

Institutional violence and humanization in health: notes to debate

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Abstract *This paper starts from humanization policies and the academic debate around them to reflect about institutional violence inside health services. Based on research on scientific publications in Collective Health, it was observed that violence in relationships between health professionals and users – which is at the core of the humanization's debate – is conceptualized as an excessive power in exercise of professional authority. Using Hannah Arendt thinking as theoretical contributions regarding the concepts of 'authority', 'power' and 'violence', our objective is to define and rethink these phenomena. Melting these reflections with the history of institutionalization of health in Brazil, and especially the changes in medical work during the twentieth century, we conclude that the problem of institutional violence on health services is not based on excess of authority and power of professionals, but rather in its opposite. When there is a vacuum of professional authority, and relationships between people do not happen through power relations, there is space for the phenomenon of violence.*

Key words *Violence, Power (psychology), Health services, Humane care*

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Introduction

The present reflective essay is one of the products of the research carried out regarding the ongoing academic and political debate of humanization in health in the field of Collective Health¹. The relevance of examining such debate is evidenced by the growing number of publications on the subject, reinforced by enactment of a national public policy in 2003, namely the National Humanization Policy (PNH).

The objective of this study was to identify the different themes and conceptions of humanization within the aforementioned debate, addressed through two documentary bodies that are the empirical basis of the research¹: the bibliographical production in Collective Health, resulting in the analysis of 98 scientific publications, as well as the official texts of the PNH.

Examination of these documents showed how the contents of the national policy, were consistent with the publications of the field, and ended signaling institutional violence as one of their main targets¹, linking deeply both institutional violence and humanization themes.

In this essay, we will examine the link between institutional violence and humanization in the way it is presented in the academic debate developed in the scientific publications examined, as a reflection on one of the main results of this research.

Both at international and national levels violence is recognized as a social and health issue, and a subject of research in several countries. These studies show that in addition to the economic and infrastructure problems that the various health services suffer, there are socio-cultural aspects related to violent institutional practices²⁻⁵. Empirical research through interviews with professionals and users of the most diverse services show that health violence issues are not personal or isolated matters^{6,7}. The consistency and largely spread distribution of episodes of violence characterize it as an institutional matter, implying that there are elements within the structure of the relationship between the service and the user that embed violent relations. This violence may be expressed⁸ as neglect in care, as different forms of social discrimination and physical or even sexual violence. The content of the reports, in spite of contradictions, express the perception of the urgency with which this problem needs to be faced: *Then they went to do the touch examination, the damned touch examination. Because he went with all his force. Sheesh, I*

think it hurt more than in labor. That's why I did not like him. [doctor]. Because I do not think he went with... If that was delicate, whatever wasn't delicate would kill me [...] Then came a lady doctor [...] So nice, I think she was about forty years old, sort of, she was so nice. She broke my water, did the touch exam and I did not feel as much pain as the with the man⁷.

However, although the subject is being explored extensively, a number of problems remain in debate.

Perhaps because of its complexity or because of the great diversity of epistemological perspectives and methodological designs, Collective Health studies appear to be more (perhaps due to its pragmatic character, as pointed out by Paim and Almeida Filho⁹) about 'how to fight' the institutional violence than to question 'what is' institutional violence, thus identifying its causes and effects. Because of this, we observe series of conceptual overlaps that hinder the already complex debate about violence within this camp. Thus, even though Collective Health is a field deeply marked by the use of Michel Foucault's philosophy, which insists on the existence of a fundamental difference and discontinuity between power and violence^{10,11}, is usual in texts of this area to conceptualize violence and power as synonyms^{12,13}, to look at violence as a product of excessive power¹⁴ and the lack of distinction between authority and power¹⁴⁻¹⁸.

The same can be said about the use of humanization within the field of Collective Health. Corroborated by the vision of several authors¹⁹⁻²⁶ who criticize an overly generic use of the term. All through the bibliographic survey¹ the term 'humanization' appears mainly in the form of proposals to confront, contain and discourage violence within the health services. Thus, it will not be the purpose of this paper to propose a positive conceptualization for humanization, but to dwell on these notions, namely, authority, power and violence, which appear to be causes of institutional violence within health services and create the need to debate the proposals and the humanization policy.

Thus, in order to bring new contributions to the already existing debate, we will proceed to two orders of consideration. First, we will present a possible reading of the concepts of 'authority', 'violence' and 'power', distinguishing them from those identified in the Collective Health publications in the theme of humanization. We used as a main reference the reflections of Hannah Arendt. Ms. Arendt is a thinker that resorts to ethical-po-

litical and above all moral issues, and considering that we can approach health practices, and in particular the medical practice as a technical set of actions quite dependent on the ethical and moral dimensions²⁷, we may have a glance of the potential of the Arendtian contributions in order to expand our understanding. Next, we will focus on the adjective ‘institutional’ that follows the ‘violence’, that is, we will articulate these concepts with the history of the institutionalization of health in Brazil, finally inserting them in the debate of the field of institutional violence.

However, some observations of a methodological nature are needed in which our considerations are anchored.

Methodological aspects

Collective Health can be defined as a field of production of interdisciplinary knowledge, at the intersection between the Science of Nature and the Human Sciences. While the former are concerned with the regularities of phenomena through general laws of functional character of causes and effects, the latter would be concerned precisely with the singularity of the phenomena²⁸. We chose Hans-Georg Gadamer’s reflections to work on this intersection, as a methodological reference for the present work. The author²⁹ constructs a critique of the Cartesian method, stating that the exclusive use of reason excluding tradition and authority, obfuscates alternative ways of approaching the truth, in addition to not achieving the “clear and evident” certainties that the program of modernity prescribes. Gadamer rejects the truth as adequacy, meaning that it is possible to achieve a correspondence between the human perception of the object that one wants to know and the way the object is.

The Gadamerian critique of the impossibility of a complete correspondence between the knowledge about an object and the object of research itself is anchored in the author’s view on language. This has an inseparable connection with tradition: the use of words necessarily resonates with the meanings they have had in the past, even though they are operative in the present with new contents. In this way, rational itself can only be understood within the parameters of tradition and never outside of them. It implies regarding the observing subject (the subject of knowledge) as historical and contextual, impossible of a neutral and direct apprehension of the world. All knowledge, in this sense, is interpreta-

tion and it is impossible to grasp the objects of the world as they are, as new contexts necessarily generate new interpretations. The knowledge of philosophical hermeneutics does not seek to seek constant, verifiable and predictable repetitions of empiricism, but precisely its opposite: it seeks the unique, something that is experienced out of the ordinary.

Thus, for Gadamer²⁹, we know the world not through a method, but through a horizon, since the acquisition of language and the process of acculturation constitute a perspective of the world through which we see it. The Gadamerian hermeneutics does not develop a set of universal rules for the conduct of the human sciences, but argues that interpretation takes place through the “fusion of horizons”²⁹, between the horizon of the reader and the horizon of the text. The author tries to postulate above all that there is no neutral interpretation, but that the final result is the junction between the historical perspective of the interpreters and their reading of the text.

Therefore, there is no knowledge without presuppositions as postulated by the Enlightenment and Positivism, but instead all knowledge is inevitably marked by the pre-judgments of the author and the social context that surrounds it.

What is most interesting with regards to Gadamerian hermeneutics is the fact that the author’s reflections preclude a vision in which there would be a pure or correct interpretation. In our context, this means that the meanings we present of ‘authority’, ‘violence’ and ‘power’ are not the only ones possible or better than the others. Rather, our interpretation is different from the others and can enrich the debate in the field of Collective Health. Therefore, we believe that Hannah Arendt’s theoretical reflections on ‘authority’, ‘power’ and ‘violence’ can contribute with new interpretations for the field of Collective Health, since it is a theoretical set that has not yet been fully explored³⁰⁻³².

Power, violence and authority within the theme of humanization

In the academic debate of the analyzed publications, power, violence, and authority emerged as conceptually related categories. The authors consider power and authority as equivalent concepts and postulate that both would condition the phenomenon of violence. In this sense these authors analyze that the inequality of power or authority within the relationship between health professional and user would stimulate the phe-

nomenon of violence, being this an excess of the former two.

These examined researchers understand that professional authority would usurp the speech and knowledge of users¹⁵. Authority is also seen as the element of the relationship between health professional and user that would justify control, which would require submission and obedience: “The woman is expected to be submissive, obedient, passive, silent and accepting of the authority of the professional as he is the one who has the right to control and prescribe schedules, expressions, mobility, among other behaviors”¹⁴. Correspondingly, researchers see authority as the basis for a violent relationship between the professionals themselves¹³ and come to equate authority and tyranny¹⁸. From these reflections, the researchers’ conclusion is that professional authority should in any case be avoided: “The harsh reality shows us that nurses are, for the most part, dissatisfied with their work and the recognition of their profession; they experience difficulties in communicating with the patient while demonstrating authority”¹⁶.

The power appears, in the selected publications, being used closely to authority, and sometimes as synonyms. Thus, power is treated as embedding the possibility of the exercise of violence as if power and violence were consubstantial: “as a Problem of Power: When physical, psychological or moral violence is practiced directly or indirectly by a person or group of persons, against another person or group of persons or things. Violence is only the instrument or the expression of power, and this is the crux of the question”¹³. In the more concrete level of health practices, power is seen as the concealment of information about the procedures and patients’ health status by the practitioners, with the goal, as in the case of the authority, to render more unequal the relationship between professional and user⁸. Within this inequality, power is seen as the element that would lead to the predominance of practitioners’ will on the bodies of users; any form of restriction of freedom, including the decision on life and death¹⁴.

Considering these reflections, the selected publications see authority and power as mechanisms for perpetuating an unequal relationship between professionals and users, whose purpose would be to maintain a relationship of submission, control and objectification of the other. Authority and power, thus, would be the origin of the problem of violence in health. Therefore, the solution to the problem of violence in health

would be to diminish the authority and power of professionals, including the understanding that the opposite of asymmetry is emancipation: “The proposal of humanization is an important reference point for transforming the highly hierarchical professional-patient relationship into an emancipatory interaction”³³.

But let us examine better this proposal to transform the relationship between health professional and user in a relation between equals, even when it seems like a complicated proposition to support from the theoretical and practical point of view.

The relationship between health professional and user is, by its very constitution, a relation between non-equals, since there would be no reason for a patient to seek a doctor if he did not believe that there is an asymmetry among them, at least in relation to knowledge about diseases and therapies. As the sociologist Paul Starr³⁴ puts it, the technical authority of the profession is based on the scientific legitimacy of its knowledge and on the society’s dependence on that knowledge. However, authority does not invariably unfold in command-obedience relationship, as the publications seem to understand. As we will show below, the Arendtian interpretation argues that one of the relational situations that do not belong to the authority is the one referring to automatic obedience.

Liberal medicine: authority and tradition

Contrary to the selected publications in the field of Collective Health that see authority as a problem because of its predominance in contemporaneity, the historical-interpretative analysis of Arendt³⁵ takes note of the existence of a deep crisis of authority in the modern world. Arendt understands authority as a specifically asymmetrical relationship between two individuals. This difference between the two poles of the relationship is not based on violence, as in a relationship between master and slave, nor is it based on persuasion and conviction, since these can only exist within a relationship between equals: “[...] what they [the one that commands and the one that obeys] have in common is the hierarchy itself, whose right and legitimacy both recognize and in which both have their predetermined stable place”³⁵. Authority in Arendt is based on the recognition of the two poles about their unequal condition.

In this reading, institutional violence would not be linked to an excess of authority, but to its

contrary: "(...) The authority excludes the use of external means of coercion; where force is used, authority in itself has failed"³⁵. If it works neither by violence nor by persuasion, what is the mechanism of authority? How may it produce any kind of obedience? According to Arendt, authority is "more than advice and less than an order"³⁵, therefore authority lies precisely in this nebulous terrain between a relationship between equals that functions through persuasion and the relation of violence. For there to be the authority it is necessary that this is endowed with legitimacy. In this way, the crisis of authority is a crisis, above all, of legitimacy. To understand this crisis, it will be necessary to present Arendt's reflections on the concept of tradition.

The tradition in Arendt³⁵ is understood as the postulates of the past that aided the men of the present in the moments of (In)decisions, of difficulties and changes. These postulates are questioned during the Modern period, mainly because of the new place of science in the life of society. Thus, the thread linking the past to the future is broken by the imperative of Cartesian doubts that puts in check every form of authority, hierarchy and inheritance of the past. It is necessary then to think to what tradition medicine (as the first and main profession of health) binds itself, that is, what elements have helped physicians to name and select, transit and preserve.

Following the interviews conducted by Schraiber²⁷ with physicians from São Paulo, the tradition in medicine is linked to the ideology of liberal work, in which the producer has control over the means of production of his work. Thus, the liberal professional has autonomy over the flow of his clientele, the value of the exchange of his service, the way of organizing and producing his service, and a technical autonomy in making clinical decisions²⁷.

The image of that doctor who carried a small suitcase to his patients' home, knew their family, work and habits, is the social imaginary that conformed the traditional referent of medicine.

A low technology job, in which the professional based his decisions, on the one hand, on the anatomico-pathophysiological elements of the transposition of the abstract body of science to the clinical case and on the other hand, in the dynamics of life, work, customs and social conditions of their patients. Schraiber²⁷ shows that liberal medicine was still the time when practical knowledge, the daily work experience, took place in clinical practice. Thus, medicine as a liberal practice was anchored in the belief of physicians in their own

discernments, that is, they effectively believed in their ability to articulate abstract knowledge coming from science with the experience of practice, reinforcing the physician's person as a reference of prudent and safe intervention.

As a consulting profession, a fundamental aspect of liberal medical work is the construction of a good relationship with his patients, so that the doctor can prescribe the treatments that will be used in a given case, that these treatments are followed; and that the patient may look for him in case of need. Thus, it is necessary for the physician to gain the confidence of the patient within the clinical encounter³⁶.

Medical authority, in this way, gains social legitimacy because of several factors. Firstly, insofar as its therapeutic practices are socially recognized as efficient and effective in restoring bodies. In second place and following Starr³⁴, in the social dependence that is created in relation to medical knowledge and practices. Finally, as noted by Freidson³⁷, in their participation as 'men of state' during the nineteenth century, which allows them to create norms to strengthen their corporation, progressive legitimation of their technical knowledge and the biomedical sciences that support them, and gaining control (and sometimes exclusion) of any other therapeutic practices, finally acquiring, in a certain way, a 'monopoly on the body'.

The crisis of the tradition of medical work, from this perspective, has two consubstantial dimensions. First, it is the pressure of new (and expensive) health technologies that push the medical profession toward salaried labor. Secondly, the crisis in the tradition of medical work is the relegation of all these forms of knowing - from the patient about his body and his illness, from the doctor about everything that involves his patient beyond the body and disease and, finally, of the doctor's own experience - in relation to anatomical-pathophysiological knowledge of science.

Technological medicine and the medical work crisis

In the 20th century technological medicine, as the name itself reveals, science will become the great sorter of medical work. The machinery makes medical work impossible in the solo modality and the profession will be employed in institutions (public and private) that will have the means of production of the work. Although physicians continue to have technical autonomy,

they have lost control over client flow and negotiation over compensation. Thus, the figure of the liberal worker doctor is only as an idea in the social imaginary of the profession, a more ideological reference of the profession than practice materialized in society. As a matter of fact, we have doctors who work in a particular service in which the patients attended will be those that show up during their work period and, if it is not a basic care service, probably only for one or two consultations. In this situation it will be left to the doctor to treat his patient only in relation to that specific problem, emphasizing the logic of treating the disease much more than the patient.

On the patient's side, the reference for care ceases to be the doctor and goes to the health plan, hospital or service. Thus, patients do not seek a specific doctor, but will use the service that fits them by their health care contracts, or who is closer or better endorsed.

This phenomenon that affects the subjects of the care relationship, whether the professional agent or the service user, conforms to what Schraiber²⁷ called the 'crisis of the bonds of trust', that is, that the relationship established directly between doctor and patient during liberal medicine changes shape with the entry of a third element in technological medicine. Thus, this relationship becomes over determined by an external entity. The State or a private company determine the conditions under which this relationship will occur, which instruments, technologies, and medicines will be available, and how long the consultations may last and under which flow and assistance dynamics will occur.

The over determination of this relationship entails the de-personalization of the involved entities, in the sense that the physician becomes a name that appears in the list of a service plan contract and the patient becomes a number in the service queue. This transformation can be seen, for example, in the progressive reduction of consultation time and its almost complete replacement by lab tests. This change entails an increase in efficiency (of the service and not necessarily of the cure), but it brings with it the substitution of the patient subject, with all his context of life, by the almost immediate application of the biomedicine of the abstract body of science on the real body. The importance of technological devices has expanded so much in Modernity that the health professional becomes a mere intermediary between the patient and the technology; and from the point of view of the technique, more a hostage than an agent.

The process of diminishing the judgment of man in relation to the power of machinery is for Arendt³⁸, characteristic of modernity. The telescopic evidence that it is the earth that revolves around the sun and not the opposite, carried out by Galileo, raises the instruments created by man to the point of sifting through the truth, instituting in a general way the distrust of the human senses in relation to the search of truth. The distrust of medical judgment seems to grow in modernity in proportion to the development of instruments that would first aid the discernment of the professional, but which tend to replace it in the contemporary world²⁷.

So we see today patients who already 'know' the examination needed to detect a certain disease and the remedy needed to cure it. With this, authority over clinical decisions seems to be out of the hands of the judgment of professionals toward biomedical and pharmaceutical technology companies. The figure of the doctor as a reference of good practice is questioned and the crisis of authority seems to create in the professionals a series of defensive attitudes. These professionals seek to assert an authority they believe to be even more legitimate because of the further development of the scientific basis of their practice. Thus, they seek to impose their perspectives rather than to dialogue with the patient, ensuring such imposition by the control that still effectively have in access to the various technologies, diagnostic and therapeutic, and access to the health system itself. These attitudes reinforce the loss of interaction and present themselves in relationships in which authority is replaced by violence. Thus, the doctors' use of the former authority position that had previously occupied lost the legitimacy to do so, becoming just an exercise of command and control of the patient. In this situation in which, as it says Arendt³⁹, there is no power there, only violence.

While power is conceptualized by Arendt³⁸ as an orchestrated and determined action among men equal to the exercise of politics, and is an end in itself, violence is understood by the author as a means: "from the barrel of a gun emerges the most effective command, resulting in the most perfect and instant obedience. What will never emerge from this is power"³⁸. Thus, the more power, that is, the more we can decide and act together, the less violence. In this line of reasoning it remains to be seen to what end institutional violence in health would be a means.

It seems to us that institutional violence fulfills the role of adjusting the real bodies, their his-

tory and the subjectivity of the patient within the routines of procedures, bureaucracies and techniques of the health services. Contrary to liberal medical practice, in which the physician's job was to fit, through his judgment, the scientific knowledge of bodies in the abstract relative to the concrete body, through the famous imperative 'each case is a case', technological medicine reverses this relationship. Two orders of phenomena seem to condition this situation. From the point of view of productive dynamics within our society, the division of health work - the specialization of medical work and the emergence of all other health professions, referred to as paramedics by Freidson³⁷ - privileges the biomedical dimension in the treatment of health problems through the fragmentation of the body in autonomous units whose responsibility is a routine of constant and disconnected procedures. From the epistemological point of view, the hegemony of science (and byproducts such as technology) as the only criterion of truth in Modernity excludes from the clinical scene all sorts of other knowledge, ignoring the patients' knowledge about their own experience of illness and professionals' capability to judge the specific case through its singularities.

Through this way of thinking we can understand how cases of institutional violence in health are so different and so frequent. It is through these mechanisms that mental health users experience violence as the massification of their condition⁴⁰. Women feel violated in services if they do not have a standardized behavior during labor⁷ and they feel the service environment as constituting an industrial standard, such as a 'baby factory'.

Therefore, we defend that violence in health services is not based on an excess of power or authority of professionals. We do not see institutional violence as caused by tyrannical power on the part of health practitioners, as if they were imposing a personal will on the bodies of the users. The landscape that appears in the reports¹ within the field of Collective Health shows violence perpetrated within health services as the literal and unrestricted imposition of technical, management and technology standards. Thus, violence seems to have been originated by the end of health authority of professionals and the emptying of political spaces of power within the clinical relationship, taken as a result of technological development, by the division of health work that generates a piecemeal mechanism of care and new conformations of work within health. It is not a question of excluding the division of labor

or the technology of services. Instead, the great need seems to be how to find a balance between technological development and the new conformations of the work with the singularity of each case. What makes each case (in truth, each subject) unique is precisely the element that cannot be encompassed by science or its technological derivations.

Singularity is not the object of science in its quest for uniformity and constancy in the phenomena it studies. The singularity, in truth, is object of the care that seeks the transposition of the abstract entities that science creates for the real bodies of the clinical cases.

Final considerations

First, it is important to note that the criticisms of technological medicine and its comparison with the previous model do not mean that we defend a return to the times of liberal medicine, as a romantic nostalgia of the past. The institutionalization of health work, the division of labor and the scientific-technological development of the area were decisive changes for the access of large portions of the population, since in liberal medicine, service coverage was restricted to elites and small portions of urban middle classes³⁶.

Secondly, it seems that the problem of institutional violence on health is not a problem that can be solved through educational changes within the curricula of health graduations. As our interpretation generates a critique of the place of science within the regimes of what is truth in contemporary societies and the new conformations of health work, educational proposals can act on the first question but hardly affect the second.

The crisis, for Arendt³⁵, is not seen as a maladjustment that can be fixed without disturbing the general functioning of the structure. The crisis appears to be an opportunity for change. Also it may be an opportunity to reflect and transform. Thus, we feel fundamental to rebuild the authority of health professionals. As we have already said, it is not a question of returning to the medical authority of liberal medicine, but rather constructing something new, which includes other professions from a collective and multiprofessional perspective. It is necessary to build health practices with multiple knowledge and lores, scientific or not, to be able to compose a collective judgment on each real case. In this sense, our approach is close to the reflections by Ayres⁴¹ regarding technical success and practical

success. The first would be the strictly scientific and technical dimension. But in order to reach the dimension of practical success, it will be necessary to include the patients' knowledge about their bodies (and how are they used), their experience of illness and practical knowledge from the experience of the professionals.

The problems generated by the new conformations of health production can be worked through mechanisms of direct democracy, which the Brazilian national health system (SUS) poses a large vanguard role since the constitution of 1988. In this situation, contrary to the clinical encounter that we understand to be necessarily an asymmetrical relationship, the distinctions between professionals and patients/users must be

left aside due the social investiture of both as citizens. Closer and more democratic management practices seem to be the most appropriate way to deal with the violence generated by bureaucracy and work routines.

Finally, we would like to reaffirm the importance of the philosophical contributions that have a privileged place in Collective Health within the great area of Health. The conceptual distinctions and the different visions that the philosophical contributions bring about the social phenomena are a very interesting attempt to enrich the debate providing a fertile ground for new proposals in the area of Health. The reflections of Hannah Arendt seem relevant in this sense, in order to contribute to the Collective Health debates.

Contributors

Authors YN Azeredo and LB Schraiber participated equally in all stages of the article.

Acknowledgments

This paper was supported by CNPq.

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Article submitted 05/01/2017

Approved 18/04/2017

Final version submitted 12/06/2017