Work and humanization in health: experiences within SUS

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Abstract

This paper describes experiences in Brazilian public health during the worst health crisis in Brazilian history, due to the threats of COVID-19. It highlights the work in health in its multiple dimensions and nuances, emphasizing the SUS Humanization Policy (PNH) which recognizes the unfavorable and oppressive conditions in health work. It rejects both the victimized or passive positions workers and managers sometimes take on one hand and the idealization of solutions that stem from outside workers' context or those which are hetero determined, on the other. The paper describes PNH's tools as strategies for workers' collectives to increase their analysis and intervention capacities, thus engaging in new ways of organizing and reinventing work.

Keywords: collective health; worker health; SUS-PNH.

Trabajo y humanización en la salud: experiencias con el SUS

Resumen

Este artículo describe las experiencias en la salud pública brasileña durante la peor crisis sanitaria de la historia de Brasil, debido a las amenazas del COVID-19. Destaca el trabajo en salud en sus múltiples dimensiones y matices. Destaca el trabajo en salud en sus múltiples dimensiones y matices, enfatizando la Política de Humanización del SUS (PNH) que reconoce las condiciones desfavorables y opresivas del trabajo en salud. Rechaza, por un lado, las posiciones victimizadas o pasivas que a veces asumen los trabajadores y gestores y, por otro, la idealización de soluciones que provienen de fuera del contexto de los trabajadores o que están heterodeterminadas. El documento describe las herramientas de la PNH como estrategias para que los colectivos de trabajadores aumenten sus capacidades de análisis e intervención, participando así en nuevas formas de organizar y reinventar el trabajo.

Palabras clave: salud colectiva; salud de los trabajadores; SUS-PNH.

Trabalho e humanização em saúde: experiências com o SUS

Resumo

Este estudo descreve experiências na saúde pública brasileira. Foi elaborado durante a pior crise de saúde da história brasileira, devido às ameaças da COVID-19. Destacamos o trabalho em saúde dentro das suas múltiplas dimensões e nuances, enfatizando a Política de Humanização do SUS (PNH) que visa reconhecer condições desfavoráveis e opressivas no trabalho de saúde e rejeitar tanto os trabalhadores e gestores vitimizados ou passivos, por vezes devido ao seu trabalho diário, as soluções decorrentes do contexto externo dos trabalhadores e as mudanças heterodeterminadas. Descrevemos os instrumentos da política de humanização do SUS como estratégias para os colectivos aumentarem as suas capacidades de análise e intervenção, engajando-se assim em novas formas de organização e reinvenção do trabalho.

Palavras-chave: saúde coletiva; saúde do trabalhador; SUS-PNH.

Introduction to the field and perspectives of analysis-intervention

In this text we start from some ethical-political directions and from the institutional scenario of the Brazilian health system. Called *Sistema Único de Saúde*/SUS (Unified Health System), this system was established by the 1990 Laws and must be seen in the broader social context, configuring itself as the most comprehensive public policy in the country, proposing universal and equal population coverage.

Brazil is a country of continental dimensions and with more than 200 million inhabitants, rich in its ethnic, geopolitical, and other diversities, but also marked by wide socio-sanitary inequalities. The creation of the SUS was part of the Sanitary Reform movement, carried out as an intense social movement, in which civil society played a leading role in alliance with multiple sectors and players in the health field (health services, teaching institutions, research, and others). It is very important to emphasize that this was not an initiative led by the State, nor by specific governments, but rather a mobilization that can be attributed to a broad process of democratization of the country. This culminated in the SUS legislation, with the premise that health is everyone's right and a duty of the State, thus demarcating its supporting principles, which are universality of access, equity, comprehensive care, and social participation. With the political force of these principles, the organization of the SUS articulates guidelines and axes capable of interfering in historical social inequalities and promoting citizenship to the Brazilian people. In this direction, significant investments were made, with expansion and decentralization of the service network, technological incorporation, and qualification of human resources to work in multiprofessional teams. It is worth emphasizing that in the wake of the SUS, the health workforce in the country has become one of the most rel-

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evant in number, diversification, and qualification in our market. With the SUS, Brazil has achieved prominence in the world for the impacts of actions in child care, extensive vaccination coverage, infant mortality reduction, transplant policy, and innovative attention and control of emerging problems such as HIV/AIDS, among others.

The construction of the System has been a continuous process, in a permanent challenge of financial sustainability, especially as privatization trends grow, with strong pressures from the medical-industrial complex. In times of pandemic COVID19 there were several conflicts experienced in the sphere of the SUS, which was able to demonstrate all its power in the ability to fully welcome and care for the population, especially the most vulnerable, at the same time demonstrating its enormous weaknesses, aggravated by the known disregard and negligence of the government in action (REF). In this regard, in the recent context of the pandemic, the Brazilian SUS gained visibility in important international journals, highlighting both its strength and its threats (REF).

In any case, the SUS, in its roots and in its perspectives, needs to be emphasized here as a system that is intended to be capillary and to be made through collective constructions, of networks of actions and commitments involving the subjects in the concrete of the work realities. Thus, it presupposes and induces the active participation of all the players that constitute and consolidate it daily as a public policy. And since participation and collective construction serve not merely as a guarantee or sufficient prescription for actual practice, we understand that the SUS brings both the beautiful and complex challenge (and our stakes as humane actors) of placing itself as a policy to be experienced and routinized, seeking to articulate the knowledge, power and affect that manifest in differentactors who organize services and interests put into play, keeping in mind the necessity to facilitate greater inclusion of those who produce the System and the care: users, workers and managers.

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In 2003, a group of SUS researchers and activists started networking to create strategies to think of concrete ways of operating their principles, taking the reality of health services and its many advances and gaps as a challenge (BRAZIL, 2008). Among the many aspects outlined to address health policies in the country,[1] the group found several challenging issues in individuals' approach to health work, in particular those referring to the relation between work and subjectivity. It then began to delineate an intervention/interference field in public health which required a collective approach to analyze the constantly changing ways of working in the daily life of Brazilian health services. We asked ourselves "Where to begin?"

Following Deleuze and Parnet's (2004) clues, we always find ourselves within processes whose several possible outputs (rather than their inputs) matter the most. Believing we are always in the middle leads us to consider the dimension of the movements we experience when we follow the tracks of events. Describing multiple outputs shows us the many unpredictable connections of living/working. When we were building the SUS Humanization Policy (PNH) we claimed that working in health constitutes an incessant and procedural practice, a way of sharing daily concerns, creating strategies and investing in health and work policies. We persevered, always on the lookout for events, in a delicate exercise of reverberating and resonating unsuspected connections to show the most unusual situations experienced on the everyday undertaking of services. Rather than looking for indictments, someone to blame or to be held accountable for what happened on the services we focused on the unpredictable that is common to all work. These ongoing movements within health services (pre)occupied us. These clues led us to the collective effort of formulating a National Humanization Policy/PNH (BRAZIL, 2008), which deemed work activity[2] as a privileged direction.

We should stress that we never aimed to provide any kind of model of experience or replicable protocol professionals should follow, choosing rather to indicate and experiment with co-constructing itineraries, betting on the tireless collective analysis of the work in concrete situations.

Some questions accompanied us: what policy do we want to build? How the current policies have being operated? What a policy can do? How can we resist the State machine swallowing us in its bureaucracies? How can we build an effectively public health policy? We drew lines that strengthened our work at the PNH as it emerged, always starting from concrete situations and the regional contexts in a continental country with extremely rich cultural productions.

The development of concepts and the interventions at service level were always taken as inseparable processes. Concrete experiences fueled the construction of conceptual operators. We valued the experiences forging an open and inconclusive history of encounters with health workers. The micropolitical dimension can change larger, stabilized sets. The molecular dimension of the policy lies in permanent connection with the molar-macropolitical dimension of State regulations and norms. We stood for the micropolitical level of interventions as a field of intensities which never ceases to shake and relocate macropolitical segments. We stood for a micropolitical approach of groups discussion and work analysis processes which could continuously change large binary or polar clusters, emptying the distinction between the social and the individual, managers and workers, crucially distinguishing

[1] We refer to the issues taken as challenges during the construction of the SUS National Care and Management Humanization Policy (PNH) – discussed in this study –, which articulated a set of publications on them. Official Ministry of Health documents are available at http://www.saude.gov.br/bvs; www.saude.gov.br/humanizasus.

[2] Brito and Athayde (2003, p. 65) state: "It seems to us that the definition of the objectives of research in health and work requires reversing the approach: it must start from the field, i.e., it should privilege the point of view of the activity," thus indicating the importance of starting from the point of view of the activity in the situated analysis of labor practices.

between the molar field of representations, whether collective or individual, and the molecular field of beliefs and desires in which this distinction loses its meaning.

This was not a small challenge. We walked the fine line between the State machine and government and public policies. We aimed to undo polarities and bring differences together by a way of fighting and working which enabled Brazilian health actors' broad dialogue and participation. We favored dialogical meetings as a way of overcoming prescriptive attitudes or specialisms as per the socioanalysis.[3] Our work aimed to build a collective subject as a polyphonic space which could increasingly expand our power to act. An incessant process that progressively turned into constitutive problematizing attitudes that favored a public policy experience over only a government policy. We sought a posture which tirelessly questioned established ways of working since, as Foucault (2013, p. 356) claims: "Criticism fails to entail claiming that things are not as quite as they are. It consists of seeing what types of acquired and unreflected evidence, familiarities, and ways of thinking lie accepted practices […]."

Public policies, as a dimension of the common world and as a capacity to expand lives, imply a smaller presence of the State, rendering them a plan for established forms; valuing and pursuing local, situated composition exercises which may further the forces transforming the state of Brazilian public health. We wanted a public policy that democratized management and stressed social participation, placing the latter in every gesture and institutional intervention in health establishments.

We took thinking-doing-saying-working as an indissociable guiding thread, showing that health — rather than remaining a personal, individual problem — constitutes an inseparable condition of living and working processes. This path implied building normative exercises aimed to destabilize a prescriptive normalizing logic; normative since we find that life happens from normativity proper to those living, as per Canguilhem (2009). Thus, the PNH became a normative attitude, creating a heterogeneous set of devices capable of inscribing power in minority struggles[4] in health. Returning to the socioanalytical maxim (LOURAU, 2004), we aimed to transform to acquaint ourselves with the concrete work situations within services, creating analytic devices based on debates as a production of groupalities, the collective sharing of experiences, raising of interest, the construction of affective networks, and especially of methodologies and formative processes which begin, *par excellence*, from the concrete of experiences.

We also faced another challenge: we claimed the distinction between management and administration[5] as with the processes of contagion and persuasion. Contagion, as per Tarde (2003), refers to a process propagating beliefs and desires in a field of openness and affinities built in affinity, thus surpassing persuasion. We could persuade workers to participate in the interventions we proposed for their workplaces, but we wanted much more than convincing them. We wanted to share dreams and desires with them so they would also embrace our proposal and produce strategies to continue participating and talking about their experiences to displace the usual ways of working/living. Contagion understands this openness in the common plan as intensifying and strengthening the lines which build a heterogeneous collective. Its process engenders relationships and refers to the effectiveness of interventions whose effects are yet to be seen and learned. It doubly implies its subjects and the movement undertaken to produce changes. This movement means co-creation, stating a way of acting together, achieving working relations. Thus, it refers to a way of training workers to analyze unanticipated work situations. An assemblage[6] emerging from the communication between beliefs and desires, from jointly building a mode of production of public policies, which requires time, dialogue, and the constitution of a common plan that enables, in turn, a plan of affectation, sensitivity, openness, engagement, and connection. Contagion is production, an unceasing movement which continues to affect and move subjects toward the desires built in the collective. It constitutes a process which enables participants to share their dreams, always stressing the common plan of work in how it articulates differences, singular inventions, collectively elaborated and managed forms of care, and generating trust, co-responsibility, and leading roles to further lateralize[7] the several positions of subjects involved in health work processes.

Thus, we aimed to form subject groups (GUATTARI, 2004) that could anchor a network of encounters and knowledge so the collective analysis of their work could become their own formative process. An unconditional bet on the explosive ability of life. This ethos supported us to challenge how the hegemonic discussion on health work and refrain from obstructing the potency of re-normatization as a possibility of transforming the experienced into work situations. A way of working that must not avoid organizing it to support displacements and modifications, thus referring to thinking public policies from collective to collective (SANTOS FILHO; BARROS; GOMES, 2009) and analyze-perform interventions as a clinical gesture dismantling prescriptive attitudes and inventing devices to be built with workers.

[3] Rather than identifying itself with specialties, specialism indicates a hierarchy of knowledge which attributes a hegemony to scientific knowledge over other forms of knowledge, disqualifying what lies outside the academic production of knowledge. Specialisms indicate the knowledge-power clash Foucault signaled in his works (FOUCAULT, 2013). On this topic, see Barros (2005).

[4] Rather than referring to what is small or irrelevant, minorities allude to that which escapes the forces standardizing modes of subjectivity. Minority struggles express a molecular, micropolitical dimension of throes interrogating and shaking established forms of doing in health.

[5] We distinguish between management and administration: the former refers to secretaries, directors, and managers' roles, whereas the latter, to all workers' participation. This management is active in the daily relationships between workers in their environment and relates to the action and tension at stake during the development of their activities.

[6] What is assemblage? We may deem it an encounter between bodies which creates an event. Thus, assemblage constitutes an event which "is a multiplicity that involves many heterogeneous terms and establishes links, relationships between them, through ages, sexes, realms – of different natures" (DELEUZE; PARNET, 2004, p. 84). Thus, co-functioning is the only unit of assemblage: symbiosis, a "sympathy."

[7] Conception worked throughout the theoretical-political framework of the PNH, available at: http://www.saude.gov.br/bvs; www.saude.gov.br/humanizasus

We built many theoretical-political-aesthetic-social dialogues along the way, which sharpened our intervention tools. Pursuing these goals favored work clinics.

Work clinics[8] as intervention strategies

As indicated, we focus on health work according to National Humanization Policy/PNH principles and strategies. Among these principles, we highlight that quality of care is inextricably linked to working conditions and their organization (BRAZIL, 2008; SANTOS FILHO; BARROS, 2007). This was an important clue since it warned us of hegemonic, authoritarian, and vertical management modes marked by authoritarianism and a traditional exclusion of workers in conceiving and analyzing work processes, a model contributing to the often-denounced degradation of health work.

Precarious institutional relations, strict working standards (based on unshared priorities and productivity demands); isolation and feeling of loneliness during tasks; complexification of the population's demands and needs, often worsened by intense social vulnerability, such as difficulties in accessing goods and services (including health) and increased violent behaviors to which workers are exposed in medical care establishments; and lack of varied supports to develop actions. This was the framework we originally found, and which remains an issue at SUS, highlighting the difficulties regarding the "opportunity to discuss work with superiors, cooperation in teams, and the quality of communication among professionals" (LIMA JÚNIOR; ALCHIERI; MAIA, 2009), aspects essentially related to management.

In these circumstances, we found the systematic incidence of health problems, complaints about working conditions, and the restricted manner of the responses to them, i.e., interventions reduced to adaptations focused on individual approaches (treatment of cases) or legislative measures and hygiene of work environments, desired as free from conflicts or imposing norms of (supposed) conflict neutralization.

Given this scenario, our challenge was to think about technologies to trigger expanded interventions[9] focusing on the work process to approach it within the scope of its collective analysis. Led by these clues, we prioritized building a method, starting from the premise that the technical-bureaucratic paradigm, based on the so-called hegemonic managerial rationality or managerialism (CAMPOS, 2003) and centered on an logic of efficiency, is insufficient in view of what, in understanding work as an activity, always escapes the power of collective experience in work. Thus, we expected to produce an inflection in the fragmentations operated by the way of managing a supposed static, stable, and controllable work. Our approach would be different since our understanding it that work is not static – it moves constantly, it is collectively performed, it changes across time, and it reinvents itself by the encounters it encompasses (Barros; Benevides, 2007). Thus, rather than deeming work as something akin to data, we find that the marks workers imprint during their industrious activities modulate this process (SCHWARTZ; DURRIVE, 2000).

The PNH gradually instituted itself as a policy unlike punctual actions, such as programs in specific health sectors, since it aimed to cross-sectionally and collectively create effective manage-care conditions. Thus, it considered that nothing would be guaranteed, or ready. The incessant exercise of its constitution expresses the public dimension of a policy: it is not given forever or, much less, forever and ever.

The t developed technologies aimed to bring workers together -all of them being the real protagonists – to rethink the production of norms, summoning them in their ability to produce local knowledge and create norms filling the normative gaps of protocols since, as per (SCHWARTZ, 2007), living in health is to never accept determinations without evaluating their use – living in health is refusing to become a mere instrument of injunctions. We aimed at methodologies that could expand subjects and worker collectives' power to act, recognizing subjects' leading role and co-responsible autonomy (CLOT, 2010).

We opted for analyzing work as an activity since this conception claims the impossibility of humans to automatically perform previously formulated (prescribed) procedures, a premise which interests us very much especially regarding health and SUS. Schwartz and Durrive (2000) claims constant "uses of the self," rather than just the mechanical performance of procedures. We must consider that values, knowledge, and activities merge in an unceasing process. Living, for Schwartz (2010), is to produce value, to produce history. Every experience is an encounter (SCHWARTZ, 2010), the confrontation of a living being with norms and antecedent values so concrete situations always produce renormatizations. Workers create numerous ways of dealing with the variability of work means, covering historical, political, economic, and cultural processes. Industrious activity refuses any docile readability (WISNER, 2004). It always configures historical living beings who build their environment according to a complex of values, testing norms which precede concrete situations and remain insufficient to deal with each experience. Humans show an inability to always do work in the same way. Human activity, therefore, configures a transgressive power in all dimensions of life (SCHWARTZ, 2000).

Thus, the PNH, also known as HumanizaSUS, built interventions and strategies considering work management as workers'inventive potency, a space to problematize events and a time to plan and evaluate the produced interferences. "[…] An idea of work which […] would be able to free (from nature) the creative forces latently sleeping in its bosom" (BENJAMIN, 2013, p. 16). Following Benjamin, we understand that we can open ourselves to other questions based on unpredictable guiding

[8] Despite conceptual-methodological differences, we dubbed labor clinics those which enable us to claim goals questioning the processes producing ways of thinking, feeling, and acting to explore how we can expand our power of action in the world within the experience of health work.

[9] Campos (2003), in line with the notion of expanded clinic, opens/expands the understanding of the objects and purpose of health work, refraining from reducing them to the sphere of care practices aimed at the other (users) and assessing the organizational aspects and subjective, social bonds permeating worker-manager-user relationships.

work situations, evaluate daily life, and expand the possibility of analyzing work situations, considering work an industrious activity (SCHWARTZ; DURRIVE, 2000).

We highlight, then, the subjective aspects of work processes, indicating that work and subjectivity remain inseparable. Such aspects evade substantialisms that begin from already constituted individuals whose nature is always already given and essential, unable to move away from itself. On the contrary, it belongs to a conception of subjectivity committed to inventing new existing and existentializing possibilities. Subjects are neither given nor a starting point which would have an immutable essence and a fixed stable identity, but rather the effect of a process giving rise to subjects and the environment. In this context, work relationships are a fundamental dimension in subjectivation processes, referring us to the sphere of co-management — an important PNH guideline (CAMPOS, 2003; BRAZIL, 2009) —, actualizing itself as an ethical-political arrangement enhancing changes to expand living. And, if so, we must consider the plane of subjective changes moving health practices and provoking variations in those who try to silence life, thus refusing the merciless desire for guardianship that constitutes many discourses and practices in this field.

From this conceptual-methodological framework, the PNH also claimed that the process of subjective constitution fails to take place by isolated subject-workers since subjectivation implies a collective process. By refusing to assume that the individual is an immediate starting point and accepting that they constitute a collective joint action, "in the plurality of voices, that is, in the public sphere" (VIRNO, 2004), we find that collective productions increase the force of action. Thus, this conceptual web takes the notion of collective as a plan of forces in permanent struggle. Rather than reducing the professional collective of workers to a group of people or grasping the notion of collective as opposing the individual.

Thus, the focus turns to organizing work in services, the violence of working conditions and that among colleagues and users, how they relate to each other at work, and how they feel their effects. We aimed to provoke by installing other modes of analysis which implied workers reuniting with their experiences and their words and considered that their discourse incarnated many other loud voices; workers who enunciate themselves as a "connective multiplicity" at work (DELEUZE; PARNET, 2004). This aim concomitantly speaks of a personal but also interpersonal, impersonal, and transpersonal problem[10] (CLOT, 2010). Workers, by refusing to deem themselves as a body-automaton, reconfigure themselves from new compositions and forces in analysis processes taking place in and by work when they boldly come out of isolation. Thus, the methodological strategies PNH brought implied creating devices which aimed to listen to workers, who feel the effects of degrading forms of health work organization and deem themselves alone in coping with the adversities and unforeseen events entailed by their daily lives. Rather than aiming to "dictate" their path, we bet on the co-emergence of leading roles and an analytical thought from a participatory movement of encounters, producing a common objective and a shareable experience.

This process took place during our interventions via strategies such as inviting SUS militants to discuss services (including workers, managers, and users) and listing variables that constitute these services, an effective strategy to analyze work processes and give rise to vectors producing the ways of being and doing in these establishments.

Methodological references from work clinics based on expanded research communities/CAP (a nomenclature Brazilian researchers forged) supported these strategies as a method to guide practices in health and work relations. CAP stem from European workers' polls from the first half of the 19th century. Based on the premise that workers can talk about the situations they experience, polls aimed at assessing working conditions and lead workers to critically think about them and how these circumstances articulate capitalist production processes. Ivar Oddone (2020) and a group of researchers created the Italian Worker Model for The Struggle for Health, an Italian trade union movement that proposed expanded scientific communities and inspired the CAP methodology in Brazil. This encouraged the PNH interventions; a methodological clue which created a device called PFST/Health and Work Training Program[11] (BRAZIL, 2011), following expanded scientific communities and offering a set of resources articulated under collective work analyses.

Following reference authors (SCHWARTZ, 2012; CLOT, 2010), we found that the dramatic relation between autonomy and heteronomy always marks work activity. We always work amidst negotiations, choices, and mediations, which are often unconscious and consider the type of insertion of all who share both a work environment, instituted health policies, values, and practices and force and power relations in each situation. We are all co-responsible for managing work situations and can help transform them or keep them as they are.

This vector of our doing reaffirmed the inseparability between activity and subjectivity, as per Clot (2010), to constitute an analysis which intrinsically related these two terms. In the words of the author: "On the one hand, the risk of an activity without subjectivity and, on the other, of a subjectivity without activity. We can say that the clinic of activity seeks to overcome this difficulty" (CLOT, 2010, p. 226-227). Thus, concrete work processes surpass what products materialize or make visible, also encompassing

> […] what one should not do, what one cannot do, what one seeks to do without managing to do so – failures –, what one would have wanted or could have done, what one thinks or dreams of being able to do elsewhere […] [and] […] what is done so as to not do what one must or what one does without wanting to (CLOT, 2006, p. 116).

[10] We make a small inflection in how Yves Clot (2010) indicates the four dimensions of a craft.

[11] See the PNH booklet (BRAZIL 2011) on the PFST.

Still in line with the author, work situations always show tacit cultures which collectives build, guiding subjects' activities and prescribing services. Subjects make several implicit agreements, transmitting them among team members. Such combinations support workers' activity, determining the characteristic ways of acting of that group.

In its areas of (pre)occupation, the PNH faced the challenge that this guideline, aiming at the participatory management of services, would remain insufficient if it constituted a vertical prescription of ways of doing or of goals to be achieved. In many health situations, the usual is to want a product and give little importance to how it may become viable. The work process is then reduced to the product (SANTOS FILHO, 2011). PNH stressed the importance of (re)organizing work processes to change service offer, prioritizing the way of discussing, thinking, and articulating this organization as a team; "what to do" must refrain from supplanting "how-to."

This guided the PNH constitution-intervention, converging in a vector of provocation-invitation to articulate several SUS agents and sectors to strengthen a collective subject and open a polyphonic space agitated by a permanent criticism which, in Foucault's (2013) framework, configures a means of producing health at work and understanding health work. This was the exercise in which we played in the wake of the premise of inseparability between service and subject production. Our experiments produced many effects and opened several clues. HumanizaSUS still pulses, using the very understanding that humanization (as a policy) is unrelated to any hardened organizational structure within a government but as an ethics setting collectives in motion. Thus, it still pulses with the permanent tensioning power of the instituted at SUS. The experience summarized below illustrates this strength, which expresses itself in a recent project whose challenge is to function as a device to implement a health policy in new ways of instituting itself as public, as collectives. We should mention that the brief description of the following experience relates to our aim: to highlight the methodological axes that crossed the PNH as a basis for focusing on health work as its privileged object. This experience helps us to update the references we formulated in 2004.

How humanization references have been updated within SUS practices

Recently, Pasche (2020), a key actor to connect the PNH to SUS sectoral policies during its development in the Ministry of Health, states that one of the most relevant PNH developments occurred in women's health. Pasche (2020) highlights this, noting that the main projects or subpolicies in women's health, including *Rede Cegonha*, aimed to not only organize themselves to search for effective care and management and change their goals, but also to establish a certain way of running field policies and interventions and take the PNH as an ethical standard and methodological reference for the process of change they began to sponsor. Such a reference would have special relevance for *Rede Cegonha* due to its potential to analyze the complex scenario of obstetric, neonatal care at SUS, extrapolating its technical scope and bringing its permeating ethical-political elements to the fore. Thus, humanization forms a basis for analysis and intervention, a principle and method whose main pillar aims to include actors and respect and value the contradictory, operating, as Pasche (2020) stresses, with a generous dialogue between subjects and their differences to reinvent new actions. This scenario derived a nationwide project covering the network of teaching hospitals in the country, signed in an interfederative agreement and involving all three spheres of management at SUS and its adept hospitals (BRAZIL, 2017). A federal university guided the implementation of this project in partnership with educational institutions, linked hospitals, and other related entities. It focused on women's health and all its complex themes related to sexuality, reproductive planning, abortion, vulnerability, and violence, emphasizing an obstetric, neonatal care model.

Rather than highlighting the focuses of this project, |this text aims to emphasize its modes of implementation, identifying the elements forming new bases for institutional work relations (SANTOS FILHO; SOUZA, 2020). First, its objective included a challenge which will always be very dear to the perspective of the PNH, i.e., it proposed a paradigmatic change, developing strategies to tension the traditional model of care in a hegemonic scientific field, in an obstetric, neonatal hospital – and doctor-centered paradigm loaded with invasive procedures that destituted or inhibited women's leading role as the main subjects of the process which would establish itself as an act of caring. In this field of care, the (un)balance between women and healthcare providers' leading roles meets a strong medical presence – a prevailing worker/professional category with its traditional knowledge and practices –, intensifying the asymmetry both between workers and users' (women) and among healthcare providers. Thus, we should stress that SUS – which values a set of autonomy principles – still predominantly excludes and devalues women and specialized healthcare providers' several areas of knowledge and experiences. Notwithstanding these aspects characterizing work in this field, we must highlight some important repercussions and aggravating factors associated with them, such as the still high rates of maternal mortality and the increasing exposure of women to violence in health services. These indicators not only reflect important problems in women's health, but also express more general issues in the models of care and management stilling prevail at SUS. Thus, the theme/project gains transversal relevance as emblematic objects for humanization. On the other hand, the network the project covers – SUS teaching hospitals – takes an unquestionable leading role and faces several challenges in debating care models and professional training.

Thus, the project not only attests to the paradoxes or contradictions within SUS, but also tries to confront them, anchoring the PNH arsenal in the strength of its strategies of collective analysis. i.e., beyond the standard logic of a ministry or government centrally formulating a project under a verticalized planning and evaluation logic and

forcing or prescribing services to comply with its actions and goals, PNH operated in other ways (SANTOS FILHO; SOUZA, 2020). The project put the main PNH premise into practice by stating that "public policy is that one which is built by collectives" (BENEVIDES DE BARROS; PASSOS, 2005, p. 12.), breaking with the government prescriptive tradition, tensioning the public machine where the project was housed. Seeking another approach, the project has been calling for a new type of partnership, assuming it necessarily lied in an interrelation between the local and the general, operating with interinstitutional actors' movement. It especially involved subjects of daily work, disputing and mixing their (several) interests and rearticulating them in the production of a common object. In this context, PNH surpassed the ministerial tradition of ordinances and physical and financial resources, and especially the intermanagements-teams agreement put in place by the institutional support[12] strategy (CAMPOS, 2003; BRAZIL, 2014), which aimed to evaluate the processes established in services and the co-responsibility with, changes in care, management, and teaching practices. It sought to change practices, inviting us to use references that set work and subjectivity in dialogue.

The project took off with a team of institutional supporters in field agendas within services, with local groups in each hospital as permanent interlocutors, consisting of strategic sector heads and professionals' representatives (including residents and students). The main focuses of the project structured its action fronts (with their desired targets and horizons); however, its work methodology led it to take them as experimentation challenges, respecting local singularities, progress stages, care model gaps, and their management and work organization traditions. Thus, it sought the desired aforementioned indissociability between a political-conceptual formulation and service interventions in which concrete experiences would feed the construction of conceptual operators. To follow this path, we borrowed all PNH supporting elements, as we highlight below.

Based on humanization as a policy, the project not only aimed to deal with its target foci in a restricted or isolated sense, but also allowed itself to analytically question and explore the work-activity in the act of carrying out the actions, procedures, and practices in that field of care, emphasizing the work persisting in servicing, managing, and training in obstetric, neonatal care and setting it in dialogue with the broader themes of women's health. Care, management, and training constituted the components of our project, and inspired by the PNH, were taken as inseparable, thus opening the way for reflection on the work permeating them and placing them as analysis-intervention targets. Our 'work object' became a vector and background in the development of our project since, despite perspective changes, it configured an area of great dispute of interests, expressed in models of services/practices which conflicted with various aspects beyond technical-assistance issues. A field in which, amidst 'noises and silences,' several types of practices coexist, both those indicated by evidence-based and those deemed unnecessary, invasive, and inadequate. However, 'choices' and the prevalence of one or the other evade explanation only by a technical lack of preparation or individual objections. Obstetric, neonatal care and teaching hospitals show multiple subjects of interest and values of scientific interest involving women (and men), families, students and workers from several categories, functions, training scenarios, and experiences, etc., their general organization and its multiple sectors, social and gender movements, the church and its dogmas, the State and its principles expressed in regulations which are never self-implementable, etc. Professionals show a marked power asymmetry between categories, workers and their managers, and they and users. On the other hand, as health work in general, this work occurs in amidst various types of current transformations in the productive system and reflexes in local organizational processes, with increasing technological incorporation, expansion of pharmacomedicalization, excessive adoption of protocols, and practice hypercoding and standardization, often stiffening care relationships and aiming to limit workers' autonomy in the exercise and control of their doing (SANTOS FILHO; SOUZA, 2018). Models of attention are disputed in this scenario, coexisting amidst diverse interests and disputes of meaning in which multiple actors argue and act from different places and technoscientific and ethical-political orientations.

In this complex scenario, what are the challenges of working in care, in training people, and in managing them? How would we be unable to make this discussion in this field of work? Or, what are the consequences of restricting the discussion – about training, management, care – only to qualification (technopractice) for professional practice? Note that the project expanded discussion spaces on the established ways in which such work is effective, minding that, in its fragmentation, one of its main marks is the fact that it is learned, executed, reproduced, and centered on procedures, maneuvers, etc., in a centrally instrumental bias (necessary but insufficient qualifications to guide a care model). These configured issues to guiding analyses and always leave it as the background of the project, in the sense of a horizon of vigilance in refraining from reducing the discussion to a 'simple prescription and/or professional/institutional preparation for a certain type of practice.' This is not the case as, if thus, the existence of guidelines and rules to ensure a particular practice would suffice. In women's health, this scope of analysis (and alertness) can be easily illustrated when we observe, for example, that the Ministry of Health, as a formulating and regulating institution of actions in health/SUS, has a set of policies and regulations on the (good) model it proposes and, nevertheless, the reality of the services still show several inadequate practices and the dismissal of its guidelines (SANTOS FILHO; SOUZA, 2020).

[12] Institutional support constituted one of the main PNH strategies. Campos (2003) proposes it as innovative management to create groupality, setting up organized collective networks to produce health and increasing managers, workers, and users' participation.

Therefore, the perspective of the project aimed to expand and displace movements, which we channeled as perspectives of analysis-intervention, in the references brought in this text, constituting a displacement, especially from the perspective of promoting opportunities for an approach with teams in the established modes of practices, their ways of being at work, and (re)inventions necessary in the light of an ethics of care. We operated this idea of intervention to create collective, participatory spaces, analysis of reality, and the joint construction of the conditions necessary to change/improve working processes in management-teaching-care. It configured a challenge in the very ways of approaching hospitals/teams, enabling, on the way, the confrontation of many objections under resignification, many gaps opening in work processes spaces, and above all, in the directions of expanding conversations. In these databases, the project deemed work as a meeting (SCHWARTZ, 2012) and, well-fitting in the conception of expanded research communities, added multiple actors/teams and composed a network of about 100 hospitals in a transversal movement of analysis and intervention in their own actions. We indicate the methodological matrix of this experience in the references (SANTOS FILHO; SOUZA, 2018; SANTOS FILHO; SOUZA, 2020) and in all its cartography under current systematization.

In conclusion: how to claim the usefulness of humanization during a health system crisis

As we attempt to implement projects, we observed their instituting challenge, offering the tension of established modes of management, processes, and care operationalization at SUS, thus constituting work intervention technologies. This implies assuming that projects are insufficient to implement actions for change – the projects fail to necessarily enable or guarantee them – requiring that they establish themselves as tools to innovate institutional partnerships and show devices to analyze work, mobilizing subjects so they can (de)construct practices, processes, and subjectivities, creating conditions for change.

The PNH taught us this challenge, which we find to remain valid (or be even more so) during the current crisis in Brazilian public health. The authors of a recent issue of *Ciência & Saúde Coletiva*, dedicated to the 30th anniversary of SUS (ABRASCO, 2018), evaluated its advances and gaps, warning and denouncing the threats to it. In addition to disinvestment vectors and government dismantling, SUS lacks the support of essential sectors and movements and suffers the demobilization and opposition of professionals and the media and the financial interests of the health business market. The worsening of work conditions is its most explicit and perverse face as it represents 'carelessness' with the subjects making the machine work daily. Thus, SUS not only remains an incomplete and open health reform as a mark of a public policy (thus evaluated at the time of construction of the PNH), but also currently faces the risk of regression and dismantling. Given this context, we claim that the ethical-political reference of humanization is not only current, but also necessary and urgent to cope with conjunctural adversities.

At the time of this draft, Brazil is experiencing the worst health crisis in its history, with the threats of COVID-19 and total negligence (and even attack) from its government on measures which would mitigate it (CAMPOS, 2020). Health work occupies the center of this crisis, suffering, risk, threats, (pre)occupations, and even the tragic effect of death due to insufficient and precarious health working conditions. Obviously, discussions on basic infrastructure should have taken place immediately, such as that on inputs and protective equipment for professionals, but such punctual debate fails to reverse the worsening of health work or solve the complex chronic issues of its organization, which still demand attention. This is an essential agenda of the PNH, a program which aims to focus its discussion on valuing work in an expanded dimension of value, such as increased participation, inclusion, emancipation, recognition of different knowledge and experiences, and reduction of asymmetries in knowledge and power relations within institutional hierarchies and between subjects in spaces of professional conviviality (SANTOS FILHO; BARROS, 2007). Thus, we must stress the PNH premise of recognizing unfavorable and oppressive conditions in health work, rejecting the victimized or passive positions workers and/or managers sometimes take, often idealizing 'solutions from the outside or from the other' or by merely 'change in the agendas' (SANTOS FILHO; BARROS; GOMES, 2009). These idealized expectations would go against PNH perspectives. This chronic state of affairs, in which problems have intensified, requires the idea and tools of humanization because they produce collective involvement to increase their analytical and intervention capacities, thus engaging in new ways of organizing and reinventing work.

Reinforcing the challenge we articulated, we evoke a maxim from the time of the birth of the PNH, when Benevides de Barros and Passos (2005) stated that it was necessary to understand that the paradox (and challenge) is/lies in the operation of a public machine which must experience a relation of tension or even repulsion in the face of the public thing. Currently, the State has aimed not only to derail the changes necessary for the consolidation and improvement of the SUS, but also to damage its principles and structuring bases, requiring that we remind ourselves of the PHN perspective to maintain us in the active surveillance of our own capacity to resist or re-exist, as per the PNH itself.

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References

ABRASCO. Associação Brasileira em Saúde Coletiva. Trinta anos do SUS: contexto, desempenho e os desafios do SUS. *Revista Ciência & Saúde Coletiva*, Rio de Janeiro, v. 23, n. 6, p. 1704-2078, 2018. Disponível em: https://www.abrasco.org.br/site/revistas/ciencia-saude-coletiva/30-anos-do-sus-contexto-desempenho-e-desafios/34846/. Acesso em: 4 jun. 2021.

BARROS, Maria Elizabeth Barros de; BARROS, Regina Benevides. Da dor ao prazer no trabalho. In: SANTOS FILHO, Serafim Barbosa; BARROS, Maria Elizabeth Barros de (Org.). *Trabalhador da saúde: muito prazer*!: protagonismo dos trabalhadores na gestão do trabalho em saúde. Ijuí: Unijuí, 2007. p. 61-71.

BARROS, Maria Elizabeth Barros de; SANTOS FILHO, Serafim Barbosa (Org.). *Trabalhador da saúde: muito prazer*!: protagonismo dos trabalhadores na gestão do trabalho em saúde. Ijuí: Unijuí, 2007.

BARROS, Regina Benevides. A Psicologia e o Sistema Único de Saúde: quais interfaces? *Psicologia & Sociedade* [online], v. 17, n. 2, p. 21-25, mai/ago, 2005. https://doi.org/10.1590/S0102-71822005000200004

BARROS, Regina Benevides; PASSOS, Eduardo. Humanização na saúde: um novo modismo? *Interface: Comunicação, Saúde, Educação* [online], v. 9, n. 1 7, p. 389-94, 2005. https://doi.org/10.1590/S1414-32832005000200014

BENJAMIN, Walter. O anjo da história. Belo Horizonte: Autêntica, 2013.

BRASIL. Ministério da Saúde. Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização. *HumanizaSUS*: documento base para gestores e trabalhadores do SUS. Brasília: MS, 2006. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/humanizasus_documento_gestores_trabalhadores_sus.pdf. Acesso em: 10 mai. 2021.

BRASIL. Ministério da Saúde. Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização. *HumanizaSUS*: documento base para gestores e trabalhadores do SUS. Brasília: MS, 2008.

BRASIL. Ministério da Saúde. *Gestão participativa e cogestão*. Brasília: MS, 2009. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/gestao_participativa_cogestao.pdf. Acesso em: 25 ago. 2021.

BRASIL. Ministério da Saúde. Trabalho e redes de saúde. *Cadernos HumanizaSUS*: Cartilhas da Politica Nacional de Humanização. Brasilia: MS, 2011. p. 95-106 Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/caderno_textos_cartilhas_politica_humanizacao.pdf. Acesso em: 15 ago. 2021.

BRASIL. Ministério da Saúde. *Cadernos HumanizaSUS*: Humanização do parto e do nascimento. Brasília: MS, 2014. v. 4. Disponível em: https://www.redehumanizasus.net/sites/default/files/caderno_humanizasus_v4_humanizacao_parto.pdf. Acesso em: 3 set. 2021.

BRASIL. Ministério da Saúde. *ApiceON*: aprimoramento e inovação no cuidado e ensino em obstetrícia e neonatologia. Brasília: MS, 2017. Disponível em: http://www.cofen.gov.br/wp-content/uploads/2017/08/Revista-Apice-ON.pdf?undefined=undefined. Acesso em: 27 ago. 2021.

BRITO, Jussara; ATHAYDE, Milton. Trabalho, educação e saúde: o ponto de vista enigmático da atividade. *Trabalho, Educação e Saúde* [online], v. 1, n. 2, p. 239-265, 2003. https://doi.org/10.1590/S1981-77462003000200005

CAMPOS, Gastão Wagner Souza. *Saúde Paidéia*. São Paulo: Hucitec, 2003.

CAMPOS, Gastão Wagner Souza. O pesadelo macabro da Covid-19 no Brasil: entre negacionismos e desvarios. *Trabalho, Educação e Saúde* [online], v. 18, n. 3, e00279111, 2020. https://doi.org/10.1590/1981-7746-sol00279

CANGUILHEM, Georges. *O normal e o patológico*. São Paulo: Forense Universitária, 2009.

CLOT, Yves. *Função psicológica do trabalho*. Petrópolis, RJ: Vozes, 2006.

CLOT, Yves. A psicologia do trabalho na França e a perspectiva da clínica da atividade. *Fractal: Revista de Psicologia*, Niterói, v. 22, n. 1, p. 207-234, 2010. https://doi.org/10.1590/S1984-02922010000100015

DELEUZE, Gilles; PARNET, Claire. *Diálogos*. Lisboa: Relógio d'água, 2004.

FOUCAULT, Michel. É importante pensar? In: MOTA, Manoel Barros de (Org.). *Repensar a Política*. Tradução de Ana Lucia Paranhos Pessoa. Rio de Janeiro: Forense Universitária, 2013. Coleção Ditos & Escritos, v. 6. p. 178- 182.

GUATTARI, Félix. *Psicanalise e transversalidade*: ensaios de análise institucional. Aparecida, SP: Ideias e letras, 2004.

LIMA JÚNIOR, Joe; ALCHIERI, João Carlos; MAIA, Eulália Maria Chaves. Avaliação das condições de trabalho em Hospitais de Natal, Rio Grande do Norte, Brasil. *Revista da Escola de Enfermagem da USP* [online], v. 43, n. 3, p. 670-676, 2009. https://doi.org/10.1590/S0080-62342009000300024

LOURAU, René. Implicação: um novo paradigma. In: ALTOÉ, SONIA (Org.). *René Lourau*: analista institucional em tempo integral. São Paulo: Hucitec, 2004. p. 246-258,

ODDONE, Ivar. Ambiente de trabalho: a luta dos trabalhadores pela saúde. In: ODDONE, Ivar (Org.). *Ambiente de trabalho*: a luta dos trabalhadores pela saúde. 2. ed. ampl. rev. São Paulo: Hucitec, 2020. v. 1, p. 11-142.

PASCHE, Dario. Prefácio. In: SOUZA, Kleyde de Ventura; SANTOS FILHO, Serafim Barbosa. *Educação profissional em saúde*: metodologia e experiências de formação-intervenção-avaliação. Porto Alegre: Moriá, 2020.

SANTOS FILHO, Serafim Barbosa; BARROS, Maria Elizabeth Barros de; GOMES, Rafael Silveira. A Política Nacional de Humanização como política que se faz no processo de trabalho em saúde. *Interface: Comunicação, Saúde*, Educação [online], v. 13, supl. 1, p. 603-613, 2009. https://doi.org/10.1590/S1414-32832009000500012

SANTOS FILHO, Serafim Barbosa. Análise do trabalho em saúde nos referenciais da humanização e da relação de serviço. *Tempus - Actas de Saúde Coletiva*, v. 5, n. 1, p. 11-32, 2011. Disponível em: https://www.tempusactas.unb.br/index.php/tempus/article/view/987. Acesso em: 12 out. 2021.

SANTOS FILHO, Serafim Barbosa; SOUZA, Kleyde Ventura. Pesquisa-intervenção sobre as práticas de atenção e de formação nos hospitais de ensino no Brasil: rede de inovações para a mudança de modelo de formação e atenção ao parto e nascimento na rede SUS. In: CONGRESSO BRASILEIRO DE SAÚDE COLETIVA, 12, 2018, Abrasco. *Anais*... Rio de Janeiro, 2017.

SCHWARTZ, Yves. *Le Paradigme Ergologique ou um Métier de Philosophe*. Toulouse: Editions Octarès, 2000.

SCHWARTZ, Yves. Reflexão em torno de um exemplo de trabalho operário. In: SCHWARTZ, Yves, DURRIVE. Louis. (Org.). *Trabalho e Ergologia*: conversas sobre a atividade humana. Niterói: Eduff, 2007. p. 37-46.

SCHWARTZ, Yves. *Manifesto ergológico em clínicas do trabalho*: novas perspectivas para compreender o trabalho na atualidade. In: BENDASSOLI, Pedro; SOBOL, Lis Andrea P. (Org.). São Paulo: Atlas, 2010. p. 132-167.

SCHWARTZ, Yves. *Le travail comme rencontres*: entre le visible et línvisible, le defi d´évaluerle travail. *Tempus: actas da saúde coletiva*, Brasília, v. 6, n. 2, p. 27-44, 2012.

SCHWARTZ, Yves; DURRIVE, Louis. Travail et gestion: niveaux, critéres, instances. *Rev. Perform. Techn*. (Paris) n. hors-série, p. 10-20, 2000. Disponível em: https://www.paristechreview.com/. Acesso em: 2 jul. 2021.

SCHWARTZ, Yves; DURRIVE, Louis (Org.) *Trabalho e ergologia*: conversas sobre a atividade humana. Niterói: EdUFF, 2007.

TARDE, Gabriel. *Monadologia e sociologia*. Petrópolis, RJ: Vozes, 2003.

VIRNO, Paolo. Multidão e princípio de individuação. *Lugar Comum*: estudos de mídia, cultura e democracia. Rio de Janeiro: LABTeC/UFRJ, n. 19, 2004. p. 27-40.

WISNER, Alain. *Inteligência no trabalho*: textos selecionados de ergonomia. São Paulo: Fundacentro, 2004.