

'Otherness' of pain in Collective Health practices: implications for healthcare for the aged

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Abstract *This article seeks to understand the significance attributed by the elderly in the community to their experiences of pain based on the approach given to pain in collective health practices. The survey adopts a qualitative approach of an anthropological nature, grounded on the prerequisites of ethnography. Individual interviews were held, using a semi-structured script, with a universe of 57 elderly people. The Signs, Meanings and Actions methodology oriented the collection and analysis of the data, making possible investigation of the representations and concrete behaviors associated with the experience of pain. There was the sense of the experience of pain in the practice of public health in relation to two analytical categories associated with the health / disease process and care relationships in public health services. The experience of pain modulates the concept of health / disease of respondents and mediates the production of otherness in collective health practices, showing the need of a other-related dialogue that does not always established with the professional care. It is essential that this dialogue happens to be transmuted into care that soothes and comforts.*

Key words *Pain, Alterity, Elderly, Public health services*

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Introduction

Pain is an unpleasant sensory and emotional experience associated with tissue damage - actual or potential - and described in terms of such damage¹. With an aging population, health services need to respond predominantly the demands of people with chronic diseases non communicable such as arthritis, stroke, diabetes. Such conditions often associated with complaints of chronic pain² can considerably compromise the autonomy performance in basic activities of daily life, impacting on functionality, independence, self-esteem and quality of life of the subject³.

Since this is an experience, the perception of pain is characterized as a multidimensional experience, whose quality and sensory intensity are affected by different affective-motivational variables⁴. This experience constitutes a double inscription, in objective biological concreteness of the body⁵, but genuinely subjective and personal, subject to interpretation from the universe of the meanings of his own uniqueness^{5,6}. Pain is the most subjective symptom, whose visibility and measurement depend on the reporting of who experiences it, with no imaging or laboratory examinations that can show it⁷.

In the Human and Social Sciences, the body and pain are defined as symbolic constructions, constituted in the kernel of the relationship of the subject with the social world and the world in which the subject lives, thus going beyond the configurations of the clinical signs proposed by medicine⁵. Ethnographic studies on pain, suffering and emotions attest to the cultural diversity of this human experience⁶, because not only to feel, but to express pain, implies cultural codes that sanction the forms of manifestation of the feelings, in the sense of an experience that is socially and culturally inscribed⁶.

In the distinction between pain and suffering proposed by Joel Birman⁸, pain is a markedly solipsistic experience, in which the subjectivity is closed in on itself, there being no place for the 'other' in the suffering involved - there being no dimension of alterity, since the interlocution with the Other fails or is reduced, restricting the expression of pain to a murmur or lament, depending on how acute and intense the pain is. In this view suffering, on the other hand, is essentially an alterity experience, in that the subjectivity of the person suffering is directed to the Other as an appeal and direction of its demand. Thus, in contrast to the solipsistic dimension of pain, Birman⁸ inscribes suffering in a dimension of ac-

tivity, because it is in the encounter and in the interlocution between equals that it is registered.

Thus, recognizing that the fullness of health-care, more than the mere production of consultations and meetings, takes place through encounter between people, it is fundamental to understand how the approach to the elderly subject with pain takes place in the practices of public health. Also, due to the accelerating aging of the population and the epidemiological transition that Brazil is going through, it is necessary to acquire better familiarity with the repercussion of both phenomena on the production of care carried out by the public health actions and services. The objective of this article is to comprehend the meaning attributed by elderly people of the community to their experience of living with pain, and to discuss it using as a starting point the approach conferred upon pain in public health practices.

The theoretical context

This work has been undertaken from the point of view of the qualitative approach, of an anthropological nature, and is grounded on the assumptions of ethnography, with influences from the hermeneutic philosophy of Gadamer⁹ in his concept and practice of health and care. One of the contributions of hermeneutics is the concept of *dialog*, which does not refer to having recourse to obtaining of required information by instrumental handling of the process of becoming ill in the narrative of the classic anamnesis, but to a fusion of horizons¹⁰, that is to say, an encounter and an exchange of two visions of the world that confront each other¹¹. *Dialog* is described as production of compartments, of mutual familiarization and appropriation of what until then was unknown in the Other, or only supposedly known. Thus, in the relationship between the professional and user in health services, it is important that dialog should be established, it not being enough only to make the user speak about what the professional thinks it is relevant to know, but to hear the elderly person in pain who demands care of his/her self, and what she perceives to be indispensable, so that both can know how to put the existing technical resources at the service of the desired practical successes¹⁰.

Also, three major contributions of anthropology to health have served as a basis for the considerations of this study:

- (i) The concept of *culture* proposed by Geertz¹², for whom culture constitutes a universe

of symbols and meanings which allows the subjects of a group to interpret their experience and guide their actions. In it, culture is understood as the context that confers intelligibility to the situations and events of life, structuring the social field in a semantic fabric. Culture is, thus, an interpretable text in which the elderly people construct their singular experience of aging and becoming ill by psychosocial means, producing their own experience of pain based on the data of the local culture.

- (ii) The *emic*¹³ perspective, an innovative conceptual and methodological framework where interpretation of the scientist is built from the perspective of the respondents, not the view of the researcher or literature. Thus, to investigate the proposed theme of this study, the Elder was invited to talk about life and about themselves, specifically about their health and pain experience, enabling the researcher to diving in local and cultural her environment;

-(iii) *alterity*, a central concept of Anthropology¹⁴. This is understood to mean the state or quality of that which is other, distinct¹⁵, characterizing the position of the non-I, whose feelings and places are investigated to show the Other as different, revealing that Other's characteristics and specificities¹⁶, and also incorporating the notion of a plural humanity. This breaks with the idea of the existence of a center of the world and expands the possibility of knowing into the diversity of cultures with their own complexities¹⁷, including in public health. Thus, in the ambit of public health, the experience of alterity characterizes the place of meeting between recognized human beings using their differences as a starting point.

Methodological path

This study is part of the project "Anthropological Approach to the Dynamics of Functionality in Elderly People", conducted in the city of Bambuí, in the western part of the Brazilian state of Minas Gerais. The criteria for inclusion of elderly people (age 60 years or over), registered in the six Basic Health Units of the municipality, served by the Family Health Strategy, sought to ensure heterogeneity of the participants in relation to: Territory of the teams, gender, age and functional condition. Only elderly people without cognitive alterations were interviewed (since such alterations would have made interviews impossible), and the criterion of saturation regulated the size of the universe researched, which was constituted at 57 elderly people interviewed.

Collection and analysis of the data was oriented by the *Signs, Meanings and Actions*¹⁸ model. This model is a highly effective instrument of anthropological investigation of the concrete representations and behaviors relating to health/illness predominant in the local culture. It makes possible a systematic knowledge of the contextual elements that intervene in the construction of concrete behaviors adopted (ways of acting), and also access to the conceptual logics (ways of thinking) that are most used by a given population¹⁹, to understand and explain a given condition²⁰; in this present survey, pain.

In this point of view, the methodological proposal chosen²¹ inverts the procedure generally used in studies on representations and uses the pragmatic level as a starting point from which to rise to the semantic level. The *Signs, Meanings and Actions*¹⁸ model takes as its starting point the concrete behavior of individuals, to identify the conceptual logics that underlie them, and the different factors that intervene in the concretization of these logics in particular situations²², making it possible to systematize the singular thinking and action in the context of the local culture¹⁹. This specificity of the cultural construction of each community in conceiving its own universe of health problems sustains a certain continuity in the manner of perceiving and interpreting them, and, consequently, developing typical procedures for confronting them²¹.

The investigative technique used was individual interviews, at home, with a semi-structured script, to widen the field of speech of the subjects. The interviews were recorded and transcribed, making possible a careful reading for identification of the analytical categories and the interaction between them, and also their articulation with the current social-cultural context²³.

The analysis of the data included two types of work: (a) the descriptive work of organization, panoramic reading, identification of categories, reading in depth, then modifications of categories; and (b) theoretical work of relations with other findings and interpretations that exist in the literature and in secondary data.

The analytical categories perceived as representations of the experience of pain are constituted culturally, producing an analysis centered on their meaning²⁴. In this perspective, the experiences of living with pain in the daily life of aging, and with functional incapacity, are articulated with their context of material and symbolic production, expressed in the individual and intersubjective narratives, and with the logics of social and cultural field.

Ethical aspects

This research project was approved by the Ethics Committee for Research on Human Beings of the René Rachou Research Center. All the participants signed a free and informed consent form, in accordance with National Health Council Resolution 466 of December 12, 2012.

Results and discussion

The universe investigated comprised 27 men and 30 women, aged between 61 and 96, served by the Family Health Strategy. In marital status: 24 were married, 7 single, 25 widowed and 1 lived in a stable union; the majority with children. In the group, a low level of schooling prevailed, a strong predominance of the Catholic religion and rural origin, the main reason for moving from the rural area to the town being the greater proximity of the health service and/or the children's school.

After various readings under a careful and specific eye regarding the experience of living with pain in the practices of public health, two categories emerged from the analysis: "The experience of living with pain in health and in illness", and "Pain and care in the public health services".

Living with pain in health and in illness

When asked why they thought their health was good, a woman and a man answered, respectively: *I don't feel anything, my dear! Thank God! I'm so strong that when everybody says: 'My spine is killing me!', I say: 'I don't have a spine!'. Thanks to God, I don't feel anything.* (M5, aged 77, widow). *I'm healthy – I'm not feeling anything.* (H18, aged 65, married). In another man's view, the construct of good health is based on the fact of not needing a medical visit nor medication because he doesn't feel anything: *I go for a whole year without going to the doctor, I don't take pills, there're no pills. I just take one direct remedy for blood pressure, but that's all. I don't consult the doctor, I don't feel anything that would need a medication* (H45, aged 90, widower).

In turn, another elderly explains why it is not in good health: *It has a pain in the back here, girl. A pain here in the chest, arm, back. Got bad* (M31, 77, widow). Likewise, asked how health is, a man replies: *Right now, I'm not well, not well, no. There is pain in the legs and... it hurts in the legs, it hurts in the calf muscles [...] I mean at the moment, right now, 'well', I am not, no, but – we put up with it.* (H7, aged 84, married).

In the speech field of the elderly, health is an experience of absence from pain and the illness interpreted as pain felt in own aging body. It should be noted that the local culture old age is not conceived without disease, as demonstrated by this story of an elderly man: *Well the real thing that is really not good, is old age... Because old age is something ill. There's an expression that says something like: senectus esculopus: age is illness. And it is.* (H15, aged 79, married). Consequently, the elderly people who were the subject of the research recognized the experience of living with pain as a specific quality of old age, as this gentleman reported it: *It's hurting because now it really is mostly just my age, it's my spine, and my spine also hurts a lot – too much – at night, when I wake up.* (H47, aged 69, married).

However, each culture or social group has its own singular language through which people who are unwell demonstrate to others the meanings of what is making them suffer²⁵. Specifically in the field of speech of the subject of this survey, pain is an experience of living; to have health is *not to feel anything*, and to be ill is to *feel* the pain in the body itself.

Thus, one can discuss the sign *to feel* under the specific meaning of 'an experience of living', as proposed by Walter Benjamin²⁶: what one lives through is individual, connected to the feelings, present in the consciousness, lived through in daily life and in the immediate temporality of the moment. In Benjamin's view, the experience is the singular appropriation that the subject makes of a given fact or event in his history which, although individual, is still marked by elements, symbols and signs present in the social-cultural context²⁷. Since what is lived through is never only the property of the subject, in the individuality of the subjects researched one noted a social mediation of the meanings captured by the subject in the data of the culture, conferring upon their experience of pain a collective meaning.

However, in another perspective, Birman²⁸ believes that pain restrains a person to himself, characterizing a solitary experience and one that is without symbolic and social mediation. In this case, the interlocution with the Other is impoverished, limiting the pain to the corporal registry and to a language with difficulty of expression in the field of inter-subjectivity. This dimension of the experience of living physical pain that limits itself to the corporal registry characterizes a solipsistic experience²⁸, without social mediation. This produces the sensation of isolation of the person, restraining her/his language and verbal

objectivation, forming an obstacle to capacity of communication of the pain in the social field²⁹.

In turn, the sign *I don't feel anything* means health experience, which has its repercussions in actions in the social fabric and modulates care practices, including the decision whether to go to the doctor and / or make periodic follow-ups. For the respondents, the actions of need or no consultation, drugs, tests, medical monitoring reflect the experience of feeling or not the pain in one's own body, and are associated with the possibility of limit or prevent the suffering that the pain causes, maintaining the experience of living, in a sense, centered at the level of the body and of action²⁸.

In Gadamer's view, all understanding is interpretation, characterizing the hermeneutical act of seeking for meaning of anything in our social-cultural world as universal, whether it be the meaning of life, of health or of illness, among other of the most common interpretations of the ideas and situations that characterize the objects present in day to day life³⁰.

Thus, in the universe of this investigation, the perception of the experience of pain in old age as a sign of health/illness produces an interpretation of its condition and of its suffering addressed to and conditioned by the social field. Further, since *old age is something ill*, this same legitimating idea that associates pain, illness and old age, present in the interpretations³⁰ on the body and the health of the subjects, is conditioned and strengthened by the cultural codes naturally accepted based on negative stereotypes surrounding the understanding of old age as an illness³¹ and of its adverse effects as 'things of old age'³².

This semantic condition of the local culture is present in the narrative of one lady, widowed for the second time, when asked how she would recognize an old person: *I don't think there's a particular age that you can say that person is old, no. If the person has health, she doesn't think she's old, no. For example, if she feels well [without any pain], if she eats well, if she sleeps well, if she walks, if she converses with everybody, if she's disposed for everything...I think that if a person has this disposition, they've not got old age, no. They're not old – ... Look, I married my second husband, he was already 60 plus quite a lot. We lived 18 years. He died at 88. He was never one of those people to look crestfallen, and he died. He got ill, and in one instant, he died. He died without being old* (M5, aged 77, widow).

The biomedical knowledge produces a culture that mutually reinforces the inexorable as-

sociation between pain, sickness and old age so that if a person is not feeling anything, no pain, and with full functional capacity, even in old age, it cannot be considered old³². If the field speaks of the universe researched the pain of living modulates the condition of disease associated with the very meaning of being old age, the great fear of the elderly to confront their pain is to recognize old. Accept your pain is accept their own old age, characterizing in the social field of public health practices the production of 'otherness' which is what Hanna Arendt means when she says that all pain is bearable, as long as we can construct a history about it³³, understanding the historic construction to be collective and produced in the public space.

Similarly, the thinking of Benjamin refers to experience as the action of meeting of the subject in the relationship with the Other²⁷, a route capable of re-signifying the experience of life. It's at the moment when a narrative is constructed about the fact experienced that, in the process of inter-subjectivity, new meanings can be attributed to one's life experiences. So that new meaning can be attributed to it, the experience of pain claims 'otherness', which often happens in the search for care from the health services. The space of health is mediated by the collective, by difference, and, thus, by otherness itself³⁴. In the health service networks they subjects involved in care are: the users, the health professionals, and the managers. Since health is situated in the social/public sphere, being produced by the collective of social actors and of the social-cultural contingencies and realities of human existence, it is fundamental to comprehend the configuration of the experience of pain based on and taking as a starting point the look in the eye of the elderly patient, is silent or is assisted by the health team.

Pain and care in the public health services

One gentleman describes his health: ... *well, my health is – 'more or less': in the last two months I've even been to a consultation feeling pain in the legs.* (H3, aged 75, married). Asked what she does when she's in pain, this woman explained: *I go to the doctor. Now, for example, I consulted three times already to this leg pain. None of them found anything. Pass medicine to take away the pain. Takes the pain to see if it discovers. So, go see if you find what.* (M19, aged 83, widow).

Thus, in the public health practices that serve the elderly people in the survey, the experience of pain establishes the concept of health / disease and mediates otherness production activities.

Consult is action of those looking for others to give you the chance to find another place to them or to rediscover the ability to not feel pain and so experiment again the health. In this search for an answer and or some feature to take the pain, sets up the prospect of a other-related experience in the search for a possible tell of their pain for a therapeutic intervention of relief or is possible for healing.

In his statement, the youngest man in the group justifies: *We get so quietly, with all the pain, but no one to blame. Speaking on the stage of pain, replies ... It's too bad. It's too bad the following: the pains that are too. Conditite this causes a lot of pain, gout causes a lot of pain, now even this came osteoarthritis in the knee. It causes pain. I feel a lot of pain in the cervical spine, that under the column. The only part of me that I do not feel pain is still in the hands. Shoulders, leg, back, I do not give account either to take a hand in the head. Then I'll supporting, there will leading a decent life.* It explains fatalistically how you react to it: *Nobody is to blame, so we have to learn to live with the disease. If it came to me, I'll have to face up to that when I arrive.* (H43, aged 62, stable union).

In the old age of Bambuí, pain understood as part of the process of old age/illness, instead of denoting a form of 'resistance'³⁵, signifies the contrary. That is to say, a desistance – it is necessary to accept without complaining. Thus, in the local culture, pain does not result in opening to the Other. This makes it difficult to express it as suffering, a space marked by Otherness in which the elderly person establishes the relationship with the Other and delineates a horizon of an inter-subjective order³⁶. This difficulty in being able to direct one's appeal to the Other characterizes in today's world the evidence of the subjectivity that is essentially narcissistic²⁸, which condemns the subject of our investigation to submergence in the solitude of his/her experience of living with pain. However, specifically in the field of public health, the individualist set of ideas has given support to the clinical model in the practices of various health professionals, restricting pain to a previously established conceptual figure, a nosological category³⁷. In the view of Birman, this contemporary feeling of being ill is characterized principally as pain and not as suffering^{8,28,36}.

One of the ladies spoke of how she confronts her own pain, and imagines solution for her problem: *Just this moment I was lying down over there, and I said: What will I do with this pain in the arm? I don't have anything to take. I was thinking that the doctor would come here today to give*

me a consultation... There's a doctor who comes here. When I can't go there, he comes here. (M53, aged 82, widow). Another man explains that he visits the health service frequently, but has a discouraging dialog with the professional: *I go to the daily doctor, only. My Doctor is X. X – he's my doctor, and he gives me that boring old speech, he provides that medication and he says: "You take this home and go on taking it, when the prescription runs out you get another, and when it gets worse, you come back".* (H23, aged 82, married). Another woman highlights the limited availability of the professional to hear what she brings as a demand: *The SUS – we go there, they give us some little prescription, we... we don't need to say much and they just give us the prescription right away. Then I pay [for the consultation].* (M55, aged 86, married).

Thus, the elderly person shows a way of looking at her pain with the meanings, elementarist and with a positivist fragmentation, that are present in the culture of biomedical knowledge, because when she seeks care, the doctor prescribes drugs. In this point of view, the experience of living with pain in old age characterizes a singular appropriation, through which the subject claims interaction in the collective field, delineating and provoking in the health services actions of assistance in relationships of production of care, which can make possible the acceptance of people, and allocation of value to them as human beings³⁸ in a social relationship²⁵. At the same time it confronts the elderly person with the need to establish a different point of view in his/her singularity, because the I and the Other do not get confused with each other: The place of the person who feels the pain remains distant and separate from the person who 'knows' about his/her pain.

This experience of living with pain challenges the public health services, particularly in relation to the technologies of healthcare relationships³¹, because it's necessary to find in the relationship with the Otherness the necessary welcoming of its expression – a cornerstone condition in the field of health. It is necessary, thus, to construct a practice based on understanding of care as a relationship experience and one that mediates between the elderly person and the health professional in the horizon of interpersonal exchanges³⁸. Further to this, often the interactive game of passivity dominates the person when something in itself hurts, expecting that someone will take an attitude for them in their pain²⁸.

In public health, the ability to perceive the other as different and equally valued extension

of itself imply successive actions of inclusion, dignification and liberation of that other³⁸. This construction of a professional health-user relationship in the daily routine of the production of care is made up of subjective encounters and crossed by multiple forms of knowledge³⁹. However, the perception of the universe surveyed, the professional medical care so the public service reveals hurry in attendance, compromising the resolution and the effectiveness of health actions³¹. This incapacity to listen on the part of health professionals is part of the complaints of the elderly people interviewed; by disqualifying the factor of warmth, welcoming and acceptance, it cannot be effective as care, because it does not enter a dialog with the patient on the subject in relation to which the patient is making a demand.

When reflecting on the production of otherness in the experience of pain in old age, from the point of view of the elderly subject, some questions arise for us: The elderly subjects seek the health services when they feel something; how does the health system care for the elderly subjects when there are no symptoms that characterize pain in the body? To merit care, does the elderly person necessarily need to complain of pain? If, for the elderly people and for the professionals that they consult, pain is part of old age, how does the health system care for elderly people whose bodies are in pain? How is an elderly person welcomed when the actions of care and attendance do not claim 'otherness'?

Understanding this algic user experience is central task to approach the pain of public health practices, building understanding of the saying of user pain and professional host who makes your listening a configured dialogue as a hermeneutical act³⁰. For professional properly interpret the magnitude of the problem being able to make this meeting an act of caring and otherness production is necessary to overcome this impasse: the pain that feels old can mingle with the records you care?

Understanding the Old pain may not be the unilateral registration of knowing the pain of those who care, but the narrative of those who experience it. Only when the person indicates the other your pain is that it has the ability to be understood in their personal and unique registration⁴⁰. While the experience of pain is only seen from the outside by health professionals, care not become effective, remaining the impasse and antagonism between vertigo isolation who feels the pain and the professional who takes care of algic living in old age naturalizing pain at this stage of life.

From the perspective of Gadamer, the dialogue takes place in the fusion of horizons - term that describes the activity of understanding between the horizons that each person is³⁰. A "horizon" is a vision of insight into the lived world that brings us to the use of language encounter with another horizon, in a merger that creates linguistics agreements⁴¹. The purpose of this meeting is that couples understand to each other⁹, considering the existential concreteness of those involved and shared decision making possible, between the Elder and the professional who cares about the most appropriate health care on that particular condition - in this case the pain. In this sense, the otherness that pain and dialogue trigger set up in a public action oriented to difference, diversity, including different social identities which are in public health⁴² spaces.

Thus, the challenge of the field of health becomes that of succeeding in approaching, interpreting and transforming the pain as suffering⁸ of the subject who is living through it in his/her social-cultural context and in relation to Otherness, since the pain felt and the suffering manifested are reflected in this relationship with the Other - in this case, the health professional. This professional welcomes and accepts, or rejects, the person who is having the experience of living with the process of chronic pain, making himself available (or not) to the place of listening and of meeting, whether it be in a home visit or at the health service.

Final considerations

This work, anchored in the amplitude of anthropological point of view, recognizes the experience of pain as constituting an opportunity relationships and encounter with the otherness of the other, qualification of technology care relationships and appreciation of experience wholeness and history elderly person who experiences algic situation.

Thus, the experience of living with pain is the privileged place of reflection on the culture and the practices of public health that still understand the illnesses and adversities that occur in old age to be merely things of old age. However, one does not see the desired change to a care model that produces links through a welcoming acceptance centered on listening and on dialog. On the contrary, the model that the elderly people perceive and portray listens little, and continues to privilege the concept of care for the

elderly as a process, rather than as an experience, negating dialog with the singularity of the elderly person who is suffering the pain.

Nevertheless, it is essential that, in health, the otherness of the pain is a constituent ethical principle of relations. When configuring the look of otherness in the experience of taking care of the pain of the other, the Elder becomes the sub-

ject of his own experience and your body, there is a reception of transmuted pain in care that soothes and comforts. This alterity can take an inducer function of the humanization process of services subject to proffer elderly person, since it the professional to understand old age as a natural stage of life, worthy and deserving of care with, without or despite the pain.

Collaborations

WJ Santos, KC Giacomini and JOA Firmo participated equally in all stages of the write-up of the article.

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