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1.2 *New practices in collective healh care*

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This text intends to continue a socio-anthropological discussion initiated with a paper to the 4th Latin-American Congress of Social Sciences and Health (Cocoyoc, 1997), about changes in the health paradigm occurred in the last decades of the 20 century, with the considerable development, and process of inclusion in health care services of the so-called "alternative therapies", latter designated as "complementary medicines", their relationship with distinct medical *rationales*, and with bodily health practices in the society. This discussion was deepened in the 4th Brazilian Congress of Collective Health (Salvador, 2000), with an attempt to interpret both phenomena as part of a process of cultural re-signification of social actions, relations and representations related to sickness and health or, in a more general way, *to life* and its extension and conservation in contemporary society.

The core of the proposed interpretation is in the hypothesis that in this cultural re-signification process a set of central values of capitalist society is exacerbated, while others are put aside by a growing part of society, through new health practices and activities that work as forms of sociability recuperation and ethical resistance strategies. These new forms of sociability emerge with the "new practices" in development, in civil society as well as in health care institutions – in the latter in an incipient way. From our point of view, the new collective health practices express the existence of new senses and meanings in culture related to health and life. These new forms of sociability refer to the creation (or "re-creation") of values indicating the construction of an ethic, different from– and perhaps opposite to, the dominant capitalist ethic, and to the "spirit of capitalism", in what they have of most harmful to life in common and, in the final reckoning, most contrary to life. The last part of the sentence is difficult to understand. A key point of this work is, therefore, the discussion of cultural values associ-

ated to the present collective health practices, mainly corporeal practices, and the production of new cultural senses and meanings related to these practices.

Theoretical studies and empirical researches: the medical rationales and health practices project

The lines of reflection and argumentation developed in support to our hypotheses in the following pages originate, on one hand, from the results of a set of theoretical studies and empirical researches in the Institute of Social Medicine of the University of Rio de Janeiro, initiated in 1992. The so called "Medical Rationales and Health Practices" project, now in its third phase, began with a comparative theoretical study of complex medical systems (contemporary western medicine, homeopathic medicine, traditional Chinese medicine, Ayurvedic medicine). The central hypothesis of the first phase of the project, concluded in the beginning of 1994, is that there is actually more than one medical *rationale*, contrary to western common sense, which admits only biomedicine (or modern Western medicine) as the bearer of rationality in medicine, that is capable not only of practical efficacy but of verification and confirmation of (theoretical) meaning in experimentation. The Project further aimed to demonstrate that distinct medical rationalities effectively coexist in contemporary culture. The complex medical systems are supposed to have five basic structured dimensions in theoretical or symbolic terms: 1- a human ***morphology*** (denominated human *anatomy* among us), which defines the structure and the form of organization of the body (or bodies); 2- a human ***vital dynamics***, (defined as *physiology* among us), which defines the movement of the vitality, its balance or unbalance in the body (or bodies), its origins or causes; 3- a ***medical doctrine***, which is in fact a doctrinal *corpus* defining, what is the health/sickness process, what is a disease or the process of getting ill, in its origins or causes, what is possible to treat or cure, and what does not belong to the medical corpus as a morbid process or capable of cure , among us is simply defined as what does or does not belong to the clinic; 4- ***a diagnosis system***, through which it is determined if there is or if there is not a morbid process, its nature, phase and probable evolution, origin or cause; 5- ***a therapeutic system***, through which are determined the forms of intervention adequate to each morbid process (or sickness) identified by the ***diagnosis*** dimension. For the Project, from this point of view, only a specific complex medical system structured according to these five dimensions, elaborated to a greater or lesser degree in practical/theoretical terms, can

be denominated a *medical rationality*. For these reasons, only the four mentioned systems were object of study in the first phase.

At the end of the first phase we also concluded that all complex medical system has as a structuring root a ***cosmology***, which provides with a theoretical and symbolic basis the other dimensions. They are also more or less institutionalized systems, be it in the western culture, be it in its original culture (China and India, in the cases studied), sometimes in both, and taught in legitimated institutions for transmission of its formal contents as well as of the attitudes that conform its *habitus*. Complex systems more based in a symbolic universe than in rational propositions, such as the traditional Amerindian medicines, or other systems, which are, such as anthroposophical medicine, centered in metaphysics or in some form of religion, were not studied. However, the study concluded, in its first phase, for the perception of the *limits of rationality* in the systems, since: 1- all medical rationality has in its basis a ***cosmology***, proper to the culture where it is established, rooted in a symbolic universe of senses that include images, metaphors, representations, and even conceptions, irreducible to the plane of theoretical or empirical propositions demonstrable by scientific procedures; 2- inside each medical rationale coexist in fact two different forms of apprehension/interpretation, two "paradigms", linked to the ***theoretical*** (knowledge accumulated from the health-disease process) and ***practical*** (intervention in the bodies of sick people through the diagnostic and therapeutic procedures) dimensions. The practical knowledge "uses" the theoretical knowledge as a function of the efficacy to be obtained in its intervention, so being an "active" knowledge. In other words, the modern western duality *science* X *art* is present in a greater or lesser degree in the practice of the agents of these medicines, being clearly exacerbated in biomedicine.

In the second phase of the Project we could follow to what measure these dualities manifested *in the practice* of the public health professionals of three medical rationalities: biomedicine, homeopathy and traditional Chinese medicine. We also tried to analyze representations and meanings attributed to disease, health, treatment, cure, body, body/mind relation, among others, considered basic to apprehend paradigms in health and medicine in physicians (or therapists) and patients in the distinct rationalities in study, as well as the way the professionals and the clients shared or did not share these representations. Our nuclear hypothesis was that the patients and professionals of a certain medical system tend to share paradigms and representations of its own rationality, and this cultural "sharing" tends to facilitate the physician/patient or therapist/patient relationships, making

easier the therapeutic process. This hypothesis was in great part confirmed, for the three systems, by the interviews and ethnographic material and participant observation obtained during two years in health services in Rio de Janeiro, even considering the differences between systems. For instance, differently from the case of homeopathic medicine, where the link is established through patient's *discourse*, in acupuncture the therapeutic process is essentially *silent* and "physical" (introduction and manipulation of the needles).

Images and representations of illness

In all cases, however, it is necessary to stress that all patients, when they look for a certain medicine for diagnosis or therapeutic end, or both things, carry with them a set of images and representations about their illness, its origins or causes, and about the possibilities of health recovery, which partially coincides with the set of conceptions and representations of the chosen medical system. In many occasions, the images, conceptions and representations are "translated" for the cultural universe of the patients through metaphors and images, or even through other senses and meanings attributed to the expressions employed by doctors, what happens in biomedicine as well as in homeopathy. This is very clear in the case of public health care patients, where the social classes and cultures are different for doctors and patients, what does not happens in the case of private consultations, where the social and cultural universe is basically the same, or at least more homogeneous.

A relevant fact for the analysis is that in all medical systems, however, independently from the institutional environment where the consultation takes place, the representations are not "pure" from the point of view of the attributed senses and meanings, that is, they are not restricted to the *rationale* of a sole medical system. There is much "hybridism" and "eclecticism", or even "syncretism" in the contemporary symbology concerning body, health, disease, treatment, cure, etc. Mechanistic corporeal representations (the "machine" body) can coexist with "bioenergetic" representations (the body seen as a more-or-less balanced organization of energy levels in circulation) in the same subject, not only in patients, but also in therapists. The interpretation presented, in this case, is that the diversity of coexisting cultural patterns in the cultural complexity denominated by some authors *post-modernity*, together with its fragmentary character, induce the subjects to the practice of a constant symbolical "bricolage", al-

though in a dynamic and semi-open universe of senses and meanings, organizing veritable "kaleidoscopes" of meanings, mutable according to the occasions, interests, or social limitations. The diversity of meanings present in present culture in relation to health care, its continuous recomposition and rearrangement in a dynamic whole so that they may be harmonized ("to make sense") in the same time with the aspirations of the subjects and the social impositions, made us propose the kaleidoscope metaphor. It can be ascertained that there is not, consequently, "fidelity" to a single medical *rationale* in neither side of the relationship, since the patients can go from one to another according to the variation of their disease, and the senses they are attributing to it, and the doctors can also "conciliate" or "conjugate" therapeutic or diagnostic procedures from more than one rationality in their daily routine. There is, consequently, this further limit to medical rationality, as the *logos* of health, clearly observable *in the practice* of both patients and doctors.

Between medical rationalities and therapeutic practices

The third phase of the project had as its starting point (1997) the perception of this duality persisting between medical rationalities and therapeutic practices. The therapeutic practices, even though they may be *elements* in a specific dimension of a specific medical rationale, are frequently used in an isolated form, dislocated from a context of meanings to another, in theoretical/practical "collages" or *bricolages*, as already mentioned, obeying more an *empirical efficacy logic* than a theoretical coherence (or rationality) of the systems. This way, they propitiated the eclecticism, or even the syncretism of two distinct paradigms: an "indication" paradigm, based in the accumulation of single observations obtained from empirical experience of the agents, which is related to *intervention* (diagnosis and, ***above all***, therapeutics), and an analytic paradigm, based in the accumulation of the conceptions and propositions of the medical systems, which provides the basis of the *theoretical* knowledge for the medicines. We could perceive, during the process of investigation, that great part of the success of the so-called "alternative therapeutics" or "complementary medicines", which in fact refer to other rationality in health, is inseparable from the way that the therapist/patient relationship is conduced, the quest of the patient when he or she goes to a doctor or health care service, and the effective interaction between *therapist* and his patient. This interaction tends to developa link in a shorter or longer period, originating a process that could be denominated, according to clinical tradition, *treatment*. In the development

of the process so established, elements generally disregarded by biomedical rationality as being linked to the subjectivity of the patients, such as feelings in relation to their sickness, isolation, pain, "irrelevant" symptoms since they do not find translation in "objective" records, or sensations of worsening or innocuousness of the procedures, are given great consideration for the ratification or correction of the ongoing treatment. Such procedure is now practically inexistent in biomedicine, at least in public health services (but also in the "standard" private health plans, totally submitted to market rules in Brazil), due to the role occupied by diagnosis and specialization in this rationality. It is necessary to stress that the epistemological centering of biomedicine rationale in the diagnosis of pathologies since the 18th century had as its fruit, in the end of the 20th century, the almost inviability of therapeutics. The procedures in this dimension of biomedicine are basically of two kinds: the **medicaments**, in great part symptomatic, often bearing adverse collateral effects, and **surgery**, which rose from an auxiliary *art* of medical *science* in the 18th and 19th centuries, to the hard core of therapeutics in the contemporaneity. So, it is not surprising that individual patients as well as the service user groups are more and more interested in other forms of addressing and conducting their illness processes. In Brazil these forms of therapeutic practices, called "alternative" or "complementary", are getting more reachable for the service users, due to the *Sistema Único de Saúde* (Unified Health System).

Up to this moment we analyzed the question of the complex medical systems ("medical rationalities") and alternative therapeutics, or complementary medicines, in the health field. Its coexistence, undeniable in contemporary culture, is linked to the "practical" recognition of the professionals (medical and not medical) of the therapeutic insufficiency of biomedicine, as well as the search for care and attention to its frail health by a growing part of the population. Both phenomena are inserted, in our opinion, in a specific, albeit wide, socio-cultural picture, which may be recognized as *pertaining to the medical order*, or to the socially legitimized institutions, knowledges and practices for dealing with the questions referring to diseases and sickness. In other words, it is a historical situation strictly related with the functions and roles of medicine in the contemporary society, and its transformations, proceeding from macrostructural factors (socio-economic and cultural), as well as the accelerated development of the structural characteristics (specialization, technologisation) of modern scientific medicine.

Going beyond the medical order

However, although the importance of these factors is undeniable, we must go beyond the examination of macro-structural questions of *medical order* to analyze the new therapeutic practices, as well as the " physical health care" activities, in development in the civil society, which do not have a referential directly linked to the classic health/sickness paradigm, but are associated to a "vitality" paradigm, now associated to *well-being*, now to youth and beauty, taken as values, a paradigm which becomes more distinct when we approach these practices and their practitioners. Our interest, from now on, is to examine how these practices are oriented by certain values, what are these values, and if these values are or not important for the transformation of the senses and meanings now attributed to health and life, for the relationship of the subject with his own being, corporeal and spiritual, and with other beings, as well as the transformation of dominant values in the society as a whole. Again, we must stress the recent (last two decades) proliferation of collective practices and of diversification of senses in health. The cultural complexity supposed by this configuration prevents us from reducing the meanings of the health activities to a single model (the *fitness* model, or the *wellness* model, for example) or to a single paradigm (health/sickness, or *youth/beauty*). To understand the diversity of senses and the plurality of models present in the contemporary practices is the first step to capture and interpret the presence of differentiated values informing these practices. As social scientists, we must avoid to judge such practices as excesses perpetrated by individuals, groups or collectivities, or condemning them as values of the capitalistic society. We believe that it is our part, in this context, to understand and interpret the place and "social functions" of such practices, considering the distinct values they embody, and the symbolic role they play in contemporary culture, *in its diversity and polyphony*, without restricting then to a single set of senses and values, or to a single paradigm.

Coherently we want to point to the difference between "therapeutics practices" and "collective health practices". The first set of practices maintains their link to the health/sickness/disease paradigm, which approximates them to the medical institutions and knowledge, independently from their rationality. The "therapeutic practices" have a history, and frequently a *tradition* that may have centuries or even millennia of age. Even the "new age" therapies, bearers, in the last three decades of the 20th century, of the *counterculture* ideas, "translators" of ancient practices to the modern imagination, basically refer to the intervention in the processes of sickness/illness in individuals. They oppose to specific aspects of the biomedical *diagnosis* or *therapeutics*, playing an important role in the reconfiguration of what

may be designated as the "cure market", partly occupying the social place left vacant by the biomedicine therapeutics, creating new actors, discursive practices, professional formations, disputations of discursive hegemony and *status*, always in *the health care field*. The proliferation of these practices and their variety, whose qualitative and quantitative evaluation are still indefinite, is an unequivocal fact of the last twenty years, as is its search of legitimacy by medical institutions. Our interpretation is that his proliferation comes from the search for *care and attention* in growing parcels of the population, considering not only the growth of "objective" diseases (presence of pathologies identifiable by biomedicine), but also such situations as *stress*, psychic isolation and suffering which put people in a situation of great vulnerability, even of *helplessness*, caused not only by the objective conditions of their existence but also by the *cultural values* of contemporary society. According to our point of view, these practices in great part *attend* to this subjective demand for care and attention, mainly in the middle layers of the population, since both therapists and patients are generally from the urban middle classes. These therapies attend individuals or groups, leaning to the model of medicines centered in the *subject* (as homeopathy, Chinese medicine, or Ayurveda), which aim at the recuperation of the identities of the people, their autonomy in face of the disease and medical procedures considered limiting or adverse (medicaments, orthopedics, alimentary restrictions and others.) and their social or familiar insertion. Some of them use the *arts* as a constitutive part of their procedures (music, theater, plastic arts, and dance) and only very recently began to take part in the institutional programs in health services, in urban Brazil. The senses and values generally conveyed by these practices, in their action and results, differ not only from those characteristics of the biomedicine model of diseases and their control, but also from health culture in general. Generally they aim to offer, as mentioned above, not only autonomy for thick people, as they try to reconstruct as much as possible their identity, hit by vital perturbation processes, as well as reiterate values of a life "in harmony with the whole", that is: balanced mentally and physically, sympathetic in the familiar and social plane, not competitive or aggressive, relaxed, without cares, and, if not happy, at least humorous. The values of control, containment, *moderation*, a symbolic element important in the medical paradigm of pathologies, as we affirmed in a previous work, do not take part in this universe of senses and meanings. The so-called holistic therapeutic model has a *soft* paradigm, in the sense that it does not require from the subjects sacrifices for some "liberation" from their diseases. That does not mean that it does not require changes in conduct, values, and *life*.

Situating the sickness as a dynamic process of unbalance in the development of a *life*, the holistic therapeutic practices attribute the disease to the conjunct of behaviors, habits and values of the subjects, in all planes of life. As in biomedicine, the subject is "responsible" for his health state, although he is not considered guilty of his diseases. But the therapists of these practices often complain that the patients want "fast results" without any effort to change habits, attitudes or behaviors that cause diseases, reaffirming the moral imagination characteristic of the health/sickness field. In short, the new therapeutic practices occupy an important social role in contemporary civil society, filling the blanks of the biomedical system in the relation to the health/sickness process, and introducing senses, meanings, and values before suffering, sickness and the treatment and cure of diseases, distinct from the dominants.

Another plural universe of senses and meanings refers to the new so-called physical health practices in civil society, which are oriented by a paradigm that we denominated as the *vitality* paradigm, associated to the beauty/vigor/youth triad, that uses as the reference of health *fitness*, identified with the "beauty of the forms", or *wellness*, generally seem as being balanced, or harmonized, or "being well with oneself".

There is nowadays a trend to identify the practices and the practitioners of physical health activities with total adherence to fitness culture and to the dominant values of the capitalist culture, in the *media* as well as in the theoreticians in the health field. However, we could verify in the development of the Project, in its third phase, that fitness culture is only one universe of meanings among many, adopted by the practitioners, certainly oriented by the central values of contemporary individualism: the use of the body as a form of obtaining social status, consumerism as a prestige value and social differentiation and success as 'the' *value* for life. The activities practiced by the adherents of this universe of meanings and values are *specific*, and occur in social spaces which are also specifics, with specific practice "rituals", where the rhythm, sound, body movements, expected results of the practice, age and social group of the participants are relatively restrict. They generally are students and/or beginners in competitive professional careers, almost always typical of recent capitalist activities, individuals of both genders between 15 and 35 years, that is, basically *middle class youths from the metropolis*. The "gym" academies are the privileged space for these group practices, and the activities involve many modalities of physical exercise, such as bodybuilding, the different forms of aerobics (nowadays diversified according to the objectives and rhythms), *spinning*, and "martial arts" or fights, such as judo, karate, etc.

Other practices equally turned to physical cultivation include sports, above all the risky and adventurous ones, and refer to the same values, that is, vigor, beauty and youth as synonyms of vitality, and consequently health, to be obtained by "winners". However, it is necessary to understand that the cultivation of these values and the attribution of senses and meanings to the activities exerted by the practitioners are related with *what they do in the society* and, above all, with the *symbolic place* that they occupy in the contemporary culture. In other words: the contemporary social order *designates* this imaginary place to the middle class youth through its dominant values. For the middle-class youth, following these values and exalting them is to be *socially victorious* in contemporary culture. After the defeated revolutionary youths of the Sixties society, the last fighting losers of the Seventies, and the yuppies of the Eighties, came the *fitness cultists* of the Nineties. Universes of cultural senses and values succeeded with the passage of recent history, and some were lost, in the new capitalist culture, with the succeeding generations of young people.

Modern fitness culture has recent roots, in the Seventies, with the international campaign originated in the United States to prevent coronary diseases, through "go exercise", or "get moving", to prevent the aging of veins and arteries. Among us, the "get moving" started these values, rooted in the soil of the medical order through Doctor Cooper. Later, in the Eighties, the *fitness* enters in Brazil also through America, as a way of fighting obesity, already considered epidemic in America. The famous videotapes of Jane Fonda, then a very popular actress, encouraged "fitness" as the conservation of beauty and youth, synonym of health maintenance.

Consequently, it is not possible to separate the appeal of *fitness culture* among the youth from the emerging individualism with the yuppies in the stock market in the Eighties, uncompromised with values wider than their own success and accomplishment, and with the neoliberals of the Nineties, willing to open way at any price in the stock market of the so-called "new economy". From this point of view, it is not possible to separate the cult of the "Biomechanic Apollo" from the triumph of the capitalism values among the youth. The youth is Narcissus' mirror, where a rigid and aged society needs to see itself. We still believe, as we did a decade ago, that there are « in industrial societies, including the present Brazilian society, a continuous symbolical construction of the "youth" as a model of aspirations and conduct [...] basically aimed to assimilate him to the order, without integrating him, except in an imaginary place» (LUZ M. T.). Even with the continuously renewed invitation (above all from the media apparatus) to society to dive

in the mirage of this Narcissus mirror, not all health activities, even the *hardest* physical ones, are oriented by values of attaining bodily beauty and keeping the conservation of youth.

Final remarks: other universes of senses

The diversity of sectors of the society that look for them with specific objectives, proper to their insertion in society, their life phase and the recurrent vital and sociability need (contact with persons in the same age group or health condition) prevent us from making generalizations distanced from the survey. Nowadays, most of the practitioners of the so-called physical activities aged above forty starts the most diverse modalities, from bodybuilding to ballroom dance, from aerobics to tai chi chuan, through *medical indication.* Be it for organic diseases (diabetes, arthritis, osteoporosis, hypertension, obesity, etc), be it for "mental" problems (mainly depression, but also loss of self-esteem and isolation motivated by losses or separations), what we have heard in participant observation and in interviews is that almost always, behind a practice there is a medical advice. This indicates the existence of another universe of senses, linked to *prevention*, or to *health promotion.* Indeed, from the age of forty onwards, the almost totality of the practitioners wants to *preserve* or *recover* health. This is not necessarily separated from values of youth and beauty conservation, or from the senses of pursuit of wellness and happiness. These senses are not separated among the practitioners, nor among the physicians or therapists; what varies is the pattern of social relations established between the practitioners and their instructors, that may be compulsively individualistic and competitive, or a relationship of empathy, collaboration and, if not friendship, at least cordiality, establishing "focal solidarities" among the groups taking the activities as a starting point. This variation may also be observed according to the *kinds of activities* and their practitioners. Certain activities are more propitious to individualism or the quest for beauty and youth than others, which favor *solidarity and friendship* as consequent values. This diversity indicates, in our opinion, that among the practitioners there is the tendency to form "meaning or senses corridors" linked to the physical collective health practices of civil society. However, these meaningful corridors are not impermeable, and there can be, as in the case of health representation and practices, a certain eclecticism or cohabitation of senses and values. So, *health* can be seen as the *result* of the practices, but also youth, happiness, sociability, in short, *vitality.* The interviewed individuals, practitioners of different activities, use to say that they feel "much better", that

they recover "the joy of living", or that they feel "well disposed" (for work, for facing difficulties, for family life) after some time practicing this or that activity. This way, not only the fitness culture values, or even those related to the health/sickness paradigm (symptomatic improvement or normalization, regression of pathological states or pathologies) are present in the so-called physical activities. Values linked to personal wellness, to common living in family or at the work, to the transformation of life situations considered stressing, are linked to these activities. Often, those modifications are associated, in persons over forty, to changes of previous values: individualism, competition, consumerism, and obsession with success. It is possible to argue, with some reason, that those modifications are possible due to the age group of the practitioners. However, this only confirms what we have been trying to establish since the beginning of this paper: that there is a great *diversity* of senses, meanings and values associated to the multiplicity of the present practices and practitioners in collective health care. Some of these values are distinctly associated to the hegemonic culture and their values, as the individualistic cult of body beauty, the consumption of material goods as a way of social differentiation, the competition as a way of life and a way to reach *success*, considered as a value. Others associate to new forms of sociability and to new manners of being with themselves and others: if not sympathetic, at least cordial and friendly. In this sense, to identify the "physical" activities with the *fitness culture* is to impoverish the diversity of meanings continuously created in culture, and the *polyphony* of senses present in health culture.

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