

About health care in a general hospital

Sobre cuidados em saúde em um hospital geral (resumo: p. 14)

Sobre cuidados de salud en un hospital general (resumen: p. 14)

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This article analyzes health care practices experienced in a general hospital of the Brazilian National Health System, with the intention of problematizing and reflecting on the care and health practices that are present among people, in the daily service, in the relationships and flows that are established. We use ethnography to describe a scene that reflects the relationship between knowledge, care and un-care practices that are performed in a hospital. We propose to think of care as multiple and we observe the hospital from its constitution as a “healing machine”. We reflect the encounter between professional and user, between the caregiver and the one who receives the care, to propose that in any and all health meetings, certain care is performed.

Key-words: Health practices. Health care. General hospital. Ethnography.



Introduction

This article analyzes health care practices as they were experienced in a general hospital of the Brazilian National Health System (SUS) with the aim of problematizing and reflecting on the care and practices that are present among people, in the daily life of the service, in the relations and flows that are established, in the words, both spoken or silenced.

Based on a scene that describes concerns experienced in health practice, we focus the discussion on the care that is practiced, seeking to recognize the possible knowledge around it and how this care produces bodies.

In this analysis, we assume the referential proposed by AnneMarie Mol¹, working with the idea of practicalities, or care put into act, “enact”¹ (p. 32), emphasizing how it is constructed in practice, with the multiplicity of glances and different types of knowledge that affect bodies and corporeality, constituting more or less moral forms of intervention that denounce the tension existing in this relationship. This is a kind of care that makes the body, giving different materialities to that body.

Following Mol¹, we seek to reflect less on the fragmentation of care, which presumes, somewhere, to find its opposite: a full, un-fragmented, therefore, complete care; and more, the care that presents itself in multiple forms, recognizing that, like the body and its diseases, they are also multiple.

Therefore, the theoretical status to be pursued in this article is not care defined *a priori* as in a health practice to be followed and reproduced, but the care that is possible to be given by a human being to another human being, in certain situations and contexts, more or less precarious, that mark their lives and define what they do and how they do it.

This is an ethnographic study on health care, written from memories and situations experienced in a general hospital, bringing to the center of the analysis a triggering scene. The scene is assumed as “a presentation of the real, a verbalization of vitality”² (p. 186), where the universe of care, with other professionals, users, family members, managers, and many others, make up the multiple voices that are presented.

Mol¹ says that ethnographic studies about physicalities are recent and that, for many years, research on the physical body was the object of biomedicine, while social scientists kept their distance from the “body-talk”¹ (p. 7). However, there is something about the body that is beyond medical knowledge.

The reality of living with an illness does not fit only into physicality, nor is it a matter restricted to psychosocial issues. Therefore, what is being argued here is that the body is not restricted to biomedicine and the human does not concern only the psychosocial. The goal is not to do ethnographic “feelings, meanings, or perspectives”¹ (p. 15), which are personal interpretations, possible to each subject in a singular and distinct way, but to work with the care done in practice. When describing a health care scene, it is not the facts themselves that matter, but a possible analysis of the values brought by the scene, as



well as reflecting on the practicalities and the materialization process in which categories are formulated and activated, establishing definitions about who “provides” care, the care that “is given” and the care that “is not given”, what is understood as care; and who deserves to receive it or not.

In this way, ethnography is assumed as a mode of knowledge production, a research principle, and also as a genre of writing, articulated to politics and poetics. As summarized by Clifford³, ethnography in its dimension of “hybrid textual activity”³ (p. 61), crosses genres and disciplines, being always writing and acting. This writing enabled the description and reflection about care that was lived and seen, an analysis of the processes that operate relationships between care and health organization, how the rules operate, who sustains them, what they produce of life and death, and what effects they have on the production of care.

The constructed narrative is the result of a combination of different situations experienced during the years of work in the hospital and of themes debated in public health; therefore, a narrative permeated by the glance, memory, and by what is important to us. These are constructions in which we used resources borrowed from psychoanalysis, such as “condensations”, “displacements”, and “interpretations”⁴.

It is important to emphasize that health professionals, patients, and family members were preserved in this article. Added to the resources already mentioned, through which the facts are reworked by the memory, being, therefore, constructed and reconstructed, there is also the protection of any identity that could still escape from such resources.

Introducing the scene

A lady arrives at the hospital, brought by her children, wearing a wide dress, covering arms and legs, and carrying a wound on her foot. After evaluation by the team on duty in the emergency room, she is admitted to the Internal Medicine Clinic, submitted to tests that indicate the diagnosis of diabetes in an advanced stage and, until then, untreated.

Once the diagnosis is completed, the clinicians request surgeon evaluation, to define the treatment intervention to be performed. In the face of the foot wound, the decisions about the interventions to be made produce another corporality: “amputation of the toes” involved in the wound, and medications to “control the diabetes”.

The lady listened to the doctors who were evaluating her and marking with a pen the part of her foot that should be removed, amputated from her body. Then, very calmly, the lady said: “I came into the world with ten toes and I will come back with ten toes”. The doctors did not mind this phrase in the tone of a prophecy, and went on with their decisions and demarcations about other people’s bodies. However, the lady was determined about her own body. She did not accept the fasting that was necessary to prepare for the surgery, nor the necessary medications. She kept saying that they would not remove her toes.



This scene is one of many that make up the daily life of a SUS general hospital. A patient's refusal to undergo medical interventions is not an uncommon or strange scene for health professionals; it can provoke questions and mobilize professionals who work in assistance. On one hand, there is the idea that it is necessary to guarantee the care considered appropriate by the team, in this case: amputating the fingers. On the other hand, there is what each subject wants for his or her own body and understands as care, in the case of this woman: not wanting to lose her fingers.

The question becomes stressful: is amputation adequate for her? In the daily life of the health service, there are men, women, bodies, feet, diabetics or not, that express their resistance and refusal; we usually call these situations "abandonment of treatment". Several situations go through the daily routine and follow the prescriptions, but what do people want for their own bodies? What do they expect from professionals and services? What do they consider to be good for them? What is considered care? Is there even an open space for these questions?

In the literature that discusses the production of health knowledge, there are important reflections that problematize the intervention on the bodies and what is normative in these processes. Canguilhem⁵, reflecting on the medical stance regarding the determination of normal, health, or disease, states that "what interests to doctors is to diagnose and cure"⁵ (p. 94). The doctors' object is the sick body or the sick part of the body, and their goal is to make it return to its "normal" state. The hospital is the privileged place to reestablish this normal and for the sick person to become a normative individual again.

When discussing modern scientific medicine, Foucault⁶ shows how it is built in a continuous process of delimitation of new spaces of action, getting ownership and defining what is a health issue, normalizing and medicalizing life spheres. The medicalized hospital is configured as a "healing machine"⁶ (p. 173), with no space left for religion or for "lay knowledge". Religious knowledge and other knowledge beyond medicine, which coexisted in hospital institutions, were replaced by scientific knowledge, which still operates based on a moral, supported by a "legitimate knowledge" that defines the ways of doing health in that space and in the doctor-patient relationship.

Returning to Canguilhem⁵, the hospital occupies the space where a health practice is mechanically and automatically produced and reproduced, in which it aims at "returning to the norm a function or an organism that had been separated from it"⁵ (p. 94).

A first look at the scene described allows us to recognize the tensions that present themselves between lay and scientific knowledge, removing the possibility of dialogue around care possibilities other than the biomedical. The medicalization of life imposes itself as the only way out for health practices. At this point, we can reflect on the fact that care practices have also been medicalized and are at the service of the colonization of medical knowledge, as analyzed by Mattos⁷.



Producing care

While in the psychology room, a request arrives, requesting an opinion, sent by the Internal Medicine Clinic, about a lady in a bed in this sector. The psychologist gets to know the case. She opens the medical chart, reads the reason that took the patient to the hospital, talks to some nursing technicians who are at the medical station. The reason for the request is clarified and psychology begins to attend this person who rejects the amputation protocol suggested by the doctors. The lady is lucid and oriented, tells her story and talks about the decision she has made: “I won’t live without my ten fingers”.

The psychologist addresses the medical team, which is in an altered state, indignant at the refusal of the indicated care, considered necessary in this case. The doctors are mobilized, they say the same phrases: “the part of the foot has to be amputated”, “it’s a very small part”, “it has to be done”, “she has no choice”, raising the question if such care would be indicated or imposed.

In order to go into surgery, the patient has to sign a consent form for the amputation, however small. If she were unable to sign, a family guardian would sign in her place. However, the patient is awake, lucid, and determined not to sign for the removal of her fingers.

The doctors keep her in the hospital for a few more days, hoping to convince her. They bet their chips on the psychology department and on the family members who will help “open the eyes” of the patient to the “need to amputate those expendable toes”.

As days go by, the lady stays in the hospital; she hasn’t changed her mind about her refusal to lose part of her body. She accepted the medications to control her diabetes, but she still refuses amputation. The drug treatment can and should be done by the patient at home; therefore there is no need for hospitalization. There is no reason for her to stay in the hospital.

Despite their intentions to follow the protocol to the letter, the doctors allow the patient to leave the hospital. They discharge her from the hospital with numerous reservations and documents showing the diagnosis made, the need for surgical intervention to amputate her fingers, emphasizing the patient’s refusal to undergo the necessary treatment. Those documents back up their actions to avoid future questioning. Those are documents that reaffirm medical knowledge and discredit the knowledge that guides the production of life and the construction of this lady’s world. The patient leaves the hospital with her children and her papers.

This patient went to the hospital to take care of her injured foot, put her body to be analyzed in clinical and laboratory exams, as shown by Mol¹, in the interaction with the physicians, she did and was done through a diagnosis of diabetes, accepting the oral and injectable medications responsible for regulating the sugar levels in her blood, refusing the surgical intervention of amputation of the toes and later of the whole foot. She said she could not live without a part of his body, she recognized this as a limit of her own body, to be alive and to be in life.



In the context of health services, all professionals will have their own view of what is happening with a given treatment or patient, just as the users has their own truths about what is happening to their health. The reading proposed by Mol¹ brings interesting questions, because it allows us to recognize that each way of looking at it will produce a body, becoming a multiple body, or what Foucault⁸ points out as knowledge produced from the angle of the specific look.

A patient can relate her/his illness to her/his religiosity. A doctor may credit her/his treatment to her/his scientific-technological knowledge and access. A psychologist may make a psychoanalytic interpretation of this patient's relationship with her illness, with her doctor, and her treatment. A nurse may believe that by fully following the standard operating protocols care will be guaranteed. A manager may worry about the indicator of death from diabetic foot that may increase with the refusal to amputate this lady. There is not one of these stories truer than the other. All these possibilities and regimes of truths travel the hospital corridors, up and down stairs or elevators, in and out of sectors. All these narratives cohabit and make the sick body.

But in this scene, the knowledge of the medical team takes the place of legitimacy, overriding the lady's knowledge about her body. The knowledge of the doctors, of the psychologist, of the nursing team, of the on-duty physicians, of the technicians who collect and analyze the blood that runs in the woman's veins, all this knowledge constitutes and makes up the discourse of biomedicine and scientific knowledge. A health knowledge that, in the hospital setting, imposes itself on other ways of knowing and being in the world. A knowledge that operates to order, normalizes, and educates, defining what is good for the other.

These are different types of knowledge, with their own unfolding that take place on the bodies, which constitute biomedical rationality. In this sense, based on Mol¹, we can think about multiple types of knowledge that cohabit and make multiple bodies. Or, as Camargo Jr⁹ suggests:

The articulation of types of knowledge among themselves and between them and practice is fluid, which makes medical practice to be seen, in this particular aspect, as an endless exercise of creation of scientific ideologies⁹. (p. 184)

Such ways of articulating knowledge in health seem to build a certain path and ways of doing health, which are reproduced as a standard, creating norms. A circle is created and reproduced in different health services, such as, for example, the few words in the appointments, in which it is assumed that the person who needs and seeks care knows little about what ails her/him, and that this knowledge is up to the health team. The health team, besides knowing, has the power to give or not this care, and even the supposed cure. The patients' knowledge about what they feel is placed in secondary terms, inscribed in narratives and regimes of truth that are not allowed to enter the hospital.

It is important to acknowledge that health is not the only way to produce care or to make people feel better. Human beings have multiple expectations and may have other ways of living that do not operate within the logic of health. There is care



outside the health care devices. However, in the hospital, a device that operates in the assistentialism logic, it is difficult to recognize care beyond what health can offer and enable in relation to the already established way of doing health.

In the abovementioned scene, it is possible to quickly notice the patient's refusal to accept the intervention of amputating her finger, but there is another refusal at play, harder to be noticed or to provoke strangeness: the refusal of the medical team to accept this patient's position, a fact that makes the doctors ask for psychology services to reverse her position, that is, the doctors resort to another scientific knowledge, which also legitimizes a knowledge and doing about the other's body.

However, there is still no recognition of this woman's speech and knowledge about herself and her way of being in life. For health professionals, if you carry pathology, you are outside the so-called normal limits, therefore, you become pathological. You choose to go on being pathological and in this choice you break with biomedicine, which prescribes what is normal and the best way for this patient to go on in life. Doctors seem not to recognize that the being considered pathological may want to remain pathological, an agency of the pathological, putting in check the edifice of medical knowledge.

Health professionals, with their biomedical care, reaffirm the discourse of medical rationality, operating guardianship and control over the body. The lady with her posture reaffirms the faltering of the biomedical discourse.

The woman who appears to the doctors is diabetic, with an open wound on her foot, needing medication and amputation. In the hospital, this woman becomes just a finger to be removed, part of a body, which can be taken in its dimension of object, to be examined, accessed, opened, moved, amputated, healed.

The woman around the finger, her clothes, skin color, way of being, what she believes for her body and life, her principles, in short, her knowledge, are erased and removed from the scene. The knowledge that she carries, that has been constituted as a regime of truth for her, and the fact that she does not renounce what she believes in front of the doctors, is what we want to bring to the reflection, for making it alive that countless kinds of knowledge cohabit the body, no matter how much we try to erase them.

A reflection about health care is key; because there is no doubt that it is crossed by the biomedical logic and knowledge. But what type of opening to the debate about health care exists, when other models for the organization of care are presented?

Debating health care

The debate in Public Health has emphasized for decades the need to add care to health practices. When discussing this issue, Ayres¹⁰ brings to the analysis the invisibility of the other, the need to interact with the other, and especially the need to legitimize this interaction, which in a first step, implies recognizing the presence of the other and respect for the other in health practices.



The author offers two meanings for care: care, a common noun, which refers to activities and procedures in the common sense; and a proper noun, Care, an ontological concept taken from Heidegger and defined as “a health care immediately interested in the existential meaning of the experience of physical or mental illness and, consequently, also of the practices of health promotion, protection or recovery”¹⁰ (p. 22).

Still with Ayres¹¹, the concept of care has

the construction of the commitment of health techno-sciences, in their means and ends, with the realization of values that are counterfactually related to human happiness and democratically validated as common good¹¹. (p. 128)

The author states that humans invent themselves and their world, construct and reconstruct themselves, and understand this movement as care. Based on this, it is possible to assume that health practices are also care, since they are unprecedented, invented at each encounter between health professional and patient, constructed and reconstructed, even if there is a defined technique with protocols and regulations.

Barros¹² also states that the practice of care should not be restricted to the procedures used by the professionals, but should be “a path of encounters and problematizations that take place in the work processes”¹² (p. 120), in a collective performance, with their exchanges about health practices, transforming the work into a “continuous process of constitution of subjects and worlds”¹² (p. 120).

Mattos⁷ talks about the need to recognize the “concrete ways of living life”⁷ (p. 338) in the care practices, inviting to peer beyond what is defined by medical rationality as well as prescribed in the norms, to observe what happens “concretely” in the day-to-day of the health services, impregnated with life, with its contradictions, naturalizations, and resistances. In this sense, it is also a meeting between health professionals, who have some knowledge about diseases, and people who have some knowledge about their bodies, their diseases, and their lives.

Cecilio¹³ presents a debate regarding health care management, highlighting six dimensions to be considered: individual, family, professional, organizational, systemic, and societal. For the author, care results from the crossing of these dimensions, with different actors involved. In this way, care is understood as political encounters between subjects, with their different resources, who carry interests, needs, and meanings in their own name, and who, through their actions, are in a process of producing social life.

Merhy¹⁴ also sees health practices as an encounter: “Any health care approach by a health worker to a user-patient is produced through a live work in act, in a process of relationships, that is, there is an encounter between two ‘persons’”¹⁴ (p. 112).



In this way these authors invariably relate care to the encounter. Therefore, the focus is not only on the relationship between the caregiver and the one receiving this care, but also on an internal process of each subject, professional or health user. It is an encounter beyond the technique, steps, and procedures. The encounter that characterizes the care may or may not take place between the caregiver and the being cared for.

From this perspective, how may be called whatever happens between health professionals and users when there is no such encounter? In the scene brought for discussion, what can be said of this encounter as care? What we mobilize for debate is the reflection on what we activate and value when defining care as an encounter.

Foucault⁸ highlights the existence of an impossibility of the doctor-patient encounter, which seems not to be recognized, leaving the encounter reduced, simplified, or even romanticized. He highlights the inequality that sustains this relationship, marked by a hierarchy, subjugating both.

In this way, health care practices are inserted in the logic of medical rationality, at the same time that it constructs and maintains it. In a kind of “flywheel”, there is nothing outside this know-how, although there is always the possibility of, in the repetition, changing something, and in an act, building new possibilities.

By following this logic, we reflect that if, on one hand, biomedicine defines “the” health practice to be followed and reproduced, on the other hand, its critics have not escaped from creating definitions about the path to be followed, to build good care. Both define care practices and do so anchored in their moral operators. Both present different facets of the same knowledge and present themselves as definers of health care.

The question raised here is whether all health care practice would not take place through an encounter that is different each time. It seems that only the care that is considered “good” and “legitimate” is characterized as an encounter. We run the risk of falling into more health dichotomies: health practice and care, good care and bad care, or care and un-care.

Once again we make use of Foucault’s argument¹⁵, to think about care and its encounters, to reflect on the shift to be made in the question. It is not a matter of defining a health practice as good or bad, but of recognizing that medicalization leaves radical marks on life, which can also present in critical constructions to biomedicine, which bet on the creation of other paths for health practices and in the dialog with the sick subject. What dialogues could be possible to establish with this woman on the scene?



Outcomes

The woman who appears on the scene brings a question beyond healing and care in the hospital. She could have accepted or denied the amputation. The important thing to emphasize is the possibility of a choice to do with her body and the possibility of acceptance or not of this choice by the health team. This is a type of knowledge that refers to the knowledge and autonomy over her body and her life, which includes her subjectivity, desire, faith, intuitions, beliefs, and values. It is a knowledge about oneself that finds little space in modern science.

In the scene, medical knowledge was affirmed, but uneasiness was already established among the team, for the outcome was marked by being different from what the doctors indicated. The patient's refusal to amputate produces a cut that opens a wound in the medical team's discourse and, therefore, in their knowledge. The woman with the dead finger kept in her body shows that she is alive.

Besides reflecting on the production about health care, we consider important to also bring up for discussion what is done daily in health services, care, with or without the "encounter" prescribed by the specialized booklets on the subject. What happens between professionals and patients is care, the possible care, in the possible relationship between those people who occupy the hospital space.

Health care takes place in the relationship and interaction between professional and patient, and even more in the relationships that the subjects establish with their own worlds, with their insertion in this world, with the knowledge considered "legitimate" or not, and with the new world that is opened before the contact with the other.

In this scene, in addition to the two refusals, we can observe two indignations, one on the part of the doctors and the other on the part of the patient with what they put forward. The patient does not accept the idea of amputation and the doctors do not accept her refusal. The lady sees herself as a subject only with her 10 fingers, and only then is she able to inhabit the world she has produced for herself. Doctors only feel themselves as subjects when the patient accepts their indications for treatment, interventions, and cure. Here it is clear how doctor-patient interaction, and thus health care, takes place on a stressful terrain.

Care is provided over that body lying on the stretcher, one by one, each professional deposits his or her health care on that body. Body and care are multiple; we are interested in the coordination of this multiplicity, the recognition of how care is kept together, cohabitating and making the body.

Just as medical knowledge can colonize lives, Mattos⁷ warns us about "the possibilities of repetitions and recurrence of strategies and tactics, which also produce colonization"⁷ (p. 332). Therefore, other discourses can colonize lives and define the "right" way to do health. The author proposes, as a way out to the colonizing medicalization, "the critical reflection of our practices"⁷ (p. 332), the attempt to identify in our speech and actions the "colonizing power over the other. This implies renouncing the idea that we know the best form of conduct for people"⁷ (p. 333). The acknowledging of this absence of answers can open space for reflection and discussion about the care that happens in the daily life of health services.



The interest is not to work on the fragmentation of knowledge and practices. We cite again Mol¹, whose focus is multiplicity, not fragmentation. The goal is, based on the recognition that care is multiple, to be able to reflect on ways in which this multiplicity can happen, interconnect and connect, that is, to think about the ways in which care happens “on the ground,” in the daily life of health services. Care is multiple. Perhaps one possibility for thinking about care is to recognize its multiplicity, without trying to superimpose one form of care over another. Canguilhem⁵ recognizes the difficulty of caring in life.

Caring of oneself... how difficult it is, when you lived without knowing what time you would eat, without knowing whether the stairs were steep or not, without knowing the time of the last streetcar, because if the hour had passed, you would walk home, even if it was far away⁵. (p. 158)

Caring for other and caring for oneself continues to be difficult. We don't and will never know when we eat, if the stairs are steep, or the time of the last streetcar. Or even if we know this information, life will continue to be lived without knowing, without knowing the events that will happen to us. This is lived in a hospital: life by a thread, crossed by the last streetcar. And there is no possible prescription, not even “the” medical prescription that will take care of it.

After a while, the lady who denies amputation of her fingers returns to the hospital denying amputation of part of her leg. After a longer time, she returns to the hospital denying amputation of her entire leg. She returns to the hospital from time to time and denies amputation of part of her body. This happens until she arrives at the hospital disoriented or unconscious and the doctors, without needing her permission, perform the leg amputation surgery.

When she wakes up in the ICU, the lady finds herself without her leg, she can't speak any more, and she doesn't resist. She dies in a few days. After all, as she said, countless times, she doesn't know how to live without part of her body, without part of herself. The doctors do not understand the patient's evolution to death. After all, the patient's vital signs were great and the surgery had been a success.

Is it possible a way to preserve the patient's choice and autonomy, recognizing the differences in ways of seeing and thinking about the amputation or not of her fingers? What dialogues are possible between those who care and those who are cared for?

The lady was discharged from the hospital and went home with her papers, her children, her life, her rotten fingers, and the orientation that she could return to the hospital at any time. The health team made it clear that they disagree with the conduct adopted by the lady, but respect and will continue to care for her and her foot in the possible way: sanitizations and dressings on the wound on her toes, what in mental health is conventionally called “harm reduction”. This is the possible care between the doctors with their knowledge and ways of being in the world and the lady with her knowledge and way of being in the world.



Life went on living a few more years for that lady with her fingers. She went to the hospital when she felt the need and returned home, until the moment when death made itself present. Maybe, because “the stairs were steep”, or because “she lived without knowing at what time to eat”⁵ (p. 158).

Or we can think that none of these things happened. Upon leaving the first hospital admission with her children and her papers, after the denial of the toe amputation, the lady was run over by the last streetcar before she even got home. She died within a few days.

Toe or no toe, death will happen. And until then, care will be done.

Discussing care in public health services is about acknowledging the population that makes use of these services as human beings, with rights, who deserve to be treated with respect and not just to be treated. Receiving health care and attention reflects the recognition of a being that lives, constructs his/her knowledge, and makes his/her life choices.

The purpose of this article is not to find an answer to the questions presented here, nor to defend a theoretical status of care, but to open a space to think about them, to exchange with other studies and meetings along this path. It is an invitation to think about these questions and the ways in which they may be interconnected. An invitation to reflect on the care that is “provided” in the health services, expected according to the norms, and the care that is possible to provide on a daily basis, in the face of so many difficulties.

Authors' contribution

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

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Este artigo analisa práticas de cuidado em saúde vivenciadas em um hospital geral do Sistema Único de Saúde (SUS), com a intenção de problematizar e refletir sobre o cuidado e as práticas em saúde que se fazem presentes entre pessoas, no cotidiano do serviço, nas relações e nos fluxos que são estabelecidos. Utilizamos a Etnografia para descrever uma cena que reflete as relações entre os saberes, os cuidados e descuidados que se fazem em um hospital. Propomos pensar o cuidado como múltiplo e observamos o hospital por meio de sua constituição como uma “máquina de curar”. Refletimos o encontro entre profissional e usuário, entre o cuidador e quem recebe o cuidado, para propor que em todo e qualquer encontro de saúde certo cuidado é realizado.

Palavras-chave: Práticas de saúde. Cuidados em saúde. Hospital geral. Etnografia.

Este artículo analiza prácticas de cuidado de salud vividas en un hospital general del Sistema Único de Salud, con la intención de problematizar y reflexionar sobre el cuidado y las prácticas de salud presentes entre las personas, en el cotidiano del servicio, en las relaciones y en los flujos establecidos. Utilizamos la etnografía para describir una escena que refleja las relaciones entre los saberes, los cuidados y descuidados realizados en un hospital. Proponemos pensar el cuidado como múltiple y observamos el hospital a partir de su constitución como “máquina de curar”. Reflejamos el encuentro entre profesional y usuario, entre el cuidador y quien recibe el cuidado, para proponer que en todos los encuentros de salud hay cierto cuidado que se realiza.

Palabras clave: Prácticas de salud. Cuidados de salud. Hospital general. Etnografía.