Delivering bad news: family members who have survived armed conflicts in the trauma hospital

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Abstract

Ethnographic research in a trauma hospital made it possible to systematically accompany one of the families who have survived armed conflicts. We observed, in the work process of the Intensive Care Unit, how a body between life and death is revealed through the interactions between health professionals and family members. It is perceived that the "delivering bad news" perspective suppresses the effects produced by state practices of life and death management, in contexts of criminalization of violence reiterated in the daily routine of the trauma hospital. To rectify responses based on biology and protocol, we adopted the epistemological perspective of anthropology and social psychology. This study has shown that the discursive practices reproduced the dynamics of social inequality linked to racism and classism, while families from precarious territorialities constantly experience traumatic situations and imminent grief for violent health problems.
Key words: communicating bad news; violence; health; racism; classism.

e20814
http://doi.org/10.1590/1809-43412023v20d814

Dando más notícias: familiares que sobreviveram a conflitos armados no hospital de trauma

Resumo

A pesquisa etnográfica em um hospital de trauma possibilitou o acompanhamento sistemático de uma das famílias sobreviventes de conflitos armados. Observamos, no processo de trabalho da Unidade de Terapia Intensiva, como um corpo entre a vida e a morte se revela nas interações entre profissionais de saúde e familiares. Percebe-se que a perspectiva da "comunicação de más notícias» suprime os efeitos produzidos pelas práticas estatais de gestão da vida e da morte, em contextos de criminalização da violência reiterados no cotidiano do hospital de traumas. Para problematizar a centralidade de entendimentos com base na perspectiva biológica e protocolar, adotamos a perspectiva epistemológica da antropologia e da psicologia social. Este estudo evidenciou que as práticas discursivas reproduziram a dinâmica da desigualdade social atrelada ao racismo e ao classismo, enquanto famílias advindas de territorialidades precárias vivenciam constantemente situações traumáticas e o luto iminente por agravos em saúde produzidos pela violência.
Palavras-Chave: comunicação más notícias; violência; saúde; racismo; classismo.

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Introduction

The present article, inspired by the doctoral thesis[1], discusses the therapeutic itineraries to one of the families who have survived armed conflicts in a trauma hospital, in order to problematize the management of life and death; understanding how to reveal the person between life and death to family members who have survived armed conflicts.

The ways in which family members are supported through their suffering and the care flows for their health demands allow us to observe the effects produced by state practices, in contexts of criminalization of violence and reiterated on the daily routine of the trauma hospital. We chose "delivering bad news" as an approach for this analysis since, by subverting its conceptual scope originally linked to a technique- and biology-based tendency, it highlights the moral values involved in the care practices that position men as more or less deserving of care. Also, the conditions to recognize the pain, trauma and impending mourning of some families from precarious territories are emphasized in this way.

Visiting in the trauma hospital dwell in temporalities that intersect families and institutional pathways (Godói, 2017), such as distressing waits, corridors, and vagueness generated by the mechanisms of discipline on which hospital institutions are based. The intelligibility of violence, marked in the body, occurs to the extent of the possibility of its translation by the professionals in terms of the disease, fragmented in its biological, psychic and social dimensions (Sarti et al., 2006; Deslandes, 2001). That means that the access and support of visitors in the daily service of the hospital make the suffering for the imminent loss of a family member clear, in its difficult assessment and management by the health professionals. The violence that afflicts a son, a brother, a father, produces a subjective mark in those who wait day after day for the delivering of good (or bad) news from the health team.

There is a considerable amount of research, mainly epidemiological, on juvenile homicide victimization. However, Brazil still lacks studies on how the families of victims experience this loss, and, no less traumatic, the unsuccessful homicide attempts. The impacts on the physical and mental health of family members are strongly emphasized in literature, pointing to the need for greater involvement of the health sector, especially concerning collective health.

As Walsh and McGoldrick (1998) warn, deaths such as homicide disproportionately affect more impoverished regions, traumatizing an entire community. Special attention must be paid to the revictimization factors that intersect families' grieving process. While waiting for support and comfort, many families end up in situations of neglect, invisibility, and professional unpreparedness.

1 The Certificate of Ethical Appraisal Submission (CAAE) of the Research Ethics Council for human subject research approval is at Plataforma Brasil under no. 79992317.8.0000.5334.

Although it is difficult to assess the extent of the impact homicide has on the lives of those close to the victims, a US study estimates that each death affects 7 to 10 family members, as well as friends, co-workers, and neighbors (Redmond, 1989). The relatives and/or friends of the homicide victim are usually referred to in many studies, according to the Associação Portuguesa de Apoio à Vítima/ Portuguese Association for Victim Support (2012) and Costa Harth, et al. (2017) as "hidden victims", or "the other victims" or even "co-victims". Such nomenclatures preserve the idea that, even if these people have not suffered the homicide directly, they are also indirect victims of this violence.

The therapeutic itineraries experienced by visiting family members become unforgettable for them; these moments can either be remembered as a support of care, or foster trauma recrudescence and the medium- and long- term possibility of the elaboration of mourning (Gallego, Gomes & Peres, 2022). International studies, and to a lesser extent national studies, show that loss by homicide usually generates significant short- and long-term consequences for the victims' relatives and friends. It can trigger serious health problems, such as pictures of post-traumatic stress disorder and depression (Soares, Miranda, Borges, 2006; Zinzow et al., 2011; Mastrocinque, 2015 Connolly, Gordon, 2015). It is also correlated with a higher risk for smoking and alcohol and drug abuse (Vieira et al., 2009). It changes the family dynamics and the relationship with the community. (Associação Portuguesa de Apoio à Vítima, 2012)

We call the suffering of these family members in the context of hospital emergency services as "Corridor suffering": subjects who constantly and for lengthy periods of time need to search for tangible information about the health-disease process. It is customary for visitors to wait daily for contact with the local reference team, especially doctors, about the health status of their family members. The corridors of the hospitals surveyed are unsanitary places, with no access to food and potable water on all floors.

It is important to contextualize that the main objective of the doctoral research that gave rise to the case study below sought to understand the practices of health professionals and public security professionals inside trauma hospitals to men injured by violent conflicts. In trauma hospitals, the systematic monitoring of different health professionals (by civil service examination or residency in medicine, psychology, social work, nursing, and dentistry, and nurse technicians), as well as public security professionals (prison guards, military police, civilian police, and security guards outsourced by the services), was carried out through health care flows in various departments (emergency rooms, wards, intensive care unit/ICU).

Chosen as a methodological tool, ethnography made visible aspects denied by the institutions involved and ignored by other research methods (Fassin, 2017), seeking to overcome the notion of the subjects' individuality and to offer a larger picture of the power devices involved in public policies.

The research lasted 4 months, between 10 to 20 hours per week at Hospital Pronto Socorro (HPS) and Hospital Cristo Redentor located in the city of Porto Alegre/RS during 2018 and 2019. Open interviews were conducted with managers and professionals, however, field diary entries were the main method used, since the variety of professionals, departments involved, and the fast decision-making flows in the care process around health users injured by violent conflicts and their families made it possible to analyze new points of view on the theme.

The main findings of the doctoral research were deepened through current studies in the field of Social Psychology and Anthropology. From the analysis of masculinities from an intersectional and feminist perspective, we have realized that for men marked as "being of crime", the suffering produced by the trauma experienced is not only made invisible; it is taken as a sign of dangerousness. This dynamic governs the relationships between masculinities involved in violent conflict and produces resentment as the central affection. (Santos; Nardi , 2021a).

We conclude that the hospital is tightly associated to the public security device through discursive practices that foster criminalized masculinities. (Santos, Nardi 2021b). The devices of power operate in the providing of care when health and public security policies co-habit the emergency health instruments. This led us to analyze how the operationalization of care can produce the precariousness of lives that, when they are not physically decimated, are socially decimated. To this end, poststructuralists such as Michel Foucault, Giorgio Agamben, Loic Wacquant, Didier Fassin, and Judith Butler conferred on the ethnographic research process problematizations related to the criminalization and medicalization mechanisms that act on certain male bodies in this context. (Santos; Nardi, 2019).

Through certain groups of intelligibility, sustained in hierarchical positions of knowledge-power,[2]among health professionals and between health professionals and visitors, we observed that the measurement of pain is the naturalized violence in the trauma hospital. Sônia Maluf (2005) states that the public powers are absent as interlocutors, forcing those affected to retain their own pain in the sphere of the intimate and private. They act as if the confinement of violence, along with seclusion and muteness, were their only acceptable and possible place. However, 'pain' can also vividly express a story, just as 'suffering' can be silent or present without language.

Thus, in the present article, inseparable from the aforementioned textual productions around the thesis, the objective of this study is based on the tragedy experienced by the nuclear and extended family of brothers Marlon and David. We chose to divide the article into two subsections that highlight the main findings around the theme of accompanying family members who have survived armed conflicts.

The first one contextualizes the approaches conducted by the researcher when visiting Marlon and David's family, in the context of the Intensive Care Unit of the Hospital de Pronto Socorro of Porto Alegre. We can understand why the concept of "delivering bad news", in its origin and main assumptions given by biomedicine or even studies in collective health, becomes derisory in integral health care, since the social markers of race and social class produce inequalities in access to the support and follow-up of family members that escape any protocol action.

Bad news has been defined as any information involving a drastic change in the future outlook in a negative sense. (Fontes, Menezes, Borgato& Luiz, 2017). In healthcare, traditionally, examples of delivering bad news include the diagnosis of life-threatening illnesses, amputation, communication concerning the death of a family member, or even illnesses interfering with the quality of life(Camargo et al, 2019; Vogel et al., 2019).

It was specifically in the field of palliative care that the delivering of bad news became an issue in the field of medical sciences. Robert Buckman developed the *SPIKES* Protocol in 1992. The SPIKES Protocol[3] is the most widespread internationally, and establishes a technique divided into six steps (Setting Up the Interview; Perception; Invitation; Knowledge; Emotions; Strategy and Summary).

According to the aforementioned authors, mainly from the medical and nursing fields, this would be a vital therapeutic tool that would guarantee the strengthening of relationships, greater autonomy and trust in the professional, anxiety reduction, and an improvement in treatment adherence, allowing patients to live better with their illnesses.

2 Within this scope, in which power and knowledge are intimately linked, what is stressed, therefore, is that "there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations" (Foucault, 1995: 29-30).

3 The process involved in delivering bad news aims to achieve four fundamental purposes: the first consists in identifying what the patient knows and thinks about his situation, as well as analyzing his expectations, in order to prepare him for what he is about to hear; the second purpose is to provide the patient with accessible information for his understanding, while considering his needs and wishes; the third is characterized by offering support through mechanisms that soften the emotional shock and withdrawal experienced by the receiver of the bad news; finally, the last purpose is based on the creation of a treatment plan that involves the collaboration and participation of the patient. (Gesser, dos Santos & Gambetta, 2021).

Hospital institutional culture positions the physician as the main responsible for delivering bad news, but we will see that this affects both the interactions with family members and the relationships with the ICU reference team. Medical power is invested, even by health professionals from other areas, as the one who owns the truth and who must promptly give explanations. This contradictorily strengthens even more the hierarchical relationship between the knowledge holders and hinders interdisciplinary health practices.

Current studies draw criticism regarding the *Spikes* protocol as scarce and incomplete in the face of the complexity of care for health users and their families in situations involving crisis in the health care setting. (Gallego, Gomes & Peres, 2022; Fassin 2017; Neto et al., 2013).

Through the observations made, one realizes that delivering news is not actually giving support, and it precedes an information that carries a huge emotional charge and has the potential to change someone's life and perspective. This happens because, in the trauma hospital, subjects are rarely asked directly about their history, the tendency is to create realities about who accesses the health service. The narratives regarding health users cross corridors and departments, informal, virtual and even formal paths (such as spaces for case discussion among health professionals) and are encouraged by various institutional actors, from general service workers and nurse technicians (many of whom come from the same peripheral territories as the health users), to nurses, doctors, and others.

From this, the conditions that allow for the construction of the figures of victim and defendant are established, because, generally, the narratives about subjects in hospitalization are intersected by the process of criminalization of black, poor, and young subjects (Santos; Nardi, 2021a). This process has a direct impact on the care process of these health care users regarded as criminals, as well as on the different senses of interactions between family members and health care professionals, as we will see in this study.

This is when we arrive at the second subsection, deriving out of research observations of the narratives to the problems related to the interdisciplinary work process, that reveals communication as being directly associated with power/knowledge relations involving multiple social actors as part of hospital institutions. It is noticed that discursive practices involving family members sometimes reproduce the dynamics of social inequality with regard to the production of subjectivities considered inferior.

Poor families, from the outskirts, through the reproduced perception of some health professionals, create intelligibilities about what can be talked about and how, since, by having a distinct cultural and social access from the professionals, they are unable to understand or access part of the specialists' knowledge. We will see that situations of revictimization are even more common when the homicide victim was involved in transgressive behavior. (Costa, Njaine & Schenker, 2017). The effects of violence on the family revive previous traumas related to violent situations (Medeiros, 2018) as well as revictimize subjects in their interactions with the hospital institution.

Family as a hidden victim amid the ICU work process

It was supposed to be a Sunday lunch. The aunt (Dulce) quickly brings the family to the table. Amidst the sound of the children's laughter, the older brother, (Marlon, 25) was giving advice to his younger brother (David, 17). Also at the table, the father (Jorge) sat with the resentments that filled a history of estrangement and rapid reconciliations with his son David.

These were David's memories, until he became an ethereal body due to drug trafficking. Working with one of the riskiest weapons and roles: Whatsapp, in communications. The back and forth. Who lives, who must die, who kills whom. Automated.

His brother (Marlon) and his father (Jorge) had already warned David to abandon his role as a drug dealer's scout. His father had already been involved with crime; he knew how things had changed in 10 years. Then, men would solve matters eye to eye:

> *"There was a relationship based upon conversation, man to man. There was negotiation: "Oh, I'll pay on such and such a day, oh, then maybe I'll move out". Now, you don't even know that your death is decreed, sometimes you don't even have time to escape. It's all too fast, one sends a Whatsapp to another, and the guy who is in debt, in order to pay it, has to go there and kill the other one, otherwise tomorrow it will be him."* (Santos; Nardi , 2019, p.67)

Death has become a bargaining chip. So, father and older brother signaled that, as long as David held this role, he could not visit Aunt Dulce. There, the faction is different. The problem is that not everything can be accessed through keys on a cell phone. David only wished to go home and relive what it is to be family. To go through the gates of trafficking, without fear. Courage was all that he possessed that was humane. Courage and stubbornness. Hiding the unprotected boy from the man, the part that owes him.

In the framing of life, boys behaving like men remain little time in the supposed protection of the domestic space. (Santos; Nardi, 2019). He hadn't even had time to sit down at his aunt's table and he was already being called by someone at the gate. David opens the door. It happened so fast when his aunt and older brother pushed him into the house and barricaded the ten shots launched as an execution attempt.

This is the beginning of one of the tragedies that make up the trauma hospital, a place where not physical death stands out, but rather the struggle for life through the acknowledgment of trauma. As Medeiros (2018) explains, in the absence of a language for the enormity of family members' pain there are challenges to "borrow, steal, and create words," something to offer support. For this reason, shards and conversations, more than narrative genres, are the dialogic constructions of a Research(er). This is the first challenge, to circumscribe the temporalities of a path marked by uncertainty and losses (Vianna, 2021, p.71).

In the inhospitable, unpredictable path of total institutions[4] such as trauma hospitals, while doctors, nurses, and nurse technicians involved in the intense and fast-paced "hard" work were fighting for physical survival, social workers were providing support and follow-up to health users and their families in situations of social vulnerability. These social workers made possible a flow of systematic follow-ups of the researcher in all sectors of inpatient and emergency health care.

It was in the small room of the Social Service team that I was introduced to Marlon's father and stepmother, and after that I started to systematically accompany the family visits in the Intensive Care Unit for about 1 month/4 times a week, during visiting hours in one of the ICUs of the HPS. There were several contexts within the research: observations and conversations in the room of the healthcare technicians of the ICU where Marlon was hospitalized, accompanying medical professionals, psychologists, and social workers in what is commonly referred to as the delivering of bad news, accompanying social services to the demands and extended needs, and carrying out conversations with family members, especially the father (Jorge) in the corridors of the HPS.

The HPS has two ICUs: Dulce (aunt) was in one of them, in a coma after being shot in the head, and Marlon (25 years old), David's older brother (17 years old), was in another. As mentioned before, both of them (David's aunt and older brother) were shot with more than 10 bullets in front of the house, when they used their own bodies as a shield to avoid David's execution, who worked for a criminal faction as a "scout" for drug trafficking.

4 Society seeks to discipline individuals said to avoid socializing, and, with this purpose, total institutions emerged. According to Goffman (2001), they are characterized by being enclosed institutions that operate under a confinement regime, where a relatively large group of interns live full time, and, on the other hand, a management team that oversees the life in the institution. Trauma hospitals are not usually in the total institutions category, but the intertwining of health and security produces this inflection.

In the ICU of the HPS, where Marlon's family was taken care of, 30-minutes daily visits for family members took place at 11:30 am. Specialists came by as consultants, nutrition, psychology, and physical therapy residents, among others. And permanently, there were the intensivist on duty, medical residents, nurses, nurse technicians. Prior to visiting hours, it was necessary that professionals talked about pleasantries, a few jokes, and what would be served at lunch because the atmosphere would be heavy with family members coming through the corridor. In *line* they would start washing their hands, disinfect them with alcohol, put on their apron and gloves. Head down, silent.

Marlon and David's father, stepmother, and Marlon's 7-months pregnant wife didn't know how to divide themselves between hospital visits. David was hiding in a neighborhood in Porto Alegre, living in a house where he was taking care of a baby, a drug dealers' son from the faction he was involved with. Dad went to visit Marlon every day, filled with tubes and sheets, monitors and his eyes covered with gauze. He was usually seen slowly running his fingers through his son's hair, while Marlon's 7-months pregnant wife caressed his feet, the parts of his body left without tubes and machinery.

Initially, the HPS social workers were distressed by the narratives surrounding Marlon, which positioned him as a subject involved in drug trafficking. They claimed that spreading stories of criminalization of certain health users was difficult because it affected the institution as a whole. Their strategies to translate and re-signify the family reports, known to them while accompanying Marlon's father, stepmother and wife, took place in the institutional space named *Case Discussion Meeting* .

At the HPS, there were two monthly case discussion spaces as part of the institutional culture: one was the *Death Meeting* and the other was the *Case Discussion Meeting*. The Death Meeting was the only regular monthly space in which medical residents and multi-professional residents met to discuss a "case" that was "unsuccessful", restricted only to medical residents who chose the cases to be discussed; the multi-professional residents would only learn on that day which patient had been chosen by them and no active participation with other knowledge groups[5] was encouraged.

The other institutional space, named *Case Discussion Meeting*, was composed of multi-professional residents. The resident social worker and psychologist, Marlon's family care references, presented some analysis in the *Case Discussion Meeting*, underlining that their professional actions did not work in the "so Cartesian[6]" way, of strict biological concerns. In presenting the family's situation, they pointed out that, initially, many fantasies about Marlon were created such as the fact that "he was a criminal", and stories about David having had a hidden romance with the drug dealer, being the execution attempt due to the teenager revealing a photo of the two on social media. (Santos, 2019, p.73).

Furthermore, the social worker exposes the risky pregnancy of Marlon's wife and the stepmother, Jorge's partner (Marlon and David's father). Marlon's wife had missed her prenatal appointments, as they had to move in a hurry to avoid being killed. And the family had no knowledge of David's whereabouts. In any case, the doctors were not there and the considerations and disaffection directed at them demonstrated the effects of the hierarchical measures between medical and other professions, mainly by the absence of information to health professionals and the family about the health-disease process of Marlon.

The body, in a trauma hospital context, is apparently understood as a biological mass disarticulated from its history, affecting on understandings of what it is to give support and care. However, one perceives the body immersed in a political field, where power relations invest it, mark it, direct it, lean on it, subject it to carry out tasks, and force it to perform ceremonies (Foucault, 1979). The body, taken as an object of medical

5 Campos (2007) suggests the concepts of Field and Nucleus in health training. Nucleus would be the set of knowledge and responsibilities specific to each profession or specialty. Field would be the knowledge and responsibilities common or confluent to several professions or specialties.

6 Cartesian logic starts from the mind-body dualism; the epistemology that separates the mind from the world. (Barbosa, 1995)

power-knowledge, places the family as the most constant agent of medicalization, assuming its central objective, which is the duty of each individual to his or her own health, and, at the same time, to the general health of the population. That is, the functioning of medicine is sustained in instances of social and moral control, such as the salvation of the sick (Fonseca, 2015).

The notion of family in the nuclear and biomedical perspective denies that the body of one is held as an event for the body of another. The relationship between individual and family varies according to contexts and the social category we are dealing with. Fonseca (2000), in his book *Família, Fofoca e Honra (Family, Gossip and Honor)* noticed that, in peripheral families, the boundaries of the body are blurred and transcend any individuality. There is a sense of family care that includes sacrificing your individual projects or those of your nuclear family to save troubled individuals in the extended family network.

This is what happens with Marlon's family. David's salvation by Marlon and Dulce: Power of Love. Power to cheat the death of another with the body-shield. The salvation of the hospital: Love for the power-knowledge of biomedicine; the shield. Symbolic shield of the technologies of the body and therefore impenetrable until violence enters the hospital doors and puts this power in check.

There are subjects and their families who escape such rationalities, of what it is to be able to receive care, what care is, and what it is to be a caregiver. We will use the concept of moral economy taken up by Fassin (2014, 2017, 2018), as it allows us to perceive the practices of health professionals intersected by culturally produced principles and choices, and to understand the hierarchies put into play, the values operated in the care assigned to patients' lives, as well as the principles of justice and humanity. The actions in public health comprise a moral dimension of action, which certain context defines it as the good of humanity, and cover up the diversity of the demand in a process of multiple reductions, such as the denial of social suffering by reducing life to its biological aspect.

Crime and criminalization cross Marlon and David's family, revealing that processes of medicalization and criminalization associate in multiple territorialities that exceed the body-hospital relationship and determine logics of power, reinforced in intersectional stigmas.(Santos; Nardi, 2021). Productions of truth concerning the subject associated with crime are based on what Michel Misse (2010) calls criminal subjection, as the social construction of crime and the power devices through which the supposed subjects that will compose a social type prone to commit a crime are preventively selected. These processes begin and end based of some kind of social accusation that can be made explicit to the subjects. It can also be veiled, unknown to the health care users themselves, as it usually is behind the scenes in trauma hospitals.

Marlon's status as a defendant was reiterated by the image of a father circulating as a body marked by the state, made clear by the use of the electronic anklet. Criminal subjection in this case is directly related to ancestry, poverty and race as markers that go back to Brazilian society and its colonial logic. (author). Thus, as Gonzaga& da Costa Junior (2020, p. 243) infer, "the allusion of the family figure, appears strongly an allusion to blood ties", as a force for state and political claim and intervention. However, this same allusion is also a factor that would explain the neglect preventing possible interventions to these situations by State institutions.(Medeiros, 2018).

The roots of this association transcend the time and space of the peripheries, and make the identity exchanges between workers and criminals borderline, as well as the transits between work and crime (Efrem Filho,2017; Farias, 2019), especially when studying the past of masculinities in the history of Brazilian public health (Santos, Nardi, 2018). When a new image of Marlon was recreated, especially after the social service and psychology professionals addressing in the various departments of the institution, other feedbacks were able to place him as a victim: Marlon would be a father of a family in a few months, he was a community leader, he was a worker, a hero who sacrificed his life for his younger brother.

Death management occurs through the systematic action of the State in an effective control over living bodies, confinement, and subjective domination, via forms and devices of race and biopower, through which physical and symbolic violence is perpetrated, mostly against the black Brazilian population. (Medeiros & Hattori, 2020)

Thus, it is up to certain subjects to prove their innocence, from the beginning to the end of time. Placing a person into the "victim" model means to frame life as more than merely a biological organism, it must have adequate conditions for survival, such as: housing, food, health (which includes basic sanitation), among other aspects. The absence of these elements demonstrates that "in the face of this complex and circular process, social and spatial hierarchies are created that are measured according to the ability to access symbolically and economically valued places"(Butler, 2018).

Certain inscriptions on the body can project the person into a social limbo between life and death. The pain of family members produces a sense of vindication of the loss of a subject that, between physical life and death, also struggles against social death. (Vianna, 2021). It is a process of making trauma a banality, this mixture between a body both victim and perpetrator of violence in which the tension experienced in the scene is kept *looping*, for a long period. The waiting room, part of the possible territorialities for support, reveals the naturalization of violence. Which goes beyond square meters and chairs. Physical space is a mediation of suspended time, of the way bodies can position themselves and coexist.

Some aspects denote how social inequality is forged both in the hierarchies of power-knowledge among health professionals and mainly directed toward family members who come from peripheral areas of the city (Govil, Acharya&Datta, 2022). These are absent aspects for the dimension of health care support to family members: the unavailability of spaces for family members to rest, of private and comfortable spaces for care, access to food, as well as spaces to encourage and welcome expressions of spirituality, as a key strategy used to understand the violence that abruptly crosses existences.

Compelling examples of the aforementioned aspects reveal themselves as when the HPS civilian police officer on police duty, which is next to the visitors' entrance, listened to "all the crying, night and day" in the corridors (Santos, 2019, p.62). In cases of body recognition, before the body's arrival at the Legal Medical Institute (IML) for expert examination, this recognition can be done at the Morgue of the HPS.

The *Morgue* was an unsanitary space. A very dark and damp enclosure of 16 square meters. There was a defrosted refrigerator that had previously been used to store remains and five metal stretchers, crammed almost on top of each other. Grim territory, that once inside one could perceive a stated differentiation of values between imminent death, which can lead to survival, compared to a lifeless body; dead both physically and socially. The nurse who introduced me to what death is like for him in the hospital exclaimed: "This place is horrible, horrible, it's dehumanizing! One metal stretcher on top of the other. The body dumped with a sheet over it. This place smells like death. A family member comes here to recognize the body, what kind of space is that?" (Santos, 2019, p.63). Once death is ascertained, the patient "ceases to be a patient". The "space" is a "non-place"[7].

In these multiple institutional spaces, describing and analyzing such experiences is a way to explicit the apparent contradictions regarding the notion of modes of care, devoid of the recognition of the pain and loss of vulnerable populations in marginal territories. Moral valuations imply the conditions of what is communicated and how, as situations observable in the next subsection.

7 It would be "place" when referred to some event, a myth, or a story. This pointing will make the space linked to a differential identification, becoming meaningful to the individual who refers to it or recognizes it as a space of occurrence of one of these events. Once enclosed in this particularity, that space will present a distinctiveness that will identify it as a "place" (Kniestedt, 2010).

Hospitals as a potency for life or as maintenance of imminent death?

The following subsection situates what would be the process of "delivering bad news", or rather, the outline of punctual interactions between medical staff and the father (Jorge), or even the continuous support for the family's suffering when facing the son's health-illness process. The effects of these interactions, reliving of the violence and trauma attached to the relationship between father and surviving son (David) will also be presented.

Young men are morally positioned in the trauma hospital as "trauma-worthy" (Author, 2019b). From being a subject involved with the crime of drug trafficking, Marlon became a life that mattered[8] and a challenge to the team of medical specialists and intensivist who stated, "I don't know how he is still alive." (Santos, 2019, p.71). The biomedical team was also not exempt from many dilemmas and suffering when it was daily summoned to the ICU to glimpse that the finitude of one ceases something in the life of another.

For two months, there were days of hope from the health care team, "The patient won't die, he's strong." "Look at the size of his hands. A young Black guy, 25 years old and 1.90 cm tall. He didn't fit on the stretcher." "He doesn't want to die until he can see his son being born." On other days, it was just dismay: removal of a large part of the intestine, hemodialysis, amputation of an arm due to necrosis, and a leg that was to be amputated next. (Santos, 2019, p.71)

"My son must be dead"(Santos, 2019, p. 69), Jorge said upon arrival on a Monday, when the family had been asked to arrive an hour before visiting hours. Farewell and hope are a constant for the family and the health professionals'team, and the temporalities narrated in this case study show that minutes in the hospital corridors turn into hours and weekends, waiting for news, in despair.

On that day, the psychology and social work residents who were accompanying the situation, the researcher, and the family waited in a circle of anguish and sadness in the middle of the hospital corridor, because the medical team had not informed them of what the news would be. What they did know was that Marlon's worsening was after they belatedly discovered a large necrotic part of his intestine.

These reference professionals accompanied Jorge and Marlon's stepmother, trying to make passage, a support for what might come. They went to the ICU staff room announcing their arrival. We could see through the glass of the ICU room, about four medical specialists surrounding Marlon's bed. Fifteen minutes had passed since the agreed time with his father and stepmother, who were waiting anxiously outside the ICU. The father, as described by the social worker, "was drilling holes in the ground, walking back and forth."(Santos, 2019, p.69)

Thirty minutes had passed: the health professionals, coming and going between the ICU staff room and the waiting room, were looking for Marlon's bed, where the four medical specialists were still engrossed in low voice conversations, inaccessible to any outsider on the subject. The two residents already distressed, returned to the ICU exit where they found Jorge walking back and forth, "I just need to know what's wrong with my son, if he's alive." The stepmother, Jorge's companion, translated the scene, "He is starting to have to accept the death of his son, he spent the weekend feeling very bad." (Santos, 2019, p.70)

Forty minutes had passed: the tension between the medical team and other professionals is pronounced. The nurse, head of duty, sitting in front of the computer looked at the two reference residents[9]and said, "it's not up to me, if it were, we would already be talking to the parents." The medical resident then gets up from her chair and speaks in a loud voice: "Hey, calm down! I needed to see what the doctors were going to pass on from their evaluation."(Santos, 2019, p.70)

8 From the perspective of Judith Butler (2018) a certain group of people is seen as having precarious lives, legitimizing their deaths as something expected, making any bond in the sense of otherness impossible.

9 The reference team or reference professionals, according to Campos (2007) are health care professionals with the same object and objective in health, responsible for the subject and the community they serve, where the continuity in care is present.

Then, she walks out the ICU door. The psychologist and social worker residents followed the doctor, who, for about 5 minutes, explained to the father and stepmother what had happened to Marlon. "Everything that could go wrong has gone wrong with him. Everything single thing. The intestine is rotten, but the head is preserved." (Santos, 2019, p.70). The resident physician later justified to the team that she wanted to use a language that they could understand. Telling them that the head was preserved was a way of saying that the son would be conscious for them to say goodbye.

However, for the family, the news was as desperate as their previous vagueness: "If you have to say he's going to die, just say it, I can't stand it anymore, they don't explain anything right," vented Marlon's wife who arrived later and who withdrew upset from the conversation with the doctor, leaving the father and stepmother. (Santos, 2019, p.70).

This same resident doctor in other circumstances asked the father not to caress his son's foot because "it was rotten, and it might fall off." This professional said she was relieved that the moment would come when she would change teams: "I'm glad I'm leaving, it's just problem after problem in this case, it's hard. The day before switching teams, at the time of the visit, she drew a stick person, missing one arm and both legs. "How awful!" said one of the multi-professional residents. The intensivist gave a disapproving smile and silence reigned in the nursing team's room, "Guys, it's nervous laughter, this is the reality, this is how he's going to be!" explains the resident physician.(Santos, 2019, p.71).

After successive invasive procedures, a new reference professional took over the contact with the family members. The resident doctor, different from the previous professional, had another posture. He asks me: "What does it mean to be alive? A beating, breathing heart, is that living?" The tone of his voice was melancholy as we stood at the corner of the corridor after the visit. "I wouldn't let a child of mine get to that point." (Santos, 2019, p.73)

As usual, I accompanied the support given by this resident doctor to the family. He approaches the father who is with the pregnant wife. He shakes hands with both, and so do I. While speaking, he looked only at the father. Perhaps it was the imposing position and leadership that the father had, and as the decision-making person, who managed the family's relationship with the situation of violence experienced and who did not spend a day without going to visit his son. The professional calmly explained the boy's intestine situation. The father seemed to begin to handle certain medical terms and understandings, he used expressions like "I've also noticed that the abdomen was distended". He asked several questions and listened carefully to the health care provider who slowly warned him that no surgical measure was possible. (Santos, 2019, p.74)

The father seemed incredibly grateful for the conversation that lasted about 20 minutes. When he left, he asked the resident doctor what he thought of the conversation. He said it was good, it created a good bond with the father, that he needed to receive the information correctly. "There were many things that were not correctly explained to him." (Santos, 2019, p.74)

After almost a month, Marlon and David's father was already addressing me, and sharing some moments like, "Today I'm going to see how his tracheostomy is going to be." I then took advantage of an occasion of when I was coming down the elevator with him to find out how he had felt about the support provided: "At first it was very bad, they didn't explain things properly, but now I've started to understand the situation better, I've also started to accept that my son is leaving." (Santos, 2019, p.75)

In another moment one of the intensivist doctors admitted: "if we wanted to, we could keep Marlon alive for another month on Noradrenaline alone[10]". But how can one wish that a "half man" (the cardiologist's words),

10 In recent years, terms have been created to designate the different types of death: dysthanasia, for a slow dying process, with excessive bodily invasion and suffering; orthothanasia, for a peaceful death, with as little suffering as possible; and euthanasia, referring to a death decided by patients and doctors. However, the criteria for evaluating these end-of-life modalities were - and still are - exclusive to the medical apparatus (Menezes, 2006).

without two legs, without an arm, without part of his intestines, blind, having to undergo hemodialysis, would come back to life? It is in these distinct movements from the medical and multi-professional team that life and death acquire multiple meanings in health practices and influence the support for family members.

It is possible today to postpone, to prolong life, through technology, but little is questioned about the physical and emotional cost for the patient and his or her family, as well as for the professionals of such a procedure. The individual, as the subject of his life and the design of his death, is often silenced. Nowadays, Medicine has reached a level of technological development that allows a certain domination and regulation of death, in other words, a "domestication" of death (Menezes, 2006).

Often, professionals speak and act near the patient's bedside as if the patient is no longer alive, referring to the patient in the past tense. While Marlon's grandmother and wife stroked his head, the health professionals in the staff room discussed whether his two legs would be partially or completely amputated.

By symbolically chopping Marlon's decomposing body, one annihilates the language of the victims, leading to their social disappearance and the recognition of loss and pain (Araújo, 2012, p. 225). There is an inversion of priorities in the contemporary political and moral field, in "which the right to life would become more important than social and economic rights and would even impose itself to the detriment of these" (Fassin, 2014, p. 193).

The use of technical jargon or the adoption of childish language, which does not allow a full understanding by the patient and/or family members. How this information is passed on may reveal the effects of a racist and classist society that endures in public institutions (Ventura &Yujra, 2019). Racism is reflected on physical and genital exacerbation, intellectual incompleteness, as a characteristic associated with the black population (Conrado& Ribeiro, 2017). In Brazil, race and class are categories intertwined with the prevailing social imaginary. To think of poverty is to assume a black person, while to think of a black person is to link them to the condition of material poverty and, also, intellectual poverty (Gonzaga& da Costa Junior, 2020).

Through the specialized gaze of intangible wisdom, mystical thoughts and spirituality fundamentally intersects the grieving process. During many of these observations, I was able to observe the father and grandmother passing their hands, with some distance, on Marlon, as if they were giving him "a pass". Health professionals, including medical professionals, wondered what his religion was. The resident doctor, who was the first reference to support Marlon's family, believed that they belonged to the Umbanda religion, others assumed they were Jehovah's Witnesses, and the doctor from one of the specialties inferred, when observing the family in their farewell rituals, that they were syncretic, a mixture of several.

Spirituality, in this context, has been recognized as a means of alleviating the suffering of the health care user. Marlon's father, in an elevator conversation with me, told me that he believed in the *Kardecist* spiritualism and said that religion helped him both in "leaving crime" and in accepting his son's health condition.

Distinct decision-making processes (which are carried out all the time, by multiple social actors involved) involved humanized care in many moments, such as in the family's farewell process to Marlon. The on-call physician allowed the family to spend 24 hours saying goodbye to Marlon. This doctor said that the women in the family cried a lot, touched the body a lot. For him the farewell is a fundamental process that commonly involves actions such as "undressing the relative to see if the body has been well taken care of.

Foucault (1979, p.97) addresses popular religious rites as a kind of diffuse resistance to the authoritarian medicalization of their bodies and diseases. And he warns us, *"instead of seeing in these religious practices a residual phenomenon of archaic beliefs not yet disappeared, are they not a current form of political struggle against authoritarian medicalization, medical control?"* Rather a fight for the right to mourn.

Death and grief are social and political phenomena. Which for people already in mourning presents the fear of a new grief to be experienced, aggravating the situation, (Neto & Lisboa, 2017), when grief becomes a stable condition of lives that experience impending physical death as one of the effects of social death.

The persistence of grief in families of precarious territories frustrates the social expectation that the family members' lives will be "resumed" after a legitimate period of suspension of daily activities. Thus, grief cannot be defined as a transitory and intermediate situation that marks the "passage" of statuses of those who are gone and those who remain: alive/dead, married/widowed, child/adult. (Lacerda, 2014).

Butler, earlier, has proposed reflecting on which lives are "grievable", with "*the subject's action based on his/her offended status produces a basis for legitimizing and delegitimizing her own violent actions.*" (Butler, 2018, p. 251). The author titles her book "*Frames of War: When is life grievable?*" in order to rethink the complex and fragile character of social bonds, especially to consider what conditions can make violence less possible, as certain ethical frameworks recognize between killable lives/ lives that matter.

Marlon's family, like so many, "survive in adversity," as emphasized by Efrem Filho(2017). They live off their work, in the folds of the legal and illegal, move between risks, need to adequately respond to different spheres of values, and live with the imminent possibility of confrontation and death. Among work, religion and crime, such distinctions are materialized in overlapping territorial disputes that coexist in the subjective territories of families that are indistinctly associated with crime and violence by society (Gonzaga& da Costa, 2020).

In this way, a last and not least important aspect concerns David's search for information about his aunt and older brother, which allows us to problematize the revivals of trauma and impending social death that escapes the gaze of health institutions.

The teenager was impeded from any access to his family. The father had already threatened the social worker saying "it would get bad for her" if they allowed him to visit. She calmly explained that visits could only be prevented in the hospital with a court order, but the only person able to do that was the grandmother, as she had custody. (Santos, 2019, p.81). In any case, the Guardianship Council had stated that there was no sign of where David lived and knew that approaching the family would be somewhat impossible since they lived very close to where the aunt and brother were shot.

However, there was one day when social workers received a call from the hospital gate, "David is coming up here." (Santos, 2019, p.81). No person under the age of 18 was allowed to enter the HPS without an escort, however, guards at the reception desk were touched by the teenager's crying and clamoring for answers about his family. From then on, the social service team began to worry about a referral that would ensure David's social protection.

The psychologist and social worker welcomed the teenager into a small enclosure, "I've heard that my aunt has passed away, I need to know if it's true." Due to issues concerning hospital rules, the residents could not provide information to an adolescent, and so, they contacted their preceptors for an endorsement to enable them to reveal the information, "Can we tell him that his aunt has passed away?" Both preceptors denied the request. The two resident professionals (in psychology and social work) then looked at each other as if they were at a dead end. This time, they would not suffer for not having information about the health user, they would carry the burden of not being able to deliver what is most important to the subject.

"How are you doing?" asks the resident psychologist. David then tells of how he feels. With emotion, with eloquence. It is easy to understand him, but difficult to connect the young man standing before us with the heavy story he carried. For the well-articulated words, for the vanity that shines through. He talks about helplessness. About the mother who abandoned him in his childhood, of the estrangement from his father and the family that refuses to see him. He says, "what happened is not my fault, because my father never took care of me," and cries when the psychologist asks, "Do you feel that your father loves you?" (Santos, 2019, p.84)

David said he would forward his emancipation before turning 18. He was in limbo. His term of custody was neither under the power of the state, nor with the grandmother with whom he had always lived. He said that, when he decided to leave home, she went to the court to declare that she no longer wanted to be responsible

for him. David justifies his grandmother's action: "Because you know how teenagers are, rebellious. He says that he was at a friend's house and that he was paid to take care of her baby. (Santos, 2019, p.84)

The health professionals, after hearing the young man's story, begrudgingly passed on the preceptors' decision: that they could not pass along information about whether the aunt was alive or dead without a guardian over the age of 18 present. One of the health professionals asked him to try calling his stepmother at that moment, hoping that she would pick up and tell him what had happened. He picks up his cell phone and dials, and according to him, there's no answer. Seconds of silence and a look between them manifested their suffering, this time for knowing and being unable to speak.

After saying goodbye to David, one of the professionals vented to me: "what if he learns that his aunt passed away out there, how will he react? I would rather he got the news from us, we could offer him support in the best possible way. This is so hard." "I also think he wants to avoid talking to me because we didn't tell him his aunt passed away. We broke a bond of trust that could have been." (Santos, 2019, p.85)

Kinship memories and how they are mixed with other politics of memory, such as those involving diverse events and temporalities (Carsten, 2008), are relived in a situation of multiple losses and violence. However, the hospital institution, centered in health care in the biological scope, has in its rationality the "make survive"[11], exempting itself from the responsibility of strategies for the well-living of health users and their families. Health prevention, including violence prevention and referral to the intersectoral network is perceived as part of primary health care actions. However, for many men, as it may have been for David, the hospital may be the last (sometimes the only one) stronghold of social protection and health care. The hospital can covenant the policy of doing nothing, sustaining the maintenance of imminent (social) death.

Kinship, torture and loneliness are intersected in several studies on families who lack the right to grieve (EfremFilho,2017; Farias, 2019; Medeiros,2018; Lacerda, 2014). It is common practice that families from precarious territorialities are perceived as impulsive and violent subjects who should be kept at a certain distance. The trauma hospital's rationality with families who have survived armed conflicts has made invisible a trauma dynamic that includes the blaming of what happened on other family members/friends, as we will see in the father's relationship with his son David.

Aspects regarding post-traumatic stress such as flashbacks (successive intense memories of the scene) occur with greater intensity in attempted homicide (Affleck, Carmichael, Whitley, 2018, p. 03). Marlon's family in the home-hospital space constantly experienced insecurity, since they continued to inhabit the same residence where the dealers had fired the shots.

The relationship developed between State and society, in general, and the black Brazilian population and its territories cannot be seen in isolation. It is in the subjective relationship between the various sectors, institutions, classes and social groups, that the distinctive ways of fostering the material and symbolic exclusion of a given group, as well as the non-recognition of its identity as an integral part of a nation project, are expressed (Gonzaga& da Costa, 2020).

Examples of this displacement or inversion of priorities in the field of the political are well illustrated by the impending (social) death of Marlon's brother as part of an understated object compared to the technologies and interventions that sometimes escape the very organic boundaries between living and dying. The favela (Brazilian slums), is "a space of exception: it is a piece of territory that is placed outside the normal legal order [...] that which is excluded from it, and, according to the etymological meaning of the term exception,

11 The unprecedented absolutization of biopower is combined with the generalization of sovereign power, and biopolitics necessarily merges with thanatopolitics. In light of this, Agamben proposes a third formula that would grasp the specificity of 20th century biopolitics: "no longer to make die or to make live, but to make survive (Agamben, 2003: 108). Neither life nor death, but only the production of survival.

captured outside, included by its own exclusion" (Agamben, 2003, p. 165), since the state of exception has become the rule for this population. Its residents are indistinctly associated with crime and violence by society (Gonzaga & da Costa, 2020).

The social determination of death, correlative to the unequal distribution of life, overlaps with the denial of loss of many early annihilated lives. One's death does not end there. It takes the father, and the pregnant wife back to a territory in which they do not know if they are safe from the threats of the drug faction that has already slaughtered two of the family. With them, they take part of their existences, no longer the same, leaving the hope that died inside the hospital and David's life, in the unpredictability of fate outside the health institution.

Final considerations

The objective of this study was to understand families as co-victims and survivors of emergency situations related to gun violence, as well as ways to operationalize a qualified care for family members and/or close friends, an aspect still invisible in various professional practices. Delivering bad news should not be an indiscriminate part of every health care process for survivors of violence, especially from armed conflicts. Thus, several aspects were addressed around the narratives of life and death of Marlon's family.

However, the narratives brought to us launch us to future possibilities regarding the power of the hospital as part of the public network service that echoes the life of subjects that are often unaware of or forbidden to circulate through the decentralized services of their territories (such as those of Primary Health Care). But to do so, the hospital must overcome the notion of "fatality" and "inevitability" that surrounds the common sense view of the problem (Deslandes, 2001).

The care process of a family of health care users is an effect of some aspects mentioned above: the social inequality performed in the hierarchical power relations among health care professionals and between professionals and family members. Obviously, we can see the disinvestment in the trauma hospital, perceived in the logic of shifts and lack of replacement of health professionals (some medical specialties are outsourced and effective nurse technicians are insufficient compared to the workload), as well as the total absence of an adequate space to receive waiting visitors.

It is emphasized that the term applied in the thesis "corridor suffering" corresponds to loneliness, silencing, lack of welcoming spaces that ergonomically *spits* the family out of its circuit through an inaccessible language. Delivering news means listening and making possible a family's outline of the illness process that is as harmless as possible. Some knowledge holders, articulated among themselves, manage to move outside the confines of the hospital, but nobody will want to go beyond its walls if they are not aware of the importance of looking at the subject as a person carrying history.

Finally, we emphasize the need for a comprehensive look at these families and for the development of strategies capable of supporting them considering their multiple demands. It is also important to prioritize the training of the professionals who directly or indirectly deal with these families in their work institutions. The research findings indicate the need for an interdisciplinary attention focused on this group, considering their health, social, financial, and legal demands.

Received: June 28, 2022
Approved: January 16, 2023

Translated by: Pós-Graduação de Psicologia da Pontifícia Universidade Católica do Rio Grande do Sul.

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