Emancipating care[1]

Cuidado emancipador

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Abstract

The humanization of care has been a present challenge in the field of health in general and in the Brazilian Unified Health System. The purpose of this article is to discuss the sociological construct of emancipating care. While care is strongly identified with common sense and tacit knowledge, biomedical clinical practice has been associated with scientific knowledge resulting from a rationalist epistemological rupture. Emancipatory care is a hybridization between common sense and scientific knowledge, or care and clinic, supported by the professional's ethical-political position, to replace heteronomy with autonomy in the health-disease-care process. The purpose of this article is to present an innovative perspective on the discussion of care, which is not new, bringing some historical references, not with the purpose of developing an epochalist or chronological analysis. The objective is to expand the space for reflections on heteronomous care as a hegemonic event in contemporary culture, as well as to expand the debates on the possibilities of building care practices that privilege people's autonomy and point to their emancipation. It is concluded that the concept of emancipating care can advance a second epistemological rupture with the development of emancipating practices in the health-disease-care process.

Keywords: Medical Sociology; Public Health; Standard of Care; Health Care Models; Culture.

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Resumo

A humanização do cuidado tem sido um desafio presente no campo da saúde em geral e no Sistema Único de Saúde brasileiro. O objetivo deste artigo é discutir o constructo sociológico de cuidado emancipador. Enquanto o cuidado tem forte identificação com o senso comum e com os conhecimentos tácitos, a prática clínica biomédica associou-se ao conhecimento científico resultante de uma ruptura epistemológica racionalista. O cuidado emancipador é uma hibridização entre senso comum e conhecimento científico, ou cuidado e clínica, sustentado pelo posicionamento ético-político do profissional, para a substituição da heteronomia pela autonomia no processo de saúde-doença-cuidado. A intencionalidade deste artigo é apresentar uma perspectiva inovadora sobre a discussão do cuidado, que não é nova, trazendo algumas referências históricas, não com o propósito de desenvolver uma análise epocalista ou cronológica. O objetivo é alargar o espaço de reflexões sobre os cuidados heterônomos como um evento hegemônico da cultura contemporânea, bem como ampliar os debates sobre as possibilidades de construção de práticas de cuidado que privilegiem a autonomia das pessoas e apontem para a sua emancipação. Conclui-se que o conceito de cuidado emancipador pode fazer avançar uma segunda ruptura epistemológica com o desenvolvimento de práticas emancipadoras no processo saúde-doença-cuidado.

Palavras-chave: Sociologia Médica; Saúde Coletiva; Padrão de Cuidado; Modelos de Assistência à Saúde; Cultura.

Introduction

Although a humanization movement in the field of health is in process, which in the Unified Health System reveals itself with the production of specific policies (Brasil, 2004), there is a need for a "socio-logical" construct that broadens the meanings of care and promotes autonomy. The purpose of this article is to present an innovative perspective on a polysemic concept that is not new, bringing some historical references, with the purpose of not developing an epochalist analysis, nor a historical analysis. The aim is to expand the space for reflections on heteronomous care as a hegemonic event in contemporary culture, as well as to expand the debates on the possibilities of building care practices that privilege people's autonomy and point to their emancipation.

It is necessary to discuss the reification process (Berger; Luckmann, 1983), promoted by the epistemological rupture between common sense and scientific knowledge to emancipate relationships in the health field. Santos (1995, 2012) took the notion of epistemological rupture to explain the formation of scientific knowledge in Modernity, from the break with common knowledge, and to develop the argument of the need for a second epistemic rupture to overcome the current limits of scientific knowledge.

The first rupture resulted in a process of exclusion from practical common sense, related to trajectories, social experiences, horizontal social relations and equal access to speeches. Although scientific knowledge produced techniques, values and symbols, which broke with ecclesiastical dogmas and founded Modernity (Hall; Held; McGrew, 1992), the Modern civilizing project strongly emphasized the dualities and polarities, hierarchies and verticalities, which provided asymmetric and established/outsider relationships (Elias; Scotson, 2000). Common sense, empiricism and religious practices, producers of knowledge and senses, were considered superficial, illusory or false, throughout the process of building "scientific truths." In addition, the intuitive has been replaced by the rational, the feminine subjugated by the masculine, the nature dominated

by culture and the social interactions subjected to knowledge-regulation.

Throughout the 20th century, different shortcomings and limitations of scientific knowledge were glimpsed (Peters, 2000). The great advance of the scientific paradigm itself and the many blows suffered by science invite for a second epistemological rupture, centered on the production of an emancipating process. According to Santos (1995), the second rupture does not mean a return to the pre-scientific period, but the transformation of scientific knowledge itself into common sense enriched by science. This common sense does not disregard the knowledge produced by science, but seeks to ensure the translation of technological development into life wisdom, especially for oppressed, marginalized or excluded social groups. For Salazar and Walsh (2017), this means being based on the principle of solidarity as a form of knowledge, through reciprocity and, consequently, the differences between types of knowledge.

Based on these reflections, the sociological construct of emancipating care is discussed, based on the translation of the notions of common sense, scientific knowledge and emancipating common sense, elaborated by Santos (1995), to the field of health with the notions of care, clinic and emancipating care. The perspective of emancipation is also supported by Paulo Freire's (1996) ethical-political construction, mainly in the proposition of a "pedagogy of autonomy." For this, we start with the identification of socializing actions promoted by care and common sense; then we present the reification promoted by scientific knowledge and clinical science; so that we can develop the idea of autonomy practices, driven by emancipating care.

Common sense and care: socializing actions

Common sense is a knowledge built between people and between people and things, which makes cause and intention to coincide, based on creativity and individual responsibilities, reproducing spontaneously in everyday life. It is able to provide confidence and security to the subjects, offering equal access to goods and services by privileging actions that do not produce significant disruptions in experiences and trajectories. Common sense is rhetorical and metaphorical, it does not teach, but persuades and implies aid for restoration, that is, there is an effort to return to the original state (Santos, 1995, 2012; Sennett, 2012).

Care, commonly associated with love, solidarity, exchange, altruism and spirituality, as well as duty, obligation and loyalty (Phillips, 2007), responsibility, restlessness of the spirit and object of care (Rossi, 1991), was intentionally confused with the domestic, female, common sense and unpaid work. People act and react to care, since it is a fundamental co-builder of our individual and collective identities, and it draws complex structures, based on its different meanings and associations with the health-disease process (Phillips, 2007). There are initial discussions of what constitutes a sociology of care and not a theoretical-conceptual matrix itself in the national and international literature. On the other hand, there are abundant discussions about the sociology of the workforce associated with formal and informal care.

Among the many characteristics associated with care, we are interested in highlighting its relational aspect, since it has accompanied humanity since the beginning of existence, influencing daily life, moral conduct and ethics. More specifically, the proposal is to reflect on the care in the social framework of the interactions developed in the care practices of the health field, conditioned by a positivist-functionalist matrix, which is based on the (docilized and obedient) role of the patient and the role (of reduced listening, diagnostic and prescriptive) of the professional. It is not, therefore, a matter of developing a philosophical reflection of the reactions of power, but a sociological one of contemporary actions of autonomy-heteronomy of care practices. Even self-care is relational, as it is a care exercised for oneself having the social group in which the subject is inserted as reference. In this aspect, we can learn that care is also part of common sense, which, in turn, is responsible for establishing, over time and in different social contexts, the notions of what is a "good" or "bad" care.

Care is an attribute of the human species developed over centuries of relational experience and directly linked to different aspects of culture, such as values, symbols, power and hegemony (Barros et al., 2012). It is necessary, however, not to naturalize it by associating to the instinct present in various ways among the different species, mainly to understand the process of social constructionism that shapes it in the multiple cultural contexts (Otani; Barros, 2012).

Like common sense, care can also be associated with tacit knowledge, which resides "in-corporated" in the different meanings of the knower, sometimes consciously and others unconsciously. It is different from explicit knowledge, since it is almost always difficult to be transmitted or placed in specific theoretical-conceptual matrices, as its reproduction occurs mainly in "mouth to ear" relationships, in which the expressed and not expressed cultural codes are "in-formed."

Care, as tacit knowledge (Polanyi, 1966), is socializing, it is related to the practices of a culture that develops in permanent change. In addition, it is a personal ability to act according to rules collectively built in a context, in which the agent is able to judge whether their skill is well developed in the experience, as observed by the maintenance of their social interactions in the reference group (Shibutani, 1955).

When care started to be enriched, specialized and conceptualized by scientific knowledge, there was the process of the first epistemological rupture between common sense and scientific knowledge, and, consequently, the distinction between multiple meanings of care. First, the notion of informal, domestic and unpaid care, still with the characteristics of common sense and tacit knowledge, maintained and reproduced as an ethics of the human (Boff, 1999). However, formal, institutionalized, paid, specialized, technological and scientific care, closer to the biomedical clinic produced in Modernity (Foucault, 1988), gained the sense of clinical care, of intervention that increases survival and of objective action. More recently, clinical care has also been identified as responsible for triggering psychological distress, bioethical and boundary conflicts, thus configuring important debates and needs for change.

Scientific and clinical knowledge: reifying actions

Scientific knowledge requires, for its construction, the exercise of epistemological rupture with common sense. Its proposal to classify, name, objectify and rationalize served to break with dogmatic thoughts. By depriving the power of empiricism, religion and magic, as producers of meaning and structural knowledge, science has reached the position of legitimate producer of truth or true knowledge. Thus, those "old" forms of knowledge production were colonized or totally delegitimized, as well as their actors were subjected and made inferior when they were identified as producers of vulgar and unreliable knowledge.

Scientific medical knowledge has adopted an important separation between the practice of "care" and "cure," with the prominence of the latter in university medical courses, already well-structured since the 16th century. It also transformed the hospital institution, which lost its religious character and was directly associated with death, to privilege the scientific treatment of diseases (Foucault, 1989). Medical-scientific practice in hospitals has become a training ground for new generations of professionals, with an emphasis on curing pathological events, to the detriment of the care of sick people. The practice of nursing, whose formal object of knowledge was related to care, direct or indirect, remained restricted to the sphere of domestic services until the middle of the 19th century (Silva, 1989).

Consequently, the way of treating diseases and patients has changed with the epistemological rupture of common sense for scientific knowledge. The body, now symbolized as a machine, demanded a fragmented approach to the whole, privileging the analysis of the parts. Understanding the disease has become more important than interacting with the patient, who has been progressively stripped of their emotional and spiritual dimension, reducing them to their

biological, material, palpable and quantifiable aspect (Freidson, 2009).

Modern medicine has rejuvenated words and things related to medical knowledge. It broke with the ancestral tradition of care, while maintaining some of its elements, in order to undertake an exercise in the visibility of implicit and non-visible parts of the health-disease process, as well as of unimagined elements of the same process. The word clinic, which originates from the Latin *clinicus*, "doctor who visits patients in their beds," and from the Greek *klinike tekhne*, "practice at the bedside," from *klinikos*, "bed, what you lie on," from Kli, an Indo-European base, "lay back, lean," gained in the 19th century, according to Foucault (1988), the sense of clinical science.

It is an appropriation of the past under the new condition of positivist science, which qualifies the clinic as an action to arrange the truth that already exists in a new system of codified unveiling, that is, available almost exclusively only to the initiated. This new set of perceptions and enunciations represents for doctors: (1) new distribution of discrete elements of body space; (2) reorganization and definitions of the pathological phenomenon; (3) responsibility for diagnoses, interventions and treatments; (4) unveiling the cause of a disease through the symptoms; (5) governance of favorable moments to operate the solution; (6) decision between various treatment methods; (7) becoming master of the sick and their affections (Foucault, 1988).

The biomedical clinic is not the first sphere of knowledge in search of ordering natural events, since members of natural history societies in different countries have been doing this for centuries. The clinic develops its progress by adding to its classificatory, comparative and combinatorial practices of the natural sphere some elements of the social sphere, which demand from the observer an identity supported and justified by the medical institution. Thus, clinical science becomes the practice of a social agent distinguished by their ability to make decisions, intervene and monitor deviants. In other words, the clinic develops and identifies with the functionalist civilizing project of different Western cultures, so that its agents occupy fundamental positions in the gears to be conserved (Freidson, 2009). In this way, it is a practice associated with capitalist production, in which clinicians slowly improved within a culture in conflict between autonomy and authority, intuition and protocol (Sennett, 2012).

Clinical science has the reach of a discourse on the disease that the positivist modernity project lacked, mainly because it acts beyond medical knowledge, standardizing and normalizing the world of individual and collective life. For Foucault (1988), it is a construct established in the passage of the 18th and 19th centuries, which shaped the dark and solid plot of our experience of objectifying diseases and the sick. Through close relationships in the natural and social spheres, naturalizations were built for clinical science to develop the reification of the human and of care. Human phenomena started to be dimensioned as things, that is, in non-human or possibly superhuman terms. This reification process impressed the need to forget the very authorship of the human in humanity, and more, it implied the loss of dialectical awareness between the producer and their products (Berger; Luckmann, 1983). So that the reified world of clinical practice has, by definition, become a dehumanized world.

In addition, the objectified biomedical clinic project organized hierarchical relationships to create, maintain and reproduce various forms of inequality related to access to information and the right to speech. Clinical science, to that extent, has taken on a reifying dimension; not producing autonomy, but dependency; not an amplifier of meanings, but of reductions (Sennett, 2012).

The sum of reification and social stratification operated by the clinic in the health field has brought many consequences, as studies on medicalization have shown (Conrad, 2005). The substitution of socializing care for the dehumanized clinic left senseless suffering in large numbers of the population. It is known that people are less destroyed by the experience of suffering than by the lack of meaning of suffering. Possibly, the reduction of meanings imputed by the clinic of a scientific nature has been more devastating than the very experience

of illness for many people. The arsenal of images and prescriptions, almost always, only expands heteronomy, strangeness and alienation (Williams; Gabe; Davis, 2008).

The relationship between the practices of biomedical clinic and care practices has a socio-historical path already developed in the literature in the field of public health. In this article, given the constraints of space and focus, the interest is to broaden reflections on contemporary possibilities for developing autonomy production practices.

Emancipating common sense and emancipating care

The notion of emancipation has been inaccessible to some and inaccessed by others (Silva, 2013). The meanings of emancipation were questioned and debated throughout the 20th century, mainly by the theorists of the Frankfurt School, which sought in Marxist sources for practices of social emancipation. In the contemporary world, theorists of post-colonial studies (Said, 1990) and cultural studies (Salazar; Walsh, 2017) have also reflected on the emancipatory process, but through the post-structuralist path of social emancipation through difference.

Emancipating is the human being's ability, from reflecting on contingencies, to perceive the dialectical contradictions and differences that enable individual and collective transformations. It is, therefore, the individual exercise of subjectivity of objectivity and, in addition, a practice of objectification of subjectivity (Berger; Luckmann, 1983), which prints more sensitive relationships between individuals and undertakes the search for more humanity in unequal social relations. The emancipated look produces possibilities for new paths and experiences, thus expanding the "socio-logical" repertoire in order to discuss the evidence for each time.

In order to develop an emancipatory process, it is necessary: to go beyond protocol actions which are generally heteronomous; to guarantee direct or assisted access to information; and to facilitate the "in-corporation" of information, an epistemic and transforming exercise of "knowledge into self-knowledge," that is, to make information, social, political, cultural, economic and other practices, part of the physical and psychological body that condition the exercise of autonomy.

When analyzing the crisis in the modern scientific paradigm, Santos (1995) proposed a new topology of knowledge with "emancipatory common sense," which has the properties of scientific and non-scientific knowledge. According to the author, in the interaction between common sense and science, the emancipatory, non-conservative and less mystifying dimension develops, seeking transparency among agents and facilitating the distinction between incomprehensible knowledge and common knowledge. It is a process that combines individual and collective forms of citizenship, in which emancipation is the cause and effect of a theoretical and practical democratizing means.

When rescuing the importance of the common, in the sense of being possible for all, emancipatory common sense allows and admits the plurality of social agents. Their practices and knowledge enable the emergence of a new rationality composed of interepistemicity, which establishes fluidity in social relations, invents new forms of sociability, in which the "other" is no longer a mere "object" or "thing" and becomes significant, recognized and respected. It is about the humanization of relationships, that is, an action against reification, which, therefore, reconfigures and "re-creates" the form, functioning and interactions, amalgamating inheritances and innovations.

The notion of emancipation, mirrored in the field of health in the form of emancipatory care, undertakes an unstructured process, as it can occur in different ways, paths and times. It is dependent on the social contexts in which it develops and, therefore, it is a non-essential process. Care oriented towards emancipation requires different, complementary performances, marked by the positionality of agents in interacting. In addition, it demands awareness about the technical contribution that professionals can contribute to the understanding of the health-disease-care process, as well as, it requires the effort of permanent epistemic surveillance.

In the health field, the second epistemological rupture comprises the opening for the development of emancipating care, which does not exclude clinical or scientific knowledge, but proposes the inclusion of the stories, experiences and autonomy of the subjects being treated. The agent ceases to be patient and becomes "experienced" (Andrade; Maluf, 2017) of their health, illness and care.

Since heteronomous care, to the detriment of autonomous care, was privileged in the care model of contemporary Western medicine, on the one hand, a certain objectification process of bodies was established, on the other hand, the autonomy-heteronomy synergy was broken, leading to a phenomenon of counterproductiveness with the increase in iatrogenesis and the reduction of the reaction power of each agent. Care oriented by biomedicine imposes the need to support the heteronomic order, and the concentration of heteronomic power by professionals can not only block autonomous care but deprive agents of a critical view of their habits. The hypotrophy of autonomy makes it difficult for the different agents to reduce heteronomic production, as it is there that the answer to care is sought (Illich, 1975).

Emancipating care requires a reduction in heteronomic production and an increase in autonomous care in a more positive synergy between these polarities, however, it is necessary to be aware of the difficult transition from heteronomy to autonomy. It is not natural, but social, to alienate most of the "experts" from their bodies in the face of the health-disease-care process. Subjections, whether voluntary or legally and legitimately imposed, control instincts to adapt lives to institutions, they are products and reproduce forms of domination. In medieval times, "pastoral power" established control; in modern times, positivist-functionalist principles were responsible for maintaining the order of vigilance and punishment. In the contemporary world, the health field has been a highlight, perhaps as the most important, conservative of the heteronomic order.

Emancipating care conveys a decolonizing perspective in the field of health and invites interculturality, which is based on the recognition of cultural diversity, equitable relationships and respect for differences. With these principles, colonialism is faced through the development of decolonial actions against the speeches of docile alterity and the false coexistence of differences. In this perspective, the encounter between the different builds mutual enrichment and relational spaces enriched by difference.

In intercultural-based emancipating care, hierarchies tend to become unfixed, with a reconfiguration of forms of sociability, stimulating exchange and sharing of knowledge. In addition, the dialogic dimension of care avoids the cancellation of differences and communicative asymmetries between interagents, configuring interactions that facilitate commitments and the identification of different needs. The contemporary intercultural project has fundamental elements for the emancipating care because it is part of the social stock of knowledge. This supply is accessed daily, transmitted between generations, maintained based on the interactions and certainties of common knowledge.

As part of the social stock of knowledge, emancipating care allows the location of participants and the management of their natural and social needs. The identification it promotes is due to belonging; and a scheme of common classifications of each culture, which, at the same time, operates identities, antagonisms and belongings. In the social stock of knowledge there is more common knowledge of everyday life and less scientific evidence, but the challenge is to bring them together in an integrative perspective, ending exclusion as a fundamental epistemological principle. Thus, emancipating care is a process, a becoming, in the construction of "practical wisdom" (Ayres, 2004), in experiences that stimulate decision and accountability, that is to say, respectful in relation to care. In other words, emancipating care, composed of knowledge of everyday and scientific life, forms an interpreted and subjectively endowed reality with meaning and coherence. It is, therefore, a "social + logical" construct to operate, in the interactions between professionals and health

professionals, emancipating practices of a second epistemological rupture, oriented towards the production of autonomy.

Final remarks

Many of the professionals who perform the care and the "experts" who receive it share the culture of the first epistemological rupture and, consistently with their bases, devalue non-scientific knowledge, with a routine of classifications, interventions and prescriptions. The incorporation of technical certainties in the formation of scientific culture happens *pari passu* with the installation of repulsion to ambivalence (Bauman, 1999), which translates into the presumption of the agents of that culture almost never asking themselves if the interventions help more than they disturb.

The protocol knowledge added to the discourse of unequivocal evidence, in general, feeds the culture of reifying care. Thus, agents of scientific culture not only specialize in diseases, but also develop biosociabilities. From the pathogenesis, they guarantee the classifying praxis of bodies that vary between docilized and problematic, that is, between those who stick to the reifying technical certainties and those who exercise the right to compare, choose, break, decide and assume the decision by refusing partial or total protocol interventions.

Docile and problematic represent the pair of opposites formed by heteronomy and autonomy. These two forms contribute to the achievement of social objectives and may come into sharp conflict, and the effectiveness of care depends on the degree of synergy between the two. Caring is the result of autonomous initiatives that each carried out alone with their family or neighbors in the not-too-distant past.

Freire (1996) taught educators some ways to expand autonomy and control heteronomy, and we can transfer their reflections to the field of health, as the educator or caregiver is a professional who performs moral authority in institutional relationships. Translation is possible because respect for autonomy is an ethical-political imperative of every professional, education or health, and not a favor that can be granted. In the Autor's words:

> As [professional] [...] I cannot allow myself the naivety of thinking like the [experienced], of ignoring the specificity of the [professional] task, I cannot, on the other hand, deny that my fundamental role is to contribute positively so that the [experienced] will be the artisan of their [care] with the necessary help of the [professional]. [...] I must be attentive to the difficult passage or journey from heteronomy to autonomy, attentive to the responsibility of my presence, which can be both helpful and can be disruptive to the restless search of the [experienced]. [...] Primarily, my position must be to respect the person who wants to change or who refuses to change. I cannot deny or hide my posture from them, but I cannot ignore their right to reject it. In the name of the respect I owe to [experienced] [...] my role is that of those who witness the right to compare, choose, break, decide and encourage the assumption of this right by the [experienced]. (Freire, 1996, p. 36)

These teachings reveal not only an epistemic perspective in the notion of emancipating care, but also a pedagogical one, since in Freire's words there is a set of principles that can be taught, supervised and even evaluated in the practices of health professionals. In this way, emancipating care is an operative sociological construct, with broad implications still to be further investigated.

Based on its ability to integrate elements of common sense and scientific knowledge in interactions, emancipating care allows the connection of different health policies oriented to the perspective of humanizing relationships and also in expanding the general framework of work in health, pointing out strategies and interventions in the health-disease-care process that cause more autonomy and less heteronomy.

Emancipating care hybridizes a set of knowledge and forms tacit-technical, socializing-reifying knowledge, with legitimate rules built on social-legal interactions, without overlapping knowledge about the other. It develops a competence of know-how and know-why, which implies not only submitting to the rules

but also influencing changes in the rules and tradition. As a "bridge resource" of language and perspective, it can break down difficulties in attempts to create intersectoral and interdisciplinary constructions in the health field.

It can be inferred that the development of emancipating care in the daily work in the health area has implications in several sectors. In addition to the socioeconomic implications, there is the possibility of changes in the geography of care, with the production of new landscapes that allow unpacking the interactions of different territories in the field of health. Thus, the relationship between proximity and distance goes beyond the physical dimension, to reach the closest social and emotional debate. In the context of social relations, emancipating care presents the perspective of making constitutive tensions apparent, especially those related to the interdependence between professionals and experts. Insofar as the tensions are not hidden, it becomes possible to advance the reflections, in each context and sociability, to build integrative "discourse-bridges," which not only bring the opposite perspectives closer together, but also promote autonomy in differences.

In conclusion, we live in a period of paradigmatic transition in which the second epistemological rupture in the health field is urgent, especially oriented towards the configuration of emancipation. It is known that paradigm changes are not immediate, they unfold according to the will, action and resistance of social agents. It is also known that in order to reduce the distances generated by the asymmetries of knowledge, there must be an intercultural effort to establish intelligibilities in communication and in the translation of senses and meanings (Fox, 1995). Emancipating care seems to be a necessary key for contemporaneity, as it is constituted, on the one hand, by tacit attributes of the species and, on the other, by well-founded "methodological" knowledge.

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