

## Authority, power and violence: a study on humanization in health


Autoridade, poder e violência: um estudo sobre humanização em saúde  
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Autoridad, poder y violencia: un estudio sobre humanización en salud (resumen: p. 15)

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This article is the result of the dissertation “Collective health and philosophy: Hannah Arendt’s contributions to the humanization debate” aiming to analyze the humanization concept in the production of the Collective Health field. The study used qualitative methodology, and the empirical material was constituted by official documents of the Ministry of Health as well as selected articles in the field of Collective Health. It analyzed how the term humanization is used, trying to apprehend how it is understood and built as a concept. The reference framework was constituted by the bibliography that examines the historical context of social transformations through which working on health in Modernity has gone through, added to the reflections about the concepts of violence and power developed by Hannah Arendt. Conceptual distinctions necessary in the configuration of medical power in health services were acknowledged, providing new approaches to the topic of humanization.

**Keywords:** Humanization of care. Dehumanization. Health work. Health services. Violence.



## Introduction

Health is going through times that are especially conducive to reflection. The questions of this research arise from the discomfort experienced by those who care to discuss the current debates about humanization in health with an attentive look: the Brazilian population is going through experiences of violence when seeking health services. Violence within services has become something so daily that the humanization of health emerged as a social demand for respect to the rights of the population and as a public policy that seeks to act on this violence.

Violence suffered by users whenever they seek health care is a serious problem being also far from circumstantial: this issue arises at all levels of health services, in public and private institutions alike, and reaches the entire national territory. It is such a remarkable phenomenon that research made by the Ministry of Health show high rates of complaints about mistreatment and lack of understanding of demands and expectations of users in health services. As the Ministry of Health itself acknowledged, these issues call more the users' attention than the lack of doctors, infrastructure of services, number of hospitals and lack of medications<sup>1</sup>.

Considering this background, organized social movements raise the banner of humanization, i.e., they fight for ensuring the rights of patients and users, for the guarantee of their physical and psychological integrity and the end of violence in health institutions.

Until the year 2000, the term humanization referred to users' struggle to respect their rights in specific contexts. The social movement for the closure of asylums and psychiatric reform of the 1970s fought against the deeply violent reality in which the users of mental health services lived.

The presence of violence in health practices has also been denounced by the feminist movement since the 1970s. This banner is particularly raised in relation to women's reproductive rights; in relation to children admitted to ICU; as well as in the quest for improving the quality of care to users in health services<sup>2,3</sup>.

In social struggles, humanization is a motto that provokes synthesis and agglutination. 'Humanization' makes the demands of social movements self-explanatory. Presently, whenever 'humanization of childbirth' is mentioned, thoughts are immediately referred to the violence that women suffer during childbirth, as well as 'humanization of mental health' reminds us of the precarious conditions of asylums.

## Methods

This study is a theoretical-conceptual contribution using documentary analysis as its empirical basis. The documents have two distinctive natures: on the one hand, the official documents of the Ministry of Health on humanization while on the other we used studies and empirical researches that have been published and are considered as significant textual productions on the theme of humanization in health, with the help of a review of the production on the Collective Health knowledge area. As a first



revision aiming at this conceptual examination, we tried to configure it as a survey of the 'state of the art' of studies on humanization.

For this purpose, a survey of official documents was carried out at the Ministry of Health website, and additionally, the study conducted another survey of articles and thesis, hereinafter referred to as 'scientific publications', at the LILACS and SCIELO-Brazil databases, in which the bibliographic production of Collective Health was queried using the keyword 'health service' crossed with the terms 'violence', 'humanization' and 'dehumanization'; and the keyword 'health work' also with the terms 'violence', 'humanization' and 'dehumanization'. In addition, the term 'clinical encounter' was queried separately.

These publications were selected according to the following criteria: with the term 'violence' we chose articles that privileged an approach to the relationship of the health professional with the user and the relationships among health professionals: we searched for productions that dealt with situations of violence involving professionals, exception made of those in which users may have suffered it in the community; or productions that study situations in which users are violent with professionals. Using the terms 'humanization' and 'dehumanization' we looked for those publications that pondered about the practices in the services -and not regarding the training of professionals. Under the term 'clinical encounter' we looked for publications that focused on the meeting between professionals and patients - or users of health services - as a practice and not as a subject of teaching future health professionals. In a final stage we eliminated duplications in each uniterm.

Reading of official documents and publications was based on hermeneutics as understood by Hans-Georg Gadamer<sup>4</sup>. For this author, there is no production of a universal and timeless knowledge, the truth itself, because knowledge always carries the anchor of the language that transmits it, and this has inseparable connection with tradition: the use of words necessarily resonates with the meanings they had in the past, even though they are operative in the present with new contents. In this way, the rational itself can only be understood from the parameters of tradition and never outside them, as if it inhabited a neutral locus. The subject is observed as historical and contextual, incapable of a neutral and direct apprehension of the world. All knowledge is interpretation and it is impossible to apprehend the objects of the world as they are - new contexts necessarily generate new interpretations. Philosophical hermeneutics does not seek constant, verifiable and predictable repetitions of empiricism, but precisely the opposite: something that is unique, that is experienced out of the ordinary. Therefore, for Gadamer<sup>4</sup>, 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.

Our objective in this research was not to define what humanization is as opposite to all other interpretations, but, in the first place, to enable a certain organization for a debate in which humanization has multiple and varied meanings while, in a second place, we aimed to contribute to this same debate with a new interpretation on the theme.

## Results

### Official documents

The National Program for the Humanization of Hospital Care (PNHAH in the Portuguese acronym) was the first governmental program of the Secretariat for Health Care of the Ministry of Health, lasting from 2000 to 2002. It predates and launches the pillars of the constitution of the National Humanization Policy (PNH in the Portuguese acronym) of 2003. A detailed analysis of these documents is in Azeredo<sup>2</sup>, used as a basis to present the main conclusions, as follows.

Although the PNHAH addresses hospital issues and the PNH proposes a general change in all levels of care in the health system, both texts are quite similar. These documents highlight the advances in the health system in the last decades, but point out the contemporary challenges: fragmentation of the work process, difficulty of interaction among teams, unpreparedness to deal with the subjective dimension, few devices for co-management and disrespect for users' rights.

The program and politics present a multiplicity of meanings for humanization. This is understood as a proposal to modify the relationship among actors, opposing humanization to the mistreatment suffered by users in services, due to the diagnosis that the training of professionals is precarious. Humanization also appears as improvements in the working conditions of professionals. Another meaning attributed to humanization is the promotion of autonomy and the inclusion of users and professionals in decision-making processes.

Although they point out important references for humanization, such as co-responsibility, autonomy or protagonism, the texts do not explain how and why these ideas concern humanization, to which conceptions and practical acts correspond, reinforcing generic and polysemic apprehensions. It ends up producing the union of several agents of health practices around imprecise notions that are later unfold into practices, many times, distinct from each other.

In this way, the generalities in the treatment of practices that are pointed out as those that would be humanized incur in the danger of ideologization, i.e., assuming this thought more as an ideology than an interpretative analysis of reality. On the other hand, there is the risk of letting the terms to become mere slogans or jargons lacking a clear mastery of their meaning.

Additionally, it calls the attention to the fact that the diagnosis of the current functioning of SUS in the documents mentioned, does not bring any historical hypothesis explaining how we arrived at the problems of the present.



## Scientific publications

A total of 98 publications were selected for final analysis<sup>2</sup> from the set of papers surveyed. The first examination conducted sought to classify them according to the approach to the problematization of humanization. The literature on the subject indicates the existence of a multiplicity of dimensions that would be considered substantively as humanization, therefore engendering a multiplicity of definitions about humanization. Thus, we categorize humanization in four different approaches: 1. Criticism of contemporary technicism in the health area; 2. Transformation of the relationship established between practitioners and users; 3. Changes in work management; 4. Project of permanent education for professionals.

We grouped these four approaches in two polar situations in relation to how they framed health practice: the first two constituted situations of the relationship between professionals and users; while the last two pointed to management situations. The publications were discriminated taking into account whether they approach humanization through the examination of the hierarchy of work, the organization of the service and the division of work, or whether they approach humanization from within the work process, through the interaction between the professional and the user.

Among them some aspects stand out: production on the subject grows over time; studies focused on discussing management and approaches framing professionals; studies focused on the theoretical contributions of social representations; volume of primary data production that can still be considered scarce. Thus, it draws attention to the fact that for a recently-admitted problem in the field of Collective Health, therefore demanding for this very reason, original conceptual elaboration, there is a lack of diversity in terms of studies or theoretical references used. At the same time, they present different meanings for humanization that do not dialogue among themselves.

This bibliographic production is also examined here from the theoretical perspective, in terms of the exploration of the notion of 'care' underlying the published study, and in terms of the conceptualization of 'humanization'. This examination sought both the definition of these terms throughout the publication and the use of these notions in the epistemological relationship between the topics: 'introduction', 'methodology', 'analysis/interpretation' and 'discussion' of the data. This examination was based on the theoretical formulation on health care made by Ayres<sup>5</sup> and the theoretical formulation on the epistemological relationship between political-political engagement and the production of scientific knowledge made by Schraiber<sup>6</sup> and applied in an examination of the bibliographic production of Collective Health regarding the use of the concept of gender by Araujo *et al.*<sup>7</sup>.

Regarding 'care', Ayres<sup>5</sup> points out two articulated dimensions: the one of the technical success, referring to the means and ends of the intervention delimited by biomedicine, and that of practical success, which refers to intersubjective relationships that value the perspective of care brought by the users, as part of their understanding of illness and recovery, and in this sense, shared interventions in the professional-user relationship. In that sense, publications can be examined regarding the presence or not of the problematization of care to be provided from the perspective of the humanization of both dimensions, with clear emphasis on the valorization of practical success, which replaces the user as the



participant subject of the assistance intervention itself. However, what was observed was that practical success is the subject of just 34 of the publications.

Regarding the ethical-political engagement articulated to the production of knowledge, the two studies cited will point to the importance of recognition, in the research questions brought by social movements for the improvement of attention to individuals and populations. Nevertheless, the articulation with the production of scientific knowledge would require an additional stage, in order to incorporate, additionally to the perspectives of social movements, building conceptual explanations/understandings as part of the social and cultural determinations of illness and care. It is in this sense that Araújo et al.<sup>7</sup> examine the use of the term 'gender' as an activist motto and as a concept that explains both historically and socially, social inequalities between men and women.

Humanization as an object of study puts on the table an initial difficulty, since it names at the same time a 'motto' of social movements fighting for their rights and a public policy of state intervention in health services. Consequently, publications on humanization have been characterized by diversity of research designs and plurality of definitions: humanization appears for some authors as opposition to violence; as a struggle for denied rights within health services; as a desirable and neglected attribute on the part of professionals and as a struggle for better working conditions.

To deal specifically with the conceptual dimension in the selected publications, two categories were then differentiated. First, we separated those articles that deal with humanization within the political-pragmatic horizon from the social movements that coined the term: they are publications concerned with presenting/denouncing/problematising health work through the perspective of humanization, adhering to the mottoes of social movements. Given the pragmatic nature of the Collective Health field<sup>8</sup> as well as its close relationship with social movements, this type of publication is quite common, comprising 65% of the selected publications.

Secondly, we classify in the 'conceptual' category those publications that lend themselves to the analysis of humanization through some previously defined a theoretical framework through which humanization is interpreted. That is, an explanation of what is social and human as used by the studies and, through it, compose their interpretations of humanization in health. Being less common, this category represents 35% of the selected production.

Humanization appears as a growing movement, both from the point of view of the different senses that the term may assume, and in the diversity of proposals for intervention. Within this diversity of humanization fronts, we can list the search for a certain ideal, as a common foundation among them, which represents "[...] a synthesis of generic aspirations for a moral perfection of the actions and relationships among the human subjects involved"<sup>9</sup> (p. 1344). Each publication dwells on a specific set of practical, sometimes theoretical, behavioral and historical questions, with the aim of criticizing whatever is instituted; or to propose a new humanizing dimension.

These pieces of research focus on themes that are quite distant from each other both in practice and in theory, such as: the improvement or change in the professional-user relationship, criticism of the biomedical model of health care, new proposals of popular participation and changes in the management structures of services, proposals of change



or criticism to the models of teaching in health, among others and varied propositions. Even within each of these themes, there is a profusion of different intentions that work with completely different world conceptions, resulting in humanizing proposals of a totally different nature<sup>(c)</sup>, sometimes contradictory, that only seem to coincide in the banner of humanization.

As for the concentration of the approach of social representations in the selected production, it is worth commenting the reading of Moscovici<sup>10</sup>, for whom social representation refers to the positioning of subjective consciousness in social spaces, in the sense of forming perceptions by the individuals.

The representation of a certain social object goes through a process of formation through the enchainment of interactive phenomena, that derive of everyday social processes. In this way, and based on the theory of Èmile Durkheim, it is sought to correlate explanations of common sense with ideologies and scientific theories.

Although the selected articles describe, through interviews, focus groups and questionnaires, the opinion of the interviewees about what humanization is or how it should be implemented, these articles do not advance in the analysis of the reasons for these perceptions, how they relate to reality and to the theory that support their studies, demanding that they present a discussion about the concepts of social and human adopted in their references. Because of this, they are not a departure from the common sense of health problems, limiting themselves to present facts and interpretations visited and revisited in the field. In this sense, most of the examined publications gave titles to their studies with variations of the name “workers’ perceptions of humanization” and do not enter into the question of which theory or ideology is reflected or contained in the speech of professionals. These articles form a homogenized and repetitive compendium on humanization. In it, we have those who show that professionals believe that they themselves need to change their attitude, others in which professionals expose the impossibility of humanized care given to working conditions, and those who point out the lack of recognition of what is “human” in services and society<sup>(d)</sup>.

This is due to the way in which the production of knowledge in Medicine and Public Health in general is structured, whose pragmatic character turns more to practical processes of intervention on spheres considered non-humanized of health practices than a search to understand what would be the humanization of these practices<sup>(e)</sup>.

### **Power, violence and authority in selected publications**

Power, violence and authority appear as correlated concepts. A significant part of the researchers argue that power and authority should be considered the same thing, conditioning both to the phenomenon of violence. Violence could be seen in these references, as an ‘excess’ of power or an ‘abuse’ of authority.

Professional authority appears as the one that usurps the speech and knowledge of the user; and as a justification for control, submission and obedience. Authority is seen as a negative attribute that should be avoided in any case, as it would be the foundation of a violent relationship on the part of the professionals themselves.

<sup>(c)</sup> The list of publications corresponding to each topic can be found in Azeredo<sup>2</sup>.

<sup>(d)</sup> The list of publications corresponding to each of these visions can be found in Azeredo<sup>2</sup>.

<sup>(e)</sup> This purely technological concern of health research leads to what Ayres<sup>5</sup> and Schraiber<sup>6</sup> called “theoretical rarefaction”.



“Power” appears in selected publications with a use quite similar to authority, often even as synonymous terms. Power is also treated as if it were intertwined with violence, so that the exercise of violence would be intrinsic to power: to have, to hold or to exercise power appears as a negative attribute, as if the natural path were to become violence.

In the dimension of health practices, power is seen as the concealment of information by the practitioners regarding procedures and the state of health of patients, as well as the disqualification of the users’ knowledge about their bodies and their experience in getting sick, whose objective would be to make the relationship between the two entities even more unequal.

Power is also seen as a path leading to the imposition of the will of professionals upon the bodies of users; every form of curtailment of freedom, including the basis of the decision about life and death.

Selected publications in the field of Collective Health find the origin of the problem of violence in health services in the asymmetry of power between professionals and users. Therefore, the decrease in power and authority of professionals would correspond to increased respect in relation to bodies, rights and wills of users, and through this path, to end the violence. In this context, ‘holding power’ means putting the user in a position of submission, of ignorance that aims at sustaining the asymmetry.

It seems that we are facing not only understandings of the concepts of power, violence and authority that annul any distinctions between them, but also the absence of distinction between the axis of technical action and the one referring to moral action that are articulated in daily practice, as Schraiber pointed out<sup>11,12</sup> regarding medical work. The fact that the technical aspects depend on the doctor-patient relationship and that moral elements, as well as ethical-political and social elements, are involved in this relationship - to the point that the technique in medicine can be characterized as a moral-dependent technique<sup>11</sup> - does not mean that the authority and intervention of the professional should be confused with moral action. But such proximity of the technique to interpersonal relationships, which was historically built in the phase of liberal medicine<sup>11</sup>, often makes the physicians to go from technical intervention to moral action as if it were a continuous of the same authority.

An example of this aspect is the way some practitioners position themselves on the sensitive issue of abortion, easily displacing it from technical authority to a moral one and from technical intervention to moral counseling<sup>13</sup>. In this case, it is a technical-scientific authority that invades the terrain of morality, normalizing the patients’ life experience. It thus invalidates the knowledge about illnesses or treatments and the self-care that result from this life experience, that is, the ‘practical knowledge’<sup>(f)</sup> of the patients<sup>5</sup> or their own competence in dealing with their illness<sup>15</sup>. However, there are two types of asymmetry in the clinical encounter: the one derived from the professionals in relation to their greater authority in the use of technical-scientific knowledge, and that of the patient in relation to the practical skills to follow the social way of life as a bearer of illness. It happens that, when in the technical sphere the professional acknowledges the authority of the patient, a balance is achieved between the different authorities in play, which may suggest a symmetry. On the other hand, what is happening in the daily life of the services is that

<sup>(f)</sup> Note here that this term practical knowledge does not want to refer to the technical knowledge that governs the intervention, but to a know-how arising from a judgment of the practical type, a wisdom as to what to do based on lived experience and not arising from a judgment technical-scientific, as is the operating knowledge of techniques in general and medical intervention in particular. For further details see Ricoeur<sup>14</sup>.





the authority of the patient has been annulled, seeming to occur in this annulment an abuse of power of the other authority, although it is not exactly an abuse of power, but a violence, provided that one is not recognizing the other as subject.

## Discussion

In order to distinguish these concepts, we use references from the historical-interpretative analysis of Hannah Arendt<sup>16</sup>, stating that those who recognize and follow an authority or act in the condition of command-obedience are not equivalent. Arendt also affirms the existence of a profound crisis of authority in the modern world ending in the authoritarian regimes of the 20th century. Authority is understood by Arendt as a kind of asymmetrical relationship between two individuals. This asymmetry is not based on violence, on the contrary, since every use of violence represents the failure of authority<sup>16</sup>. This asymmetrical relationship is not based on convincing either, since this could only happen in a relationship between equals. Authority, then, is based on the true recognition of the unequal condition of the relationship between the two poles, legitimizing the hierarchy in the relationship.

Authority, in Arendt, is linked to the concept of tradition, encompasses the postulates of the past that help men of the present in moments of decisions, crises, difficulties and changes. The foundations of tradition are eroded in Modernity from the new place of science and technology in society. This thread linking the past to the future has been broken by modern science with the emergence of the Cartesian imperative of hyperbolic doubt, which sets in check every form of authority, hierarchy and heritage of the past over the present.

Following Schraiber's study<sup>12</sup> regarding physicians in São Paulo, the tradition in medicine is anchored in the ideology of liberal work, i.e. that work in which the producer has control over the means of production, the flow of clients, and the organization and day of his work. The social imaginary of tradition in medicine is that of the doctor who carried a small suitcase and went to his patients' homes carrying little more than his stethoscope, knew the house, the relatives, the work and the customs of his client. Armed with little technology, such as exams, instruments, and medications, this professional based his clinical decisions on both the anatomical and physiopathological elements of the transposition of the abstract body from science to the concrete case, as well as on the dynamics of life, work, customs, and social conditions of his patients. The economic possibilities, material dispositions, side effects on the patient's life and the possible iatrogenic effects come into play. And in this context the bonds of trust between doctors and patients are created, representing the recognition and legitimization of the hierarchical relationship of authority.

Medical authority was anchored in the history of the profession through the effectiveness of its practice and the quality of its bonds of trust, which allowed the doctor to diagnose, propose therapies and follow the evolution of his patients. The bonds of trust are what link the current relationship with the past of care of the medical tradition. It is through this process that authority can be established since, as Arendt<sup>16</sup> puts it, what connects the two poles is the very recognition that the relationship only



exists through an asymmetry, that is, the legitimacy of authority is based on the stable and determined place that both recognize. The relationship between doctor and patient can never be a relationship between equals mainly because the asymmetry is the reason for the establishment of the relationship. It is through the trust the patient has in the doctor and in his knowledge that authority can establish itself as “more than advice and less than an order”<sup>11</sup>. Technological medicine severs these bonds, initiating the process that diminishes medical authority instead of increasing it - contrary to what selected publications in the field of Collective Health defend.

The crisis in the tradition of medical work will be the downgrading of all ancient forms of knowledge - of the patients about their body and their illnesses, of the doctors about everything that involves their patients beyond the body and the illnesses and the doctors' own experience - in relation to the knowledge of science. This downgrade brings up the crisis of bonds of trust and then the relationship between doctors and patients, a situation in which doctors still expect getting the recognition of authority, which, however, no longer occurs.

In technological medicine, science will become a large filter of medical work, through its renewed techniques, and the most diverse types of new technologies. This machinery will be responsible for pushing the medical class to be wage-earners with the subsequent loss of control over the flow of customers and the means of production of their work.

Without being able to appeal to the range of non-scientific knowledge - from their previous experience and from the doctors around them, as well as from the patients' knowledge about their bodies and their illness - and having lost control over the means of production and the flow of clients, doctors will only be able to have confidence in the technological apparatus, thus breaking, according to Arendt<sup>16</sup>, the thread that links the past to the future.

The commercial firm in health work transforms the relationship, in the sense that the citizens no longer look for the doctor that has been referred to, consult with them and, through an evaluation of the quality of the bond, chooses whether to remain or not. Now, citizens look for the doctors on the health plan lists, at the Health Unit in their region or whoever is on call at the hospital. A similar phenomenon occurs on the side of the professional: since clients do not have direct access to them, doctors only have access to patients through the hospital, the state or the health plan.

Thus, the relationship between doctor and patient becomes over-determined by an external entity. The institutions start to determine how this relationship will occur, what will be the amount paid and received for the service, the place and time of the consultations, which instruments, technologies and medicines are available. The precarization of this relationship leads to de-personalize the entities involved. The doctor is only the name on the list of the health plan and the patient becomes a number in the line of care.

But this transformation is somehow perceived by doctors and patients through the idea that, although medicine goes very well in its technological advances, the relational sphere goes truly badly<sup>12,17</sup>. With the severing of the bond and the entrance of an intermediary entity between the poles of the relationship, authority empties itself. This new relationship is reversed, and the company that was in the position of



an intermediary becomes the one in authority, while the professional becomes the one in access to technologies. Contemporarily, this professional appears in the view of the population as a resource that sometimes bureaucratizes and hinders their access to technology or medicines.

Ideologically, science is seen by the lay public, including the producers and operators of technology, as the best and most evolved form of knowledge production, and the only matter of access to the truth, hiding or simply disqualifying the limitations that scientific research designs impose on that knowledge, which is fully recognized by the scientists themselves.

This differentiated hierarchy in relation to the scientific status of this knowledge produces the understanding of pathology as a natural and neutral entity on which the physician will act based on scientifically founded techniques and technologies. Therefore, technical interventions of a neutral character on a dysfunction of natural origin would be. Thus, the confidence in this science grows concomitantly with the technological entities it produces.

In this way, we leave aside the doctors' previous knowledge and experience, the patients' knowledge about their bodies and their illnesses. In this transformation occurs the replacement of the subject-patients, with their whole life context and history, by the almost immediate application of biomedicine from the abstract body of science to the real body.

At the other end of the relationship, the importance that technological devices gain in contemporaneity is so overwhelming that the health professionals become applicators of their protocols of use, devaluing the need for reflection on the contingency of each case in the face of the generalizing abstraction that pathology does for all bodies. For Arendt, this process of lowering the judgment of humans in relation to the power of machinery is characteristic of modernity. Distrust of medical judgment seems to grow in proportion to the development of instruments that would first aid the professional's discernment, but which, in contemporaneity, tend to replace it<sup>12</sup>.

The patients become consumers of health supplies: with access to information, usually on the Internet, they already 'know' what exam they want to receive and what medicine they want to take. Thus, the authority over clinical decisions goes out of the hands of the professional towards biomedical technology companies and the pharmaceutical industry. This is how, if on one hand, the scientific-technological development has increased the possibilities of medical intervention, increasing the comfort of professionals in their performances, on the other, it has represented the discomfort for doctors of being reduced to devices in the access to technologies.

## Conclusion

By seeking to enforce an authority believed to be even more legitimate, due to the greater development of the scientific foundations of their practice, physicians seek to impose their perspective instead of dialoguing with the patients, ensuring such imposition by the control they still effectively hold in the access to various health technologies. These attitudes reinforce the precariousness of interaction and present



themselves in relationships in which authority is replaced by violence. Thus, the use by the physicians of the position of authority that they used to occupy, at the moment when the legitimacy to do so is lost, becomes only an exercise of power over the patient, a situation where, as Arendt<sup>18</sup> says, there is nothing left of power, only violence remains.

The first important differentiation, for Arendt<sup>18</sup>, regarding violence and power is that the former is always a means, that is, it is an instrument for a determined end, and not an end in itself as in the second case. Violence, therefore, cannot be thought of as the essence or foundation of power. For the author, power is the orchestrated action of men and women, and thus power can be legitimate and illegitimate. Violence, as an instrument, can only be understood as justifiable or unjustifiable.

Therefore, institutional violence in health seems to be an instrument to force the reestablishment of a lost authority, however, as we argue, authority should not be confused with obedience. Furthermore, violence in services can also be explained as the instrument that enables the productive chain of health services to work. Given the short time for the effective relationship between professional and user, it remains for the professional to take the concrete body of the user as the abstract body of science. Therefore, the only way to treat the disease in spite of the patient, is through violence.

Therefore, we defend that violence in health services is not based on an excess of power or authority of professionals, but, on the contrary, it originates from the crisis of authority in professionals' health and the emptying of political spaces of power within the clinical relationship.

Humanization, while respecting users and ending violence in services, seems to us to be a struggle to be fought for work conditions and demands that are compatible with a practice that can particularize the abstract entities of science within the singular concreteness of each body. To this end, it is essential to have enough time of consultation to allow for the establishment of a link between professional and user, so that both the particular experience of the illness and the previous experience of the professional can emerge. Finally, the struggle for humanization seems to be in a more structural ambit as a struggle against the production of industrial character in health. Humanizing emerges in this way, as respect for individualities and the possibility of intersubjective interaction between professionals and users, and not as a way of revisiting moral precepts of any philosophy of a humanist character.



### Authors' contributions

Both authors actively participated in all stages of preparing the manuscript.

### Conflict of interest

The authors have no conflict of interest to declare.

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Este artigo é resultado da dissertação “Saúde Coletiva e Filosofia: contribuições de Hannah Arendt para o debate de humanização” que objetivou a análise do conceito de humanização na produção do campo da Saúde Coletiva. A metodologia foi de vertente qualitativa, sendo o empírico constituído de documentos oficiais do Ministério da Saúde e de artigos selecionados do campo da Saúde Coletiva. Analisou-se como se utiliza o termo humanização, buscando compreender como o entendem e constroem uma conceituação. O quadro referencial foi composto pela bibliografia que examina o contexto histórico das transformações sociais pelas quais passou o trabalho em saúde na Modernidade até a configuração mais atual, além das reflexões em torno dos conceitos de violência e poder desenvolvidas por Hannah Arendt. Reconheceram-se distinções conceituais necessárias na configuração do poder médico nos serviços de saúde, propiciando novas aproximações do tema humanização.

**Palavras-chave:** Humanização da assistência. Desumanização. Trabalho em saúde. Serviços de saúde. Violência.

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Este artículo es resultado de la disertación “Salud colectiva y filosofía: contribuciones de Hannah Arendt para el debate de humanización” cuyo objetivo fue el análisis del concepto de humanización en la producción del campo de la Salud Colectiva. La metodología fue de vertiente cualitativa, siendo lo empírico constituido por documentos oficiales del Ministerio de la Salud y de artículos seleccionados del campo de Salud Colectiva. Se analizó cómo se utiliza el término humanización, buscando comprender cómo lo entienden y construyen una concepción. El cuadro referencial se constituyó por medio de la bibliografía que examina el contexto histórico de las transformaciones sociales por las cuales pasó el trabajo en salud en la Modernidad, hasta la configuración más actual, además de las reflexiones alrededor de los conceptos de violencia y poder desarrolladas por Hannah Arendt. Se reconocieron distinciones conceptuales necesarias en la configuración del poder médico en los servicios de salud, propiciando nuevas aproximaciones al tema de la humanización.

**Palabras clave:** Humanización de la asistencia. Deshumanización. Trabajo en salud. Servicios de salud. Violencia.