use of technology to obtain a diagnosis; satisfying, symbolically and technically, the experience of suffering lived by the subject; integrating physical, mental, social and spiritual wellbeing into

their conception of health; stimulating self-care, helping patients to develop attitudes, dispositions, beliefs, habits and practices that promote their wellbeing^{13,20}.

However, the application of the PIC is not necessarily connected with an emancipatory approach to care, as it depends, like all clinical practices, on the person who performs it and on the political philosophies of the institutions involved. Thus, some studies have shown that, in the constant attempt to obtain legitimation in the scientific community, the PIC have been investigated with the use of conventional scientific methodologies to prove the validity and efficiency of their application to the treatment of diseases^{31,32}. This modifies their original conceptual basis and brings them close to a traditional biomedical standard³².

The 'political approach to care'³³ includes it in a practice and, at the same time, develops its potential for being the vehicle of promotion of a culture of caring for oneself, present in the obtention and maintenance of the health of an individual who is aware of his needs and who, above all, aims to satisfy them both in the individual and in the collective spheres.

In this dimension, Pires³³ understands the politicity of care "As a reconstructive handling of the dialectical relation between help and power for the construction of subjects' autonomy, no matter if they are managers, technicians, health professionals, family, community – ultimately, citizens" (p. 1026).

The author argues that it is through politicity that care can become emancipatory and re-dimension itself as an ethics of humanity, so that, in this way, people are able to reorganize protection and demand citizenship. The society has been searching for a type of care that can reconstruct itself to better meet people's needs and that can manage help-power relations politically, proposing, in this way, changes to the health care model.

Bila Sorj³⁴, in turn, desires a restructuring of social policies in relation to care and, to achieve this, she believes it is necessary "the construction of a solidarity State that, by means of high-quality public policies, places care in the center of its definition of social welfare"(p. 127). The author, based on a 'sociological approach to care', discusses the articulation between work and care, and understands its effects on

gender and social class inequalities, in which the professionalization of care denotes a process of re-signification of its meaning, no longer understood as deriving from a cultural process, like naturalized maternal love, but as resulting from a work of social reproduction.

Changes in the private family scenario or in the community scenario are themes of interest in sociology. For example, the professionalization of people who provide care for children, elderly individuals and people with some kind of deficiency, or which professionals, in health care, perform care actions. However, even though care actions are performed by different social actors and the professionalization process of caregivers is influencing the creation of public policies, it is important to highlight the remarkable presence of women in the “field of care” and the economic and symbolic devaluation of this work^{34,35}.

The ‘cultural approach to care’ discussed by Prochnow, Leite and Erdmann³⁶ reflects on the comparisons that enable to question the social practice of the nurse in care management. The authors define culture “as the webs of meanings that man has weaved and in which he sees his world, always looking for its meaning” (p. 586). Therefore, it is important for the nurse, in the construction of his/her social practice, to rely on cultural diversity as an innovative resource in the expansion of his/her view of human integrity, valuing divergences, respect and the sharing of experiences. Nevertheless, Sá³⁷ discusses the need to understand and conceive some psychosociological issues implicit in the intersubjective relations that are present in the practice of health professionals and that interfere directly in the construction of humanization and health care. The author argues that the obstacles and limitations that hinder the expression of solidarity and the production of high-quality health care are related not only to the precariousness of the services concerning the offer of material, technological and personnel conditions, or to the characteristics of the dominant models – biomedical and functionalist managerial –; rather, the obstacles and limitations are related to the patterns of sociability and subjectivation present in the contemporary society.

Although the author understands the importance of qualifying professionals and

creating or expanding communication mechanisms, she believes these are not enough because she thinks that “the disposition to user embracement, hearing and to the establishment of bonds is neither an absolute and a priori capacity of the human being nor something that can be controlled exclusively by a conscious and voluntary work and/or by managerial mechanisms”³⁷ (p. 653).

Due to this, the author argues that, to overcome the challenges imposed by the complexity of the issues related to the “humanization” of health practices, it is necessary to continue problematizing the sociological nature of the impossibility of a symmetric and transparent communication among subjects in the field of health.

Another difficulty raised by Sá³⁷ refers to the understanding that themes like cooperation, humanization and care find difficulties to develop in contemporary culture, as parameters of an intersubjective relationship. In other words, the presupposition of the existence of an incomplete and precarious subject that can recognize that he/she is not self-sufficient is rendered invisible, as self-sufficiency is precisely the subjectivation model that predominates nowadays. Thus, it is possible to understand the factors that hinder fraternity and solidarity in care, as well as the impossibility of the union between caregiver and care receiver in the construction of a collective life project, in which the professional in the exercise of health care assumes a position that is equal to the one of the person who receives care.

Therefore, the hermeneutic classification of the multiplicity of approaches suggests categories of application to the daily practice of care. This involves ‘pragmatic’ actions targeted at effective answers to diseases, but under an ‘extended and shared clinic’ that respects the culture and subjectivity of the person who receives care. Such clinic should have a ‘managerial’ bias, which invites formal and informal actors to be responsible for the provision of care, by means of a ‘philosophical’ understanding that highlights the permanent need of reflection on the epistemological bases of the action that is performed, with the aim of developing an ‘emancipatory’ practice aimed at the subject’s autonomy and at the tacit place of care, always considering the ‘political, sociological and cultural’ lines that integrate any and all social practices. Thus, care becomes complex, humanized and places the person in the center of the discussion.

The Teleology of care

The notion of teleology can be understood as the passing of history presided by a purpose, a telos, possibly from the mental imagery of the action of a willful demiurge that impresses his purpose on an amorphous matter to transform it into a more well-finished shape³⁸. However, this is not the notion with which we are working here, as we do not believe there is a single best purpose for care, precisely because we deal with care in a complex hermeneutics. We have expanded the limits of the finalistic view by associating the teleology of care with the contemporary civilizing challenges and transformations, so that multiple forms of sociability, different from the traditional ones, are produced, structured between the established and the outsiders³⁹, that is, between professionals and patients. In such sociability forms, authoritarianism, violence and excessive interventions and prescriptions are reproduced. In other words, what we search for with the reorientation of care is emancipation, also through a break with the unilateral relations constructed in institutional positions¹⁹, impressed on many health professionals with the support of the State⁴⁰, which still qualifies them as superior in relation to the patients they assist.

We have identified that there is not only one form of care and that it is not exclusive of the field of health, as it encompasses social and cultural relations in its concretizations. Therefore, it is necessary to view health care as only one part of the necessary actions to meet subjects' demands, so that we give visibility to the interpersonal needs that common-sense care can reach and the traditional biomedical clinic does not approach. In this reorientation of care, the mental imagery about the provision of care, the solidarity involving care and the availability to be with the other become equally constitutive of life maintenance actions.

The contemporary teleology of care is clearly different from the previous ones, as it advances in relation to the associated pre-historical empiricisms: instincts, the cultural experiences of antiquity, the religious impositions of Christianity, the general morphophysiology laws of the modern clinic, and the protocols of the biomedical

model. While each one of these models, in its own way, and all of them together have oriented care towards maintaining life, nowadays, it is necessary, besides guaranteeing its existence, also to orient care towards emancipatory configurations³⁹ of individuals and collectivities.

Therefore, the hypervisibility⁴¹ of the process of social construction of contemporary care can make visible: the implications of its strong relation to the female gender, its association with socioeconomic conditions and its determinants regarding access and quality. In addition, it is possible to see that a “social–logic” perspective of care implies recognizing that it is not only atavistic to the condition of human social life, but constitutes countless forms of affection and diseases in social groups.

Finally, there is no guarantee that a sociology of care – that values the ontology of care models and actions, explains the multiple meanings of a hermeneutics of care and reorients its practical and symbolic teleology – will be able to build an emancipatory project. However, it can safely perform projects that lead to the emancipation of the interacting subjects with the development of a conscience of personal value, both in the political and in the existential dimensions. Furthermore, it can build paths that extrapolate the social conscience of having the right to care towards the conscience of being in the world as the bearer of his/her own care.

Collaborators

Octávio Augusto Contatore surveyed, discussed and analyzed the data, and participated in the conception, writing and review of the text; Ana Paula Serrata Malfitano was responsible for discussing and reviewing the text; and Nelson Filice de Barros was responsible for supervising the research, writing and reviewing the text. All the authors approved the final version of the text.

References

1. Houaiss A, Villar MS. Dicionário Houaiss da Língua Portuguesa. Rio de Janeiro: Objetiva; 2009.
2. Barros NF. As Práticas Integrativas e Complementares como cuidado emancipador. Comunidade de Práticas. Gestão de Práticas Integrativas e Complementares [Internet] [citado 08 Maio 2015]. Disponível em: <https://cursos.atencaobasica.org.br/conteudo/8900>.

3. Fine M. Individualization, risk and the body: Sociology and care. *J Sociol.* 2005; 41(3): 247–66.
4. Campos GWS, Bedrikow R. História da Clínica e Atenção Básica – o desafio da ampliação. São Paulo: Huittec; 2014.
5. Camargo Jr KR. A biomedicina. *Physis Rev Saude Colet.* 2005; 15 Supl: 177–201.
6. Luz MT. Medicina e racionalidades médicas: estudo comparativo da medicina ocidental contemporânea, homeopática, chinesa e ayurvédica. In: Canesqui AM, organizadora. Ciências sociais e saúde para o ensino médico. São Paulo: Hucitec; 2000. p. 181–200.
7. González Rey F. As categorias de sentido, sentido pessoal e sentido subjetivo: sua evolução e diferenciação na teoria histórico-cultural. *Psicol Educ.* 2007; 24: 155–79.
8. Canguilhem G. O normal e o patológico. 5 ed. Rio de Janeiro: Forense Universitária; 2002.
9. Foucault M. O nascimento da clínica. Rio de Janeiro: Forense Universitária; 1977.
10. Tesser CD. A verdade na biomedicina, reações adversas e efeitos colaterais: uma reflexão introdutória. *Physis: Rev. Saúde Coletiva.* 2007; 17(3):465–84.
11. Illich I. A expropriação da saúde: nêmeses da medicina. 3ª ed. Rio de Janeiro: Nova Fronteira; 1975.
12. Boltanski L. As classes sociais e o corpo. 4ª ed. Rio de Janeiro: Graal; 2004.
13. Barros NF. A construção da medicina integrativa. São Paulo: Hucitec; 2006.
14. Bocca FV. Histeria: primeiras formulações teóricas de Freud. *Psicol. USP.* 2011; 22(4):879–906.
15. Schultz DP, Schultz SE. História da Psicologia Moderna. 10ª ed. São Paulo: Cultrix; 2014.
16. Farr RM. As raízes da Psicologia Social moderna. 11ª ed. Petrópolis: Vozes; 2013.
17. Luz MT. As Instituições Médicas no Brasil. 2ª ed. Porto Alegre: Rede Unida; 2014.
18. Tesser CD. Medicalização social (I): o excessivo sucesso do epistemicídio moderno na saúde. *Interface (Botucatu).* 2006; 10(19):61–76.
19. Tesser CD. Três considerações sobre a “má medicina”. *Interface (Botucatu).* 2009; 15(31):273–86.
20. Tesser CD, Barros NF. Medicalização social e medicina alternativa e complementar: pluralização terapêutica do Sistema Único de Saúde. *Rev Saude Publica.* 2008; 42(5):91420.
21. Ayres JRCM. O cuidado, os modos de ser (do) humano e as práticas de saúde. *Saude Soc.* 2004; 13(3):16–29.
22. Malfitano APS, Adorno RCF, Lopes RE. Um relato de vida, um caminho institucional: juventude, medicalização e sofrimentos sociais. *Interface (Botucatu).* 2011; 15(38):70114.
23. Norman AH, Tesser CD. Acesso ao cuidado na Estratégia Saúde da Família: equilíbrio entre demanda espontânea e prevenção/promoção da saúde. *Saude Soc.* 2015; 24(1):165–79.
24. Cecilio LCO. A morte de Ivan Ilitch, de Leon Tolstói: elementos para se pensar as múltiplas

- dimensões da gestão do cuidado. *Interface (Botucatu)*. 2009; 13(1):545–55.
25. Cecilio LCO. Apontamentos teórico–conceituais sobre processos avaliativos considerando as múltiplas dimensões da gestão do cuidado em saúde. *Interface (Botucatu)*. 2011; 15(37):589–99.
26. Ayres JRCM. Cuidado e reconstrução das práticas de saúde. *Interface (Botucatu)*. 2003–2004; 8(14):73–92.
27. Ministério da Saúde (BR). Portaria 971, de 4 de maio de 2006. Dispõe sobre a Política Nacional de Práticas Integrativas e Complementares (PNPIC) no Sistema Único de Saúde. *Diário Oficial da União* 4 Maio 2006.
28. Luz MT. Racionalidades médicas e terapêuticas alternativas. Rio de Janeiro: UERJ/IMS; 1993.
29. Barros NF. Medicina complementar: uma reflexão sobre o outro lado da prática. São Paulo: Annablume, FAPESP; 2000.
30. Organização Mundial de Saúde. Estratégia de la OMS sobre medicina tradicional 2002–2005. Genebra; 2001.
31. Souza EFAA, Luz, MT. Análise crítica das diretrizes de pesquisa em medicina chinesa. *História, Ciências, Saúde – Manguinhos*. 2011; 18(1):155–74.
32. Contatore OA, Barros NF, Durval MR, Barrio PCCC, Coutinho BD, Santos JA, et al. Uso, cuidado e política das práticas integrativas e complementares na Atenção Primária à Saúde. *Cienc Saude Colet*. 2015; 20(10):3263–73.
33. Pires MRGM. Politicidade do cuidado e processo de trabalho em saúde: conhecer para cuidar melhor, cuidar para confrontar, cuidar para emancipar. *Cienc Saude Colet*. 2005; 10(4):1025–45.
34. Sorj B. Socialização do cuidado e desigualdades sociais. *Tempo Soc*. 2014; 26(1):1238.
35. Guimarães NA, Hirata HS, Sugita K. Cuidado e cuidadoras: o trabalho de care no Brasil, França e Japão. *Sociol Antropol*. 2011; 1(1):151–80.
36. Prochnow AG, Leite JL, Erdmann AL. Teoria interpretativa de Geertz e a gerência do cuidado visualizando a prática social do enfermeiro. *Rev Latino-am Enfermagem*. 2005; 13(4):583–90.
37. Sá MC. A fraternidade em questão: um olhar psicossociológico e a “humanização” das práticas do cuidado. *Interface (Botucatu)*. 2009; 13(Supl 1): 651–64.
38. Martins MV. História e teleologia em Darwin e Marx para entender um debate. *Passagens: Rev Intern Hist Polit Cult Jurid*. 2010; 2(4):78–93.
39. Elias N, Scotson JL. Os estabelecidos e os outsiders: sociologia das relações de poder a partir de uma pequena comunidade. Rio de Janeiro: Zahar; 2000.
40. Freidson E. Profissão médica – um estudo de sociologia do conhecimento aplicado. São Paulo: Ed. Unesp, Porto Alegre: Sindicato dos Médicos; 2009.
41. Jardim DF, López LC, organizadores. Políticas da diversidade: (in)visibilidades, pluralidade e cidadania em uma perspectiva antropológica. Porto Alegre: Ed. UFRGS; 2013.

Translated by Carolina Ventura