Article

Men between health and public safety: violence in trauma hospitals

Helen Barbosa dos Santos*
Henrique Caetano Nardi
Universidade Federal do Rio Grande do Sul, Porto Alegre, RS, Brazil

Abstract: A research using ethnographic perspective was carried out in two trauma hospitals in the city of Porto Alegre (RS). We sought to describe the convergences and divergences of practices in the intersection between health and public safety fields regarding men injured in violent conflicts. Multiple social actors' narratives (professionals in the field of public security and health) were analysed, as well as the multiple paths of patients and their families in the search for health care. The central conceptual operators are inspired by studies on power technologies (Michel Foucault, Giorgio Agamben), Moral economics (Didier Fassin) and masculinities and violence (Waldemir Rosa). We conclude that the hospital system is firmly linked to the public security system through discursive practices that encourage the production of criminalized masculinities.

Keywords: health, men, public security, criminalization, medicalization.

Introduction

Amidst the smell of alcohol, the metal doors, and elevators, the steam from the kitchen smothers the sight of the church's cross, high above the hospital. Amid blood, coffee, and snacks. The green scrubs, white coats, military uniforms. Handcuffs, chains, weapons. In front of the metal detector, between reception restrooms. Among waiting room chairs, past diagnostic machines, and saving lives technologies. Sterilized instruments, prescription papers, and the information system. Lives suspended.

We are in the trauma hospital, surrounded by the knowledge-power technologies[1] of the State. For healthcare professionals, trauma hospitals are the heart of the city. They are used to proudly remembering the stories of lives saved in extreme situations, such as when the burned youths in the Kiss nightclub[2] were hospitalized in the only medium and high complexity burn unit in Rio Grande do Sul, at Hospital Pronto Socorro (HPS). "*They all lived*", said the hospital manager.

However, more often than not, another picture emerges inside the hospital: the layout of the city in its spatial and geographic divisions, cut out by discrimination and segregation between elite and deteriorated spaces, clandestine and illegal, defines cut lines that invariably fall on the citizen body (Endo, 2005). This process is made visible when the violence previously limited to peripheral areas starts to spread across the central areas of the city; it's when survivors of clashes in armed territories hover between life and death inside hospitals.

We could then say that the hospital is more akin to the intestine than the heart. Hide[3] and sterilize the infamous bodies. In the absence of the intestines, there is no physical life, but, deprived of its guard, of what is dirty, the other becomes less human. The "gut" at Hospital Cristo Redentor is the name of the intestinal infection. "*If you're shooting to kill, aim for the bowels, not the head. It's a slow and gradual death*", vents a multidisciplinary resident in Hospital Cristo Redentor. No, we're not that leftover gut that was shot months ago but remains open, from which food escapes undigested into the world. The food bursting out of the colostomy bag and flooding the stretcher. Forgotten in the so-called "isolation" room until the cleaning assistant prepares the chair and arrives to hear the memories of those about to die. Tales about work, family, their lost youth. Who wants to see or listen to them? So often hidden under peeling paint and moldy ceilings. An inextricably political and social death.

Trauma is unanticipated and unwanted damage or injury. "*No doctor wants to be sewing intestines stitch by stitch in a trauma hospital, it's boring*", says one of the directors of a trauma hospital. The bowel is impertinent: trauma caused by firearms requires

* Correspondence address: helenpsi@yahoo.com.br

1 Within this universe, in which power and knowledge are closely linked, the emphasis is that "There is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations" (Foucault, 1995, pp. 29-30).

2 The fire that took place at Kiss nightclub was a tragedy that killed 242 people and injured 680 others in the city of Santa Maria (RS).

3 In this case, the infamous people are the (former) enslaved, scorned from the labor market, and perceived as criminals or vagabonds. When not physically, they are socially dead and, if not absorbed by unemployment, they are left to be institutionalized.

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therapeutic complexity[4], accompanied by the risk of worsening the condition due to generalized infection, demanding a longer hospital stay. As a metaphor, besides its vital dimension, the intestines put the hospital under scrutiny, being also a purge for issues related to social inequality and the place of practices "stuck within the darkness of the lower abdomen" (Pereira, 2009, p. 70), marked by processes of medicalization and criminalization that take place beyond institutionalized flows. This body of trauma is, above all, that of black, poor, and young men in our country. In the prison system, they are called the *Fallen*; in health services with a high mortality rate, they are the *Dying*. Pierced or lacerated, the traumatized body takes on an ambiguous place within the social scene.

The reports analyzed are the result of an ethnography in two reference trauma hospitals for urgent and emergency care (Hospital de Pronto Socorro da Prefeitura Municipal de Porto Alegre and Hospital Cristo Redentor do Grupo Hospitalar Conceição). Emphasis was given to Hospital Pronto Socorro (20 to 30 hours of observation per week during three months) and observations of professional practices at Hospital Cristo Redentor (HCR) as a specific field study (totaling 30 hours).

In Vinícius Carvalho Pereira's (2009) words, in the exercise of dense description, there was the need "to make the text dirty, blur it up: to make the guidelines that guide common sense thinking imprecise and relative" (p. 11). Writing calls for features and names and fits them into their pronouns. Quickly shifting and grazing. With health professionals climbing up and down the stairs, from the emergency room to the intensive care unit (ICU), from the ICU to the infirmary, until things are still. A friendly *mate tea* in the custody rooms with agents of the Superintendence of Penitentiary Services (SUSEPE) or in the petrified silence of waiting at the health emergency, with military police escorting patients wounded in violent conflicts.

Ethnography[5] (Fassin, 2017) offers a distinct image of the power devices involved in public policies and institutions. It seeks to move apart from a reductionist perception in which the responsibility would be on one side only in the domain of inanimate social devices, or even in the individuality of the subjects, such as blaming professionals for discriminatory health practices.

Health care flows in multiple territories are perceived based on how pain is recognized, the meaning of life and death, what gets in, returns, has never left, got in, or nobody has seen. The writing revives the unpredictable circulation through the hospital to access, with its help, the problematizations of the practice of public health and safety within the trauma hospital through the professionals' discursive practices[6].

It is time for social policies (including health) and penal policies to stop being addressed separately, both by social sciences and by public policies. Stop separating the body (the family-body, the professional-body, the user-body of public services), the social state, the criminal state, and urban marginality. Let's capture and explain them together, in their mutual imbrications (Wacquant, 2013). Thus, we shall demonstrate the production of a criminal potential brokered by the "mouth to mouth"; an analogy on how the story of certain health users is retold through multiple voices inside the hospital.

The recognition of how certain men are treated and have their lives evaluated and distinguished by moral dimensions related to the production of meanings as part of the technologies of government is extremely important. Therefore, we will use the concept of the moral economy taken up by Didier Fassin (2007, 2010, 2014, 2017) as an analytical operator of health professionals' practices, the hierarchies brought into play, and the values operated within care scenes. The technologies of power are not reduced to the power relations of the bodies of those carrying them out and those who must accept them (not least because their effects escape this duality); rather, they obey a logic that involves institutions, multifaceted networks out of tune with their historical events.

We will also try to narrate the details of the discursive practices present in the actions of the penal state, civil, and military police, as well as the guard, guardian of the hospital doors, and the Susepe agent, owner of the keys to the chains. That's where we'll find another synonym for the word hospital: (1) intestines; (2) prison. The hospital has another owner who hovers around the health care environments with all the disciplinary power inherent to the institution. The territory of the hospital is also a gateway to the prison system, where the population

4 One of the HPS doctors reveals that traumas affecting the intestines are recurrent and have called for new survivability techniques from specialists in the field of traumatology. According to him, currently, in Rio de Janeiro, some specialize in courses on how to proceed with assault rifle victims (American AR-15s and Russian AK-47s).

5 In his ethnography in *Enforcing Order*, Didier Fassin (2013) describes police actions aimed at immigrants that not only legitimize but also support and encourage agents to lead repressive, ineffective, and counterproductive policing. We also suggest the book *Writing the world of policing: the difference ethnography makes*, written by researchers from all continents, about the ethnographic process of those who ventured into the vicinity of policing and public safety (Fassin, 2017).

6 According to Patrícia Medeiros (2008), the discourse forms the object it comprises, that is, discourses are practices, insofar as they constitute subjects. They speak and make us speak, constituting certain ways of understanding, thinking, and living that which is urban violence, for example. Therefore, discourses are not subjective, but subjective, as the individual appropriates certain discourses, considered legitimate and true, while modifying and identifying the prerogatives of such discourse as his own. To Michel Foucault (2008), "the discourse is made up of real and successive events, and it cannot be analyzed outside the time in which it was developed" (p. 224). The author also points out that there are differences within a same discursive practice, as if the subjects "speak about different objects, have opposing opinions, make contradictory choices" (Foucault, 2008, p. 218).

management is visibly anchored by security devices[7]. Thus, we will analyze practices that reiterate the character of austerity in the security device that crosses the field of racialized masculinities within communities experiencing economic and social impoverishment in the second part of this article. Sovereign power will be analyzed in a lighter tone in the present ethnographic field. On the one hand, as a public social humiliation and/or in the restriction of access to rights. At its extreme, but not necessarily without the exposure of the culprit, the execution, which emerges from the narratives about survivors who are put under the care of hospital services. Our goal is to reflect on how this violence produces new demands and challenges in health care and how it rallies the power of public security to occupy a local scene in which saving lives and the use of force (in its disciplinary and/or punitive senses) have no apparent tactical combination.

Monster fables: narratives by public health and safety professionals.

> *Have you been to the red room? It's hardcore working there. The dude is grasping at straws and there they are, on one side, the military policeman saying that that guy is a criminal: on the other, the technicians, handing over instruments and doing things as slow as possible. The pace of the service changes if the patient is deemed a felon.* (Resident physician)

The concept of moral economy allows us to understand how criminal subjectivity and the mechanisms of power over life are produced in the context of health care. Didier Fassin (2010) took a critical look at public health, perceiving its precarity, as its attitudes comprise a moral dimension of action that a given context defines as the good of mankind.

If the governance of conduct is guided by the invention of criteria about what the subject should be, linking, marking, and identifying it with a model of being a subject, it is the power-knowledge relations, their materiality (through techniques, procedures, and practices), their success or even resistance to them that make the invention of these criteria possible (Medeiros, 2008).

In this sense, if the power relations between different masculinities happen through reiteration, assimilation, rereading, and/or rejection, there is no doubt that, in the connection between poverty and racism, the intense violence directed at racialized[8] masculinities is the effect of a subordinate condition of post-slavery societies (Rosa, 2006). Exposed to armed territorial violence, boys and young people apprehend male performances aligned with the kill or get killed logic, where home and the street clash in the production of militarized childhoods (Moura, 2007).

Masculinities vary according to social and historical contexts and are also built simultaneously in two interrelated fields of power relations; the relations between men and women (gender inequality) and between men and other men (inequalities also based on social markers such as expressions of gender and sexuality, race, class, ethnicity, and generation). Among different hierarchies of masculinities, types of violence may or may not be recognized as such, as their intelligibility permeates multiple aspects (Botton, 2007).

When good and bad, victim and perpetrator are rigid dichotomous positions, opposing sides separate those deserving of care from those who should be watched or punished. There will be a time when the translators of pain[9], emergency tightrope walkers, will have to choose the fate of the other's suffering, what is perceived as pain, and what is taken as an expression of danger.

"*I treat all people equally, without distinction*" (nurse). These propositions were also professed by narratives comprised in the studies performed by Sarti (2005), Deslandes (1999), Deslandes, Minayo and Lima (2002), and Leal & Lopes (2005). The classic statement emerges, so there are no distinctions: "*I don't want to know the guy's story*". Authors Dejours (2007), Pitta (1991), Leal & Lopes (2005) refer to the aforementioned mechanisms as strategies to support some daily work situations. Based on Dejours's (1997) and Sá's (2005) studies, this trivialization of violence can be considered the result of individual and collective defense strategies by professionals to deal with the suffering of others, as a reflection of a phenomenon of trivialization of social injustice that affects society as a whole.

In addition to the fragmentation of the technical health-patient relationship, in which the worker has his/her work fragmented in the splitting of tasks, Leal and Lopes (2005) found that psychic defenses against feelings of anguish or anger aimed at hospitalized men as a result of aggression are triggered from the depersonalization and denial of alterity.

7 According to Michel Foucault (2008), *security devices* would be integrated government actions aimed at protecting society against deviant behavior. They seek to grasp the point at which things will take place, so they do not only involve institutions such as the police, but all branching institutions and social functions seeking to comply with state regulations and powers. They aim at strengthening the positive elements of society (favoring social interaction, arranging buildings properly, allowing for water flow and air circulation, etc.) and curb the possible risks that may affect the population (diseases, theft, accidents, etc.) (Michel Foucault, 2008, p. 26). The population, therefore, is only indirectly affected by the security devices, which occurs insofar as it connects to the space and the environment. (Michel Foucault, 2008, p. 27).

8 Where we infer "racialized masculinities", we also explain that the human race is a truth constructed by science marked by the metaphysics of substance, in meshes of knowledge-power that convey the body its pathology, genetic, and/or mental disposition, justifying political actions of segregation and even genocide.

9 While marked on the body, the intelligibility of violence occurs as the possibility of its translation by professionals in terms of the disease, fragmented in its biological, psychological, and social dimensions (Deslandes et al., 2002; Sarti, Barbosa, & Suarez, 2006).

"*I don't want to know the guy's story*". Is that so? Systematic observations of a range of characters in the trauma hospital allowed for new planes of passage in the analyzes undertaken. Contrary to the author's findings, stories are alive. They take elevators, cross emergency rooms, overcrowded wards, and ICUs. Ranging from the outsourced cleaning worker, the cafeteria worker, to the nursing technicians, and specialists.

The justification of treating everyone equally is part of a discursive rationality that covers up for the moral economy in this relational game between professionals and "suspicious elements". The crime subject is also material, built in terms of narratives, loaded with moralities articulated between health and public safety, producing surveillance and therapeutic strategies for bodies deemed dangerous.

"*They assume a lot of things without actually knowing the subject's history*", complain some multi-professional residents, mainly specialized in psychology and social work. They also state that "*professionals have a lot of imagination, they have a lot of stories about health care users which we seem unable to rectify, even with all the clarification of those who closely monitor patients and family members*".

In a conversation in the hallway in front of the custody beds at Hospital Cristo Redentor, two Susepe agents state that health professionals, when treating men in custody by the State, usually "*call them to the side and quietly ask: 'what did he do?'. There is great curiosity on their part*" (Susepe agent). According to these professionals, this interferes with the work, as "*it is not even about humanizing the treatment of prisoners, but rather not letting them become a laughingstock; it is our duty to keep the prisoner from being ridiculed*".

That which is perceived as true inside the hospital can be thought of as the result of our historical desire for the truth; discourses that are based on outside knowledge from sociology, psychology, psychiatry, and medicine to legitimize truthful discourses. Where there is the desire for knowledge, there is power and, we must also point out, violence. Thus, the discourse of the truth gives away the appearance of freeing the subject from power, desire, and violence. But, in this process, such discourse is unable to acknowledge the will (power, desire, and violence) with which it is infused. The longer a man remains inside the trauma hospital, the greater the power of narratives. Tragic, sad, some funny stories. The nurse moves on to his second book on memoirs of health emergency: "*It's all here, in the memory*".

How many stories are there? How many similarities between them? Do they mix and get lost, then repeat themselves? Many narratives emerge as bulletins. They talk about the medium of violence, the type of aggression, the symptom, the diagnosis, whether the patient lived or not. Amidst it all, there is the moral valuation: "*he was a bum*", "*he was a rapist*", "*he said he was robbed, that it was a stray bullet, but you know better, right?*".

According to Brah (2006), the same context may produce several distinct collective "stories", differentiating and linking biographies through contingent specificities. Every narrative told is already part of the interlocutor and will become part of those who listen to it. It is fictional because there will never be truth in a fact that it is no longer. But it carries on as an event, producing multiple perspectives on a given reality. The look on the subjects speaks of something that belongs to the institution's life; the body-institution and professional body are concurrently managing each other.

Within these power relations, enter the service providers. As they circulate the hospital, they are placed on a lower hierarchical scale[10] than health professionals. Passersby and extras, not infrequently ascend as messengers of a knowledge that is differentiated, and that is impossible, by specialized knowledge. They bring information from the peripheral areas where they reside. Recognizing names and features in the trauma hospital; so, their veridictions acquire a productive value.

Information about other people's life is, above all, a narrative. It unpredictably connects the ears and mouths of healthcare professionals. And those who have listening as their main tool (especially psychologists and social workers) are transmuted, in many cases, into extras, therefore, deprived of knowledge on the subject.

Given these situations, as well as the research carried out by Zanellato and Dal Pai (2010) and Dal Pai (2011), the fragility of the assumptions "of humanization in health" is confirmed. The humanization[11] engendered by public policies and health discourses flees itself by evading the moral precepts that separate subjects between those for whom there is an urgent and irrational attachment and the others, whose life and death simply do not matter. Even if the emergency service professionals are aware of the purpose behind welcoming proposals during risk classification, they lack the understanding regarding its scope, identifying the welcoming[12] as a mere part of the care, a punctual stance of a procedure or specialty.

10 Jessé Souza (2011) observed class prejudices in the context of a hospital from nursing technicians, the agents who mediate the contact between patients and doctors, as well as other professionals. People who often ascend from the scum or from fractions of classes more familiar to them, also including professionals from the hospital's backstage (such as cleaning, kitchen, pantry, and laundry services).

11 As a public policy, the National Humanization Policy has existed since 2003 and seeks to implement the principles of the Brazilian Unified Health System (SUS). As per Benevides and Passos (2005), humanized health care and management are introduced as a means for qualifying health practices of access with welcoming; comprehensive and equitable care with accountability and bonding; valuing workers and users with advances in the democratization of management and participatory social control. "Welcoming differs from screening, as welcoming is an action of inclusion that does not end at the reception stage but must occur at all places and moments" (Brasil, 2009, p 9).

12 "*At the trauma hospital, we are concerned about efficiency in saving lives. There is no way for the hospital to discuss humanization assumptions as they do in primary care*" (Manager of one of the hospitals).

Humanized attention[13]? They say they will never do it, that the closest thing to that is respect for the prisoner, usually for fear, without much openness; otherwise, they become "*pals... there are coworkers of mine who are this close to roasting a barbecue with the prisoners*" (Susepe agent). In fact, they rarely achieve anything beyond what we realize, with their life management tactics, wakefulness, and a dash (or simmering pot) of punishment.

The political stance according to which "*Brazil has set nothing but rights, leaving our society like this, full of criminals*", is a common agenda. The moral economy is bound to a political view of the institutional culture and, inseparably, a production of masculinities within it.

The nurse recollects his 30 years of work at the trauma hospital:

> *Back then, several well-known criminals used to come in, like bank robbers. Nego Pinto[14] was one of the biggest criminals in the state. They were respectful. Wished us a good night, good morning, good afternoon upon their arrival. They walked with their heads down. Those who come here now arrive with an attitude. When the* [civil] *police used to beat them up, things weren't like that.*

Racist theories are called for when there is the need to illustrate the monstrosity of the criminal or offender, their abnormality, their danger, their biological inferiority. Since the 19th century, racism has been a state political doctrine used to justify the violent action of modern states (Sanches, 2009). The political recognition of the body and the origins of the suffering associated with it is what Fassin (2005) calls *biolegitimacy*. In this sense, Maluf (2005) states that the absence of public powers forces some subjects to collect their own pain into the intimate and private spheres. They act as if the confinement of violence and, with it, reclusion and muteness were their only acceptable and possible place. But "pain" can also speak and vividly express a story, just as "suffering" can be silent or present itself without language. The measure of pain is the violence naturalized within the trauma hospital. A fable of monsters.

Are we going to take them or are we going to let them die? Technologies of power for wounded men

"*We keep bringing criminals into the hospital and, unfortunately, they take the place of good people. But there's nothing we can do. We cannot leave them to die*" (military police). In the social-criminal intertwining, medicalization becomes a facet of the penal State for the population management when criminal practices have historically been reproduced through strategic health actions (as in the repression of idleness during the Old Republic and the fight against alcoholism under president Getúlio Vargas), to normalize the population.

To understand the interventions of political power in the health of the population as a means of governing life, biopower, according to Michel Foucault (2002), highlights the technologies of power that seek the social production of economically productive and politically docile bodies. It is split into two main axes; discipline, the government of the bodies of individuals, and biopolitics, which would be the government of the population as a whole.

Policing operates in the ambiguity between the law enforcement associated with peacekeeping and, in its oldest sense, the police comprise a range of human interventions in the regulation of society, from public health to child welfare, to maintaining order in the control of morals. Starting from the 18th century, it is this project of normalization of life that encompasses what Michel Foucault named *biopolitics* (Fassin, 2017).

Biopolitics is associated with the ancient sovereign right to kill – exposing to death or increasing the risk of death for some; publicly decreeing political death, exile, rejection – and the management of life (Foucault, 2002). There is the need to "making live and letting die" as means of population management. We will see that biopower only coexists in the present time described, with the configurations of sovereign power in logics of "killing and letting live," as described in the health and safety injunction.

In times of a biopolitical control built around the "war on drugs," the security apparatuses inherent to sovereign power convert subjects to the fantasy of terror and the indispensability of containment strategies. The application of a selective extermination methodology for the poorest strata is, thus, legitimized (Sanches, 2009).

> *They don't die here anymore. In the past, there was always conflict in the HPS. They used to fight here, it was crowded with people victimized by urban violence. They are now very few if compared to before. Back then there was always a fight. Now it's elimination. The logic is to eliminate each other. That, or the police kills them, then brings them here, pretending they didn't let them die. Most of them won't even make it to the hospital, they die on the street.* (Nurse working at the HPS for 25 years)

The hospital is the territory of the street, the gut of the city. It must digest whatever is spit out of it. But it ruminates, as it attempts to spit out that which is perceived as alien from its bowels. Woven of institutions, the city

13 "Most Brazilian police structures remain strongly committed to anti-democratic values and an anti-humanist training, characteristics that constitute the anteroom of violent and discriminatory practices" (Rolim, 2007, p. 13).

14 Nego-Chico, Sarará da Vó (Dornelles, 2008). The alias exposes the race as an inventory of racism. Animalization, physical-genital exacerbation, and intellectual incompleteness are perceived as inherent to black men (Conrado & Ribeiro, 2017).

is the outside that is always inside. It is when military brigade operators carry out ambiguous operations. They are the "escorts" (collecting the pain) of men in the access to health care, while the "vigilantes" (punishing the pain) of the city in a state of emergency. Sovereign power and life management merge in a clash between a principle of justice at odds with the democratic order.

The stories perceived in the therapeutic-penal itineraries provided by ethnographic research are countless. Rafael (23) was one of the young people admitted into the HPS custody room. With one side of his face still swollen and bloody, he voices his resignation to the other two health users. It was his first "arrest." He had been captured with an *Airsoft*[15] gun in an attempt to rob a military police officer outside his work hours. Identifying the fake weapon, the latter fired two shots, one in the face and the other in the back, on Rafael's shoulder. The young man in custody confided his version: "*I was stretched out on the floor struggling with pain and the policeman I tried to rob, and two more brigadiers look at me and say: 'so, are we going to let him die or do we take him in? We can't, he just got shot in the face*'".

Felipe (15) witnessed the policemen's inquiry regarding Rafael's fate and survival by the military police. He was taken to the HPS that night after arguing with his girlfriend at a neighborhood party and witnessing an armed confrontation between the police and drug dealers in the area. His arm started to bleed. Frightened, he headed home so that his mother could accompany him to the hospital until, halfway there, a vehicle stopped the car. Military police snatched the boy from inside the Uber and declared: "*Now you're going to bleed until you die*". But how could they leave him to die if he took a shot to the arm? The police skip the hospital and take Felipe straight into the corpus delicti examination. There the expert doctor finds out: he had also been shot in the abdomen. He must be rushed to the trauma hospital.

It took him three months, six surgeries, two anaphylactic shocks. "*I almost watched you die, boy*", said the doctor. These situations, such as witnessing Felipe's mother faint when seeing her son intubated or her struggle to prove her son's innocence, allowing the boy to be moved to an unchained stretcher and the right to having herself and his sister's presence as companions, instead of the custody of a socio-educational agent, are the source of suffering for health professionals.

Except for the military brigade professional, who uses only handcuffs, Susepe agents use heavy-gauge chains to secure the patient's ankles to the stretchers; a strategy adopted so that the health professional can perform procedures involving (re)turning the body face down, on from side to side, if needed. Handcuffs for the arrival, transit, and departure. Chains for the stay. Socio-educational agents do the same while escorting teenagers in compliance with a socio-educational measure. All these boy-men are the "custodians" of the hospital; a nomenclature that seems to appease the dissonance arising from the clash of the terms "prisoner" and "patient"; as well as "teenager" and "criminal".

Perpetually acting devices (handcuffs, chains, weapons, cameras, computerized systems) have a progressive effect on the force of power previously exerted on the minds of men. An orthopedics intended not only for disciplining a potentially dangerous body but also for the body performing this representation itself.

But legal intervention and discipline are also part of the punishment economy. Modern institutions demand that bodies be individualized according to their scope, and also for training, observation, and control. The discipline that goes beyond the organization of the hospital, for how public security uses this territoriality, allows for the differentiation of the general economy of power. Codes and laws are swollen with new rules. Thus, the mechanisms of discipline also intensify, there is more surveillance, control, classification, search for the pathology behind the behavior. Law, discipline, and security are layered in series (Araújo, 2009).

Survival is at stake. It is a matter to be tested by the maximum extralegal power, such as the police car, which, when transporting those men injured in violent conflicts, takes hours before arriving at the emergency service. A pact with fate: living body or dead body. The pain of the other is an instrument of justice and, if justice is not served, criminals should at least receive punishment from those who arrest them.

In the present and multifaceted ethnographic field, it is important to understand what bare life consists of; the first approximation made by Giorgio Agamben (2015) was through the distinction between *zoé* and *bíos*, made by the Greeks. He emphasizes that such terms were applied in the designation of different portions of what is simply understood as "life." While *zoé* referred to the simple fact of living (this fact is identical to all living beings, whether men or animal), *bíos* was the name given to a specific way of living, characteristic of a simple individual or collective – in other words, *bíos* symbolizes "a qualified life, a particular way of life" (Agamben, 2003, p. 9). If the political space is occupied only by *bíos* (qualified life) in the classical world, modern times functioning calls for the inclusion of the *zoé* (merely biological life) – and the body, stripped of political substance, becomes the target of absolutely any intervention; "killable life", a "life unworthy of living", which can be murdered or tortured without constituting a crime (Agamben, 2003). It is here that life precisely coincides with the political space, in which exclusion and inclusion, *bíos* and *zoé*, law and fact, inhabit an area of indeterminacy (Arán & Peixoto, 2007). Thus, the exception structure shifts into the biopolitical paradigm of current governments.

15 *Airsoft* is an action sport that simulates combat situations. To that end, it uses pressure guns that fire 6mm diameter plastic spheres. In Brazil, *airsoft* is regulated by the Brazilian Army and an orange tip is required in all equipment.

The State of exception suspends the legal framework, but does not disdain this system, on the contrary, they coordinate to compose the very logic of the exception: "The State of exception represents the inclusion and capture of a space that is neither outside nor inside, in a relationship of inside/outside, inclusion/exclusion, anomie/nomes" (Agamben, 2003, p. 56).

Within those multiple security strategies arranged between the street and the hospital, prevails the so-called "killing in the guise of letting die". The denial or suppression of the subject as a victim impacted by a health issue is the characterizing factor of the punitive decision model (Carpentieri, 2012). We must point out that, between the validity of the classic legal system and the gradual establishment of the modern legal system, there is a process of redistribution which permeates the entire "economy of punishment." In *Discipline and Punish*, Michel Foucault reconstitutes this process, linking it to a rearrangement of the technology of truth within legal practices. In the case of the classic legal procedure (16th-18th centuries), *torture* was both a core technique to extract the truth and an act of punishment. Given its truthful effect, "torture is a technique and should not be equated with the extremes of lawless anger," a hierarchy of suffering imposed by a "pain codex" (Foucault, 1999, p. 30).

The punishment on the sly, on the back of an alley, or any given street corner is a secret agreement, an informal contract between "good people" and the police, allowing them to kill, if necessary, but also offering the body an institutional path. Extralegal force is predictable and attractive (Ralph, 2017), perhaps for this reason Susepe is not as much the core of public safety as it seems, despite standing in between extralegal and legal rulings. The silencing of legal punitive techniques ranges from the blurring line separating a shot in the back and a shot behind someone's back[16], to the social and political losses that incarceration causes in the lives of detainees and their families. Other examples couldbe the cases where there is a lack of pre-hospital care (Samu), where extralegal decisions are provided by the military police. Punitive links are easily executed when nothing is institutionalized. After the confrontation, should the injured person be taken to the Emergency Department (DPPA) or the Trauma Hospital? How are these flows decided? It is clear that allowing the subject nothing (which would be) their lawful right is also part of an economy of death.

Final considerations

Our analytical considerations explained how medicalization and criminalization processes are two faces of the same coin in a vast territory composed of multiple social actors involved in the care of men injured in violent conflicts. We start with the moral economy behind health practices, that is, the different ways of perceiving the subject, as the moral valuations supporting such actions are also found in the relational axis between health professionals and users, and also between the two parties and the public safety professionals.

In a second moment, we exemplify how the ambiguous operations between making live and letting die carried out by public security operators reveal the absence of the state in impoverished areas of the city. In the inseparability between city and institution, armed conflicts in outskirts territories affect and stress the inner halls of trauma hospitals. The economy of punishment, in terms of the context and subjects to which it is directed, greatly prevails when police operations are hidden and distanced from other public policies.

Those are well-known situations. This refinement of punitive techniques speaks of the suffering of detainees with psychological and social consequences unacknowledged by society. Understanding power strategies, especially those of sovereign power in biopolitical technologies, is, above all, perceiving the metamorphosed punishment within the circuit of public security in the field of health care.

Homens entre saúde e segurança pública: a violência nos hospitais de trauma

Resumo: Em pesquisa de perspectiva etnográfica realizada em dois hospitais de trauma no município de Porto Alegre (RS), buscamos explicitar as convergências e divergências na intersecção entre práticas de saúde e de segurança pública voltadas aos homens vítimas de conflitos violentos. Analisaram-se as narrativas de múltiplos atores sociais (profissionais do campo da segurança pública e da saúde), bem como os fluxos de atendimento desses usuários de saúde e seus familiares. Os operadores conceituais centrais são inspirados nos estudos sobre tecnologias de poder (Michel Foucault, Giorgio Agamben), economia moral (Didier Fassin), masculinidades e violência. Concluímos que o hospital está firmemente articulado ao dispositivo da segurança pública por meio de práticas discursivas que fomentam a produção de masculinidades criminalizadas.

Palavras-chave: saúde, homens, segurança pública, criminalização, medicalização.

16 There is the shot in the back and the shot behind the back, which could be further discussed in the field of criminology on a different occasion. The crime will cease to exist if deemed self-defense, pursuant to Article 25 of the Penal Code. However, what constitutes a justification for the use of firearms depends on a series of contexts analyzed on a case-by-case basis. According to Rafael's account, after being shot in the face, he turned his back to try to flee and, only then, he was shot in the shoulder (Greco, 2008).

Les hommes entre la santé et la sécurité publique : la violence dans les hôpitaux de traumatologie

Résumé : Une recherche basée sur une perspective ethnographique a été menée dans deux hôpitaux de traumatologie de la ville de Porto Alegre (RS), nous avons cherché à décrire les convergences et divergences à l'intersection des pratiques de santé et de sécurité publique à l'encontre des hommes victimes de conflits violents. Des récits de plusieurs acteurs sociaux (professionnels de la sécurité publique et de la santé) ont été analysés, ainsi que les differents chemins utilisés par ces hommes et de leurs familles à la recherche de soins. Les opérateurs conceptuels centraux s'inspirent des études sur les technologies de pouvoir (Michel Foucault, Giorgio Agamben), l'économie morale (Didier Fassin) et les masculinités et la violence (Waldemir Rosa). Nous concluons que l'hôpital est solidement lié au système de sécurité publique par des pratiques discursives qui encouragent la production de masculinités criminalisées.

Mots-clés : santé, hommes, sécurité publique, criminalisation, médicalisation.

Hombres entre la salud y la seguridad pública: violencia en hospitales de trauma

Resumen: En una investigación desde una perspectiva etnográfica realizada en dos hospitales traumatológicos de la ciudad de Porto Alegre / RS, se buscó explicar las convergencias y divergencias en la intersección entre prácticas de salud y seguridad pública dirigidas a hombres víctimas de conflictos violentos. Se analizaran narrativas de múltiples actores sociales (profesionales del ámbito de la seguridad pública y la salud), así como los flujos de atención de estos usuarios de la salud y sus familias. Los operadores conceptuales centrales se inspiran en estudios sobre tecnologías de poder (Michel Foucault, Giorgio Agamben), Economía moral (Didier Fassin) y masculinidades y violencia (Waldemir Rosa). Concluimos que el hospital está firmemente vinculado al sistema de seguridad pública a través de prácticas discursivas que incentivan la producción de masculinidades criminalizadas.

Palabras clave: salud, hombres, seguridad pública, criminalización, medicalización.

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