

Gender and the establishment of a new medical specialty

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ABSTRACT

This article addresses the process of inception of Palliative Care, a new medical specialty geared to helping terminally ill patients. This concept, developed in England during the 1960s, was applied in Brazil by the late 1980s. Its aims are to give assistance during the dying process, while providing “spiritual support” to the patient and his/her family, also involving the realm of emotions. Ethnographic observation and interviews with Brazilian professionals indicated a majority of women professionals in palliative care units. This article discusses the gender representations at play among the professionals involved with this new specialty. Those reflect widely disseminated social images, beliefs and emotions associated to dying, and the roles of women and men in that sphere.

Introduction

Gender has played an important role in social organization throughout Western history, dividing spheres, spaces and jobs, according to the subject's sexed appearance.¹ According to such logic, which may be attributed to gender asymmetry and to male dominance as well², men compete for public space, non-domestic work, and are in charge of providing for the offspring³. Women, on the other hand, are in charge of the domestic space, household chores, and care of the family. Sociological theories of sexual roles and the factors that influence human behavior as far back as Talcott Parsons'⁴ assert that individuals occupy different positions in society and that their performance in such roles and positions is determined by social rules and norms. In that vein, men and women perform socially constructed roles that are assigned to their social position according to their biological sexes; they play a sexual role as if they were on a theater stage. For some time the idea of a sexual role was intertwined with the idea of a specific personality type, until Margaret Mead⁵ affirmed the non-universality of this belief. Although dated, the theory of sexual roles persists and is validated in the social imaginary, above all because it is based on ideas of custom and social stability, therefore minimizing the political dimension of how gender is socially constructed.

A representational framework is hinged upon the theory of sexual roles and an emotional and psychological specialization of the sexes which refers to specific abilities seen as innate, albeit culture-based. Thus, according to this view, the masculine is characterized by reason, agency and objectivity, whereas the feminine is associated with the emotions, affection, subjectivity and the relational⁶.

In a variety of analytical approaches on gender and society, the topic of professional choice is intimately connected with this framework of representation, which seems to hold structuring symbolic features. Even the modifications introduced in many professions due to the phenomenon of feminization – the expressive entrance of women in niches previously reserved to men, with the consequent lowering of the status of such

¹ Heilborn, Maria Luiza, 1993; Scott, Joan in Miriam Grossi, Maria Luiza Heilborn and Carmen Rial, 1998.

² Bordieu, Pierre, 1999.

³ Da Matta, Roberto, 1987, p. 31; Duarte, Luiz Fernando Dias, 1986, p.174.

⁴ Parsons, 1967.

⁵ Mead, 1969 [1935].

⁶ Salem, Tania, 198, p. 36; Zelditch, Morris apud Heilborn, 2004, p. 19.

professions shown in the drop of wages – seems not to have shaken this persistent division between masculine and feminine professional fields. In fields linked to the hard sciences, such as mathematics, physics and engineering, there is a general predominance of men, whereas fields associated with education, childcare, and healthcare (nursing, psychology, and social work, for example) are identified as belonging to the women's universe⁷. In the manufacture of feelings and their particular trajectory in Western History⁸, women were assigned attributes such as sensitivity and emotional sensibility, especially regarding feelings of piety, gentleness and amiability, particularly in relation to the care of children, the handicapped, the elderly and the ill⁹.

Studies of women's work and women's labor market participation in Brazil and other countries have shown continuity and changes. In the Brazilian case, there is a persistently large number of women in less privileged positions and in precarious working conditions in terms of wages, social protection, and working conditions *per se*. Changes are reflected in the increased number of women in jobs of higher prestige, in fields which require a higher educational level, such as medicine, architecture and law (especially in the public sector, in jobs whose access is guaranteed by an entrance exam). Until recently, such jobs were reserved for men.

A fundamental gender dichotomy informs both professional choice and the construction of new specialties within a particular profession. Medicine is exemplary: although women have enjoyed access to the profession since the XIX Century, in certain areas a persistent hierarchy limits their practice. This is reflected in the definition of the "more feminine" medical specialties, such as pediatrics, obstetrics, and gynecology, and in the relationship between male doctors and female nurses¹⁰.

The care surrounding certain events, such as birth and death, is modeled by representations of gender, of the relationships between men and women, and of socially determined identities. According to Elizabeth Hallam¹¹, death – an especially disruptive event, capable of generating social instability – permits critical reflection on hierarchy and power within a given context. In addition, according to this author, the examination

⁷ Ferrand, Michèle, 1994, p. 358.

⁸ Vincent-Buffault, 1988.

⁹ Campbell, Collin, 2001, p. 314.

¹⁰ Bruschini, Cristina and Lombardi, Maria Rosa, 1999, p. 15; Rohden, Fabíola, 2001, p. 94.

¹¹ Hallam, 1997, p. 108.

of processes surrounding death and dying makes it possible to explain power relations present in gender hierarchy.

This article on the establishment of a new medical specialty, Palliative Care, dedicated to the process of death and dying –or in its original designation, the *Hospice Project*¹²– is written from a double perspective, as in the creation of this new field of knowledge and intervention two aspects are intrinsically hinged upon each other: the hierarchy of specialties in a given profession, and the social concerns surrounding death. Both aspects are grounded on the gender representations present in a given context.

The starting point for this analysis is bibliographic data on the provided by the Hospice Project, including both sources on project's principles, and studies that addressed it as object of analysis; observation at palliative care conferences, courses and professional meetings; in addition to ethnographic research at palliative care units; and semi-structured in-depth interviews with professionals in the field¹³.

A new social construction of death

The end of life and death constitute an area of research in the social sciences since the beginning of the 20th century. Death has been systematically studied as a topic since the 1960s, when several researchers noticed a substantial change in its practices and representation, especially after World War II. In the face of evident social transformation, death became a privileged field for observation and analysis of social ties that have become fragile and of the processes that hide the dying, as well as the social exclusion of those who are dying¹⁴. Through the observation of this process, social thinkers have produced an analytical and critical literature about a death model typical of the 20th century, called “modern death” by Philippe Ariès¹⁵, which came to replace “traditional death.” These models are treated here as Weberian ideal types, with logical coherence.

¹² *Hospice* is an institution that relies on a health team, but it differs from a hospital in that it advocates for the maintenance of the ill person's personal identity and for the individual administration of time (for activities such as bathing and eating, for example). Generally, hospices are houses with individual bedrooms for patients and public areas such as living rooms and dining rooms.

¹³ Research developed by Rachel Aisengart Menezes for her doctorate in Collective Health (Institute of Social Medicine/UERJ), and post-doctorate at the National Museum (Graduate Program in Social Anthropology/UFRJ).

¹⁴ Menezes, 2004b, p.25.

¹⁵ Ariès, 2003, p. 85.

They represent notions present in social life, which are difficult to find in a pure form. The differential aspects of each model refer to the social context, to the ruling authority system, to conceptions regarding the body, death and bereavement, and to the values prevalent and the beliefs associated with death at each conjuncture.

Starting in the late 1960s and more intensely during the 1970s, a number of new publications have denounced ways in which ill persons were being expropriated from their own processes of dying. The exclusion of death and of the dying is cited as a fundamental characteristic of modernity. With the development of resources destined to maintain and to prolong life, medicine has managed to produce death as occurring within the hospital and under the control of the medical apparatus, silent and socially hidden. In this model, the ill person in the process of dying is silenced: s/he does not participate in decisions about his/her own life, his/her illness and death. There is little space for the expression of emotions within a hospital context. In general, listening to emotions is the domain of the professionals in the field of psychology, in which women predominate.

Death has come to be seen as a failure of doctors and hospitals above and beyond all else: it is therefore convenient that death lose its central importance and stop mobilizing resources and energy. This does not mean that professionals in the field of healthcare are insensitive to the suffering that comes with death in the context of their daily work. According to Claudine Herzlich¹⁶, anguish is always present in the hospital, despite the indifference or the brutality of daily institutionalized routine. For this author, the choice of a medical career does not testify to insensitivity regarding questions raised by death. On the contrary, it reveals a particularly live unconscious angst in the face of this event.

According to Norbert Elias, the suppression of the idea of death throughout the 20th Century is the result of an individual and collective process in which is part of the civilizing process that has taken place over the past five hundred years¹⁷. This same century has witnessed an increase in the medicalization of many areas of life, with repercussions on the representations of the different stages of life. Medicalization is understood as a process through which continuous technological evolution modifies medical practice through innovations in different areas (therapeutic and diagnostic

¹⁶ Herzlich, 1993, p. 6.

¹⁷ Elias, 2001, p. 75; Elias, 1997.

methods, etc). The medicalization of the social refers to the medical redefinition of events such as pregnancy, child birth, menopause, aging and death.

Movements for the rights of the ill began in the late 1960s and continued into the 1970s as a form of critique of the excesses of power by medical institutions, and of its rationalized care, in which the patient loses his/her individual autonomy.

Cecily Saunders founded the first *hospice* in 1967, in London, as an institution exemplary of the new philosophy and care model for terminally ill patients. Since the 1960s, the pioneer of the movement for the cause of “good death” was dedicated to providing care for patients in advanced stages of chronic degenerative disease. She advocates for the development of a medicine that specifically dedicated to one phases of life the disease, aimed at controlling pain and symptoms. Seeking coverage for the care provided to these patients under the British national health care system, Saunders reached out to politicians, lawyers and religious authorities, especially the Catholic Church, besides disseminating the need to train professionals in the medical field with specific knowledge in the area. The movement against the abandonment of the terminally ill by the British health care system expanded and, in 1985, the Association of Palliative Medicine of the UK and Ireland was created. England was the first country to recognize Palliative Medicine as a medical specialty in 1987.

In the United States, civil organizations were created with demands encompassing issues ranging from the right to die with dignity to the regulation of euthanasia. The first movement for palliative care in the U.S. was mainly anti-medical: it consisted of a grassroots, community organization, led by volunteers and nurses, with little involvement by doctors. The first North American *hospice* was created in 1974 by Josefina Magno, an oncologist from the Philippines residing in the U.S.

This emerging discourse introduced a new way of dealing with death, whereby the power relations between the patient (and his/her family) and the professional team would be transformed. Around fifteen years later – with the advent of the AIDS epidemic and the development of techniques to combat degenerative diseases, especially cancer, and the pain and symptoms caused by these diseases – other hospices and home care services were created. From silence, hiding and denial, death became discourse.

The Hospice Project is based on preserving the autonomy of the ill person, as well as honest and open communication between all the social actors involved in providing care. Furthermore, the care provided by the medical team is centered on comfort, pain relief, and alleviating suffering. It presupposes that the ill person and his/her family are treated as a “bio-psycho-social-spiritual totality”, in the quest of a “good death”¹⁸. This innovative model of assisting death has been disseminated at three levels that are intimately connected, but also readily distinguishable. The first level would be that of the social production and the dissemination of the principles of palliative care in mainstream media. The second refers to the creation and development of palliative care as a scientific discipline. The third is the practical implementation of palliative care services in the form of home care, inpatient care, as well as doctor’s home visits. Both in technical books and in self-help publications, a common discourse has emerged, addressing the right to “die well”, with autonomy and dignity. The emotions surrounding the end of life are expressed, and alternatives are offered in order to help the person to overcome difficulties. Death is spoken about, as are the sick person’ and his/her family’s wishes, the decision-making process, and patient doctor relations. Films and plays on the subject have made public success, especially in the 21st century. A search for new constructions and social practices around death and dying has started, especially among the more individualized middle-classes.

Since its beginnings in England and in the U.S., palliative care has become widespread in most continents and countries, with support from the World Health Organization¹⁹. In Brazil, the palliative care movement started in 1986, after its emergence in Anglo-Saxon countries, as an exclusively medical initiative, catering to cancer patients²⁰.

¹⁸ Menezes, 2004a, p.53.

¹⁹ The World Health Organization and its Program for Palliative Care have argued against the unplanned expansion of *hospices*, and in favor of a public health policy geared to pain management among cancer patients. The consideration of Palliative Care as a scientific discipline by the WHO responds mainly to the publication of a manual in 1986, under the title *Cancer Pain Relief and Palliative Care Report*. The manual was translated into nineteen languages. In Brazil it was published in 1991, reflecting the preoccupation with the difficulty in dealing with the treatment of pain in cancer.

²⁰ At first this was a service within one unit of the National Cancer Institute (INCA), in Rio de Janeiro. INCA’s Hospital for Cancer Treatment IV was built in 1998, as a palliative care unit. Currently there are two palliative care associations in Brazil: the Brazilian Association for Palliative Care, and National Academy of Palliative Care.

Palliative care: the emergence of a new professional field

The creation of a new medical specialty must be considered as a production linked to the social and historical context in which it is inscribed. The path of its implementation confirms the framework of representations of the feminine and the masculine prevailing at each social context and given historical moment.

The palliative care movement emerged both within the medical field, and as a response to social criticism against the power of the medical establishment. The movement gained social legitimacy after a specific field of inquiry was constructed, which required the production of new knowledge and the development of new techniques.

Three doctors played a major role in the creation and legitimatization of this new specialty: Cicely Saunders, Elizabeth Kübler-Ross²¹ and Josefina Magno. For Saunders, pain is not only one more indicative signs of the disease, but becomes one more problem to be treated. She breaks away from the idea, prevalent until then, that affirmed that morphine caused physical dependency, and started prescribing that drug orally, in a preventive and regular fashion. She created the expression “total pain” to describe the type of pain experienced by the ill person in the final period of his/her life. It is a complex type of pain, including the physical, mental, social and spiritual aspects in a new clinical framework, in which health professionals must attend to the patient’s experience as a “bio-psycho-social-spiritual totality”. Thus, spirituality becomes one more area of intervention by the medical team.

A re-appropriation of Kübler-Ross’s psychological theory of the five phases of dying has been incorporated into the body of knowledge of Palliative Care. When the patient learns that an unavoidable death is nearing, s/he goes through the following set of stages: denial, when he/she does not believe the diagnostic; anger or revolt; negotiation or bargaining as a way to distance him/herself from the idea of death; depression, when the person starts grieving for the loss of life; and finally, the acceptance of his/her own finitude. Josefina Magno was the main popularizer of the hospice cause in the U.S. and in other countries, especially in the Philippines. She was concerned with the lack of interest for palliative care among medical professionals and in 1984 she funded the International Hospice Institute (IHI), to provide training to doctors in the field of

²¹ Kübler-Ross, 1969, p. 112.

palliative care. Then the American Academy of Hospice Physicians was created in 1988, which in 1993 became the American Academy of Hospice and Palliative Medicine. The IHI later on became the International Association of Hospice and Palliative Care (IAHPC), the most influential international association on all continents.

It is important to emphasize the religious elements in the biographies of the three “inspiring muses” of Palliative Care. The way spirituality was brought into the field of biomedical knowledge is something to be explored. Saunders was a nurse and a social worker. Since the beginning of her hospital work hospitals, she was concerned with the abandonment of terminally ill patients. She particularly demanded attention to pain management. When she noticed that her demands were going unheard, she entered medical school in search of acknowledgement and legitimacy among doctors, which in the end she gained. It is worth mentioning that Saunders’s trajectory was strongly marked by religious values: she was a practicing Catholic,²² before all else. The choice of name for the hospice she founded, St. Christopher, is telling of her perception of death: St. Christopher is the patron saint of travelers and the dying process is perceived as a passage to another life or instance.

Elizabeth Kübler-Ross was born to a Swiss protestant family, and later on she became an American citizen. From her studies on the process of dying, she became interested in communicating with spirits and disseminated beliefs on life after death. Josefina Magno was a practicing Catholic. She became a widow when she was still young. She had seven children, which is often mentioned in her biographies as an explanation for the change in her professional trajectory. She committed to Palliative Care after surviving breast cancer and having a mastectomy. Each of one of these doctors had a different motivation to embrace the “good death”. However, religious references carried considerable weight in all three cases.

Several studies²³ emphasize the relationship between religion and the high number of women in this field, whether in the role they play in the conversion of the family members or in their vague mysticism. However, one cannot affirm that the creation of a new medical specialty responded solely to these “muses.” Their discourse resonated with

²² Clark, David and Seymour, Jane, 1999, p. 72.

²³ Fernandes, César Rubem et al., 1998.

voices of different origins. Saunders was the main leader of the movement in protest against the medical institutions' abandonment of terminally ill patients. Criticism of "inhuman" death produced by medicine as practiced in hospitals was widespread. One can say that Palliative Care is the heir of two social movements: the civil rights movement, which includes the rights of the sick person to claim his/her autonomy and changes in the relationship between doctor and patient; and the New Age²⁴ movement, which has strong anti-technological connotation. New Age influence in the Palliative Care movement is evident; especially in the way it regards life as a flux, where the individual is unique and singular, and whose inner vision is considered as the *locus* of his/her own truth. Thus, spiritual values begin to integrate a vision of the world and social practices. Palliative Care creates a space of intervention for professionals with specific knowledge, dedicated to control symptoms and to manage pain, whose work applies to the realm of social, psychological and spiritual.

The idea of a "good end" to life is associated to the five phases introduced by Kübler-Ross. She claims that the sick person in his/her last phase of life begins to voice specific demands and becomes a central actor of their own dying process. In order to address the full scope of this new approach – once it has been determined that both patients and their families need care –, an extended network of professionals needs to be mobilized: a multi-professional team. Thus, the final period of life becomes a medical problem that requires competence and a technical knowledge linked to the biological, physiological and emotional particularities associated to the final stages of the disease. A new form of relationship between doctor and patient must be established, one in which both actors play different roles, in comparison to the care model that characterized "modern death".

Palliative Medicine is nowadays a recognized specialty in several countries, such as England, United States, Canada, Australia, Italy and France, among others. Furthermore, it is a requirement in medical school curricula in those countries. It is yet to be recognized as a specialty in Brazil, but there is a movement to legitimize it, promoted especially by physicians from São Paulo and by the National Academy of Palliative Care.

²⁴ To Campbell, 1997, p. 18, New Age represents the cultural heritage of counterculture in the 1960s, in conjunction with material coming from the East. It is a heterogeneous phenomenon, a field where different discourses intersect (Amaral, Leila, 2000, p. 15). The New Age movement' main characteristic is its opposition to organized religion. It is worth noting the paradox inherent in the incorporation of references coming from this movement within the medical establishment.

Is Palliative Care a women's specialty in Brazil?

Observation at conferences, classrooms and Palliative Care service units in Brazil demonstrate that women dominate the field. For example, the first public palliative care team, assembled in Belem (State of Pará, in northern Brazil) was exclusively female. When asked about the reasons for their choice, one recurrent reference was the “natural” characteristic of women: “women are more sensitive, men are more practical, they prefer activities in which they are able to make decisions, such as in surgery. Women have a more maternal side, since God ascribed women maternity” (Palliative care doctor). For another doctor, the male presence in palliative care is justified by a common characteristic: “they are extremely sweet people. There are men with a feminine soul. That does not mean that they are effeminate. It means something else; they are compassionate, they get involved, they are affectionate with their patients and their colleagues.” This makes the homosexual stigma usually associated to male nurses explicit, and shows how it propagates current gender representations implying that the masculine is linked to action and the feminine, is to care giving. Therefore, men who opt to work in the field of palliative care demonstrate feminine characteristics. In interviews with professionals in the palliative care field, qualities such as compassion, devotion and love towards other are always mentioned as attributes necessary to a career in palliative care.

According to the concept of “good death”, palliative care presupposes the construction of a temporality and routine that differs widely from other services provided at a hospital. Health professionals must be available to listen to demands and, above all, to embrace the emotions of the patients and their families. It is a type of relationship that places particular value on the emotional expression of any social actor involved in care at the last stage of life, whether it be the patient, a relative or a member of the medical team. According to the principles of this care model, it is only when one is in touch with emotions that it is possible to reach the fifth and last stage in the elaborate process of dying: acceptance. Therefore, the professionals involved in our observations were able to postpone technical activities in order to listen and pacify emerging feelings, prioritizing communication between patients and their families.

A second pre-requisite cited by the professionals interviewed was patience and the ability to adapt to the patient's rhythm. The concept of palliative care proclaims that death should neither be accelerated nor postponed, which may be illustrated by comments made by a doctor: "a palliative care professional should conduct their practice like an obstetrician does when they assist labor". Therefore, dying is symbolically related to labor, when individual rhythm must be respected. Giving birth, providing care at the end of life, as well as support after death, are activities associated to women.

A dialogue with the "humanization of labor" approach can shed light on this issue. According to Carmen Suzana Tornquist²⁵, the Movement for the Humanization of Labor and Birth is a recent offspring of the Childbirth without Pain Principles, of the 1950s, which had a strong counterculture influence. Both concepts, "humanization of childbirth", as well as "good death", criticize a type of medicine that relies excessively on the use of technology, rather than prescribing "natural" alternatives. "Nature" as a category is central to both constructs, since birth and death are both considered natural, physiological events. Nevertheless, according to this author, criticisms of the medicated model of labor and childbirth care do not question the nature/culture dichotomy itself, but rather inverts the signs, seeing the natural dimension as positive, the Western/cultural/technological side as negative²⁶. In childbirth as well as in death, technological intervention is up for discussion, since it often fails to introduce substantial changes to the individual's condition. Thus, in this sense, care is centered mostly on providing comfort.

In Brazil, the concept of Palliative Care is often disqualified by professionals in other areas. Expressions such as "specialist in death certificates", "all you do in this is a job just to stroke somebody's head", "there is not enough scientific criteria" were mentioned to the professionals in palliative care interviewed, to which they responded, "in fact, the decisions we have to make are as technical as in any other medical specialty, if not more". The legitimacy of the new specialty is affirmed by the logic of medical

²⁵ Tornquist, 2002, p. 487.

²⁶ The same applies to the movement for natural death, created in the 1990s in England, advocating for care – according to the patient's wishes – while staying in touch with nature. The "good death," in ideal terms, occurs in the proximity of rivers (or any other bodies of running water), in forests, in contact with animals and in trees (Albery, Nicholas and Wienrich, Stephanie, 2000). This movement was inspired by the model of natural birth, having in common the claim that death can be experienced as a form of ecstasy. In order for that to happen, they suggest exercises of meditation, breathing and visualization.

hegemony, which dictates that technique, decision-making and objectivity are prominent. At confronting other specialties, palliative care reiterates values traditionally associated to the masculine. There is a paradox in this legitimization process: what palliative care professionals value – affection, compassion an expression – is subsumed under the paradigmatic values of contemporary medicine, associated to technical decisions. Furthermore, in the hierarchy of medical specialties there is an association between systems, organs and bodily functions and their moral value in each context. Since in Western society the brain is seen as the organ that demarcates individuality²⁷, neurosurgery occupies a distinguished position among the specialties, while family practice and geriatrics are less valued, for example²⁸. It is worth noting that in the above mentioned specialties, men dominate in the first while women dominate in the latter two. The hierarchy between genders is reflected in the way the specialties are valued and acknowledged. Similarly, the constitution of a new body of knowledge and of a new area of intervention, addressing the process of dying is also modeled by gender hierarchy.

In an ethnography of a palliative care hospital, a doctor from another specialty referred to the organization, the beauty and the cleanness of the institution as characteristics of a feminine administration. At the time, the hospital director of the hospital was a female nurse. In her narrative, during a lunch offered to the doctors from the head and neck clinic – a specialty dominated by males in Brazil –

“the service chief said to me: ‘now I understand why it is so cute, tidy and organized here. It is because you are all women.’ I answered: ‘Well, besides being great homemakers, we are also excellent executives because our indicators demonstrate that we have achieved our goals.’”

In Palliative Care, meeting goals, the gratification of professionals and the acknowledgement for their work are formulated in way quite different from other specialties. As a female doctor said: “our final product is a good death”. This reveals how their goal is absolutely different from that of other doctors. For them, death is often perceived as failure. Yet those working with palliative care see it differently, as revealed one of the female doctors interviewed: “it is gratifying to take care of someone who

²⁷ For more about this theme, Lock, Margareth, 2002; Menezes, 2006.

²⁸ This example also illustrates the question regarding the valorization of technical intervention (neurosurgery) as opposed of care and clinical follow-ups (geriatrics and family medicine).

nobody wants to take care of”. Thus, the devotional activity of caring for the excluded and those neglected by other health care professionals gains a positive moral value.

Acknowledgement by relatives and families of the deceased is also a source of pride among the professionals in the field of palliative care. Oftentimes they go back to visit or send flowers and cards with messages expressing gratitude. For the team, such expressions indicate the quality of their work.

Not only professional care in the dying process is considered a feminine activity, but also the majority of caregivers²⁹ are women. According to a palliative care doctor who is also a specialist in geriatrics, “the woman is the one who takes care of a sick relative. I think this is cultural. My patients sometimes ask me if I have children. I reply that I have two daughters. They usually say: ‘you are a lucky, you are going to have somebody to take care of you at the end of your life’”. When I asked about possible exceptions, he said: “I have seen a case of an only son who did a wonderful job taking care of his mother. But a person who doesn’t have children is going to die badly, especially if the other spouse is already deceased”³⁰. As a doctor in charge of a palliative care unit said: “we [the medical team, patients, and caregivers] belong to a large family of caregivers”. However, according to her, this “family” is mainly made up of women. There are only two male nurses and a (male) security guard. Furthermore, still in her own words, the male nurse is a “remarkably feminine and sensitive” man, “and the security guards have to be men who are going to protect us”. These remarks corroborate current representations associated with the masculine and the feminine: men are supposed to protect the family and the house while the women know how to provide better care.

On some occasions, professionals in palliative care – doctors, nurses, social workers and psychologists – cry with the patient’s family, especially when someone passes away. It is worth mentioning that during the period of observation, all the professionals who cried were women, never a man. A family member was surprised with the doctor’s emotional response and said, at a meeting: “I never thought doctors cried”; to which a psychologist replied “doctors are also people.” This type of event illustrates the

²⁹ “Caregiver” is the term used to describe the main person responsible for providing care to the sick person, usually a family member.

³⁰ This verbal exchange addresses a topic beyond the scope of this article: inter-generational relationships and solidarity.

construction of a new image of the health care professional, an image that is more humane, sensitive and, above all, feminine³¹. Nevertheless, it is worth noting, regarding emotional expression within palliative care, that the expression of both tears and laughter should happen within certain parameters. Furthermore, anger and the revolt coming from the patients and their families are usually rebutted by the team. This may require intervention either by security personnel, or may be contained through medication.

Several historical studies³² reveal emerging mechanisms to control women's bodies and emotions. If lack of emotional control is traditionally associated to women, it is possible to affirm that the creation of a specialty whereby expressing emotions is central, yet at the same time must be controlled, is inscribed in a broad pedagogical process surrounding death. The task of the professional in palliative care is geared to construct a daily routine toward an end of life that is adequate to current patterns of sensibility, which intrinsically include the control of affect. From this point of view, the palliative care experience fits well within civilizing process described by Elias³³, which emphasizes a increased social need for self-control and emotional detachment, indicating changes in humans' relationships with their bodies and their emotions and, consequently, to death itself.

Legitimization and the entrance of male professionals into the specialty

Women professionals have dominated the field since the beginnings of palliative care in Brazil. However, in other countries, where the specialty is established and recognized as legitimate, the situation is quite different. In England and France there is a clear sexual division in the team: doctors are mostly males, while female professionals belong to other categories, such as psychology, nursing, social work and physiotherapy³⁴. In the United States, since the beginning of the movement for a "good death," female professionals dominated the field. However, when the specialty became recognized, the male presence, especially from the medical echelons, surpassed female presence in numbers. This data

³¹ This new image of the health professional, more specifically of the doctor, has been disseminated through newspapers, especially in ads in the obituary pages giving thanks to the dedication and devotion of some medical teams from private hospitals to some of the sick people and their families. This theme deserves further research, but it is usually more common in private clinics.

³² Foucault, Michel, 1988; 1999; Costa, Jurandir Freire, 1979; Laqueur, Thomas, 1990; Rohden, 2001.

³³ Elias, 1997.

³⁴ Castra, Michel, 2003, p.297.

begs for the investigation of the Brazilian context: would official acknowledgment of palliative care as a specialty spark more interest in this specialty among male doctors? Because Palliative Care is quite new in Brazil, it is necessary to observe its legitimization in the long term.

Representations surrounding death vary according to the historical moment and the social-cultural context. Historical studies³⁵ demonstrate that the images published in texts on the theme reproduce dominant ideas on gender and the nature of relationships between men and women. Women's representation is extremely complex. Religion frequently associated women with sin, in order to justify control measures. These images were represented everyday relations and practices dealing with death in which women played a relevant role. Cultural representations of death encompass conflicting images of women. Women were perceived themselves as sources of disease and of death. The paradox in these representations marks the relevance of the death as a sphere in which gender relations and power can be modeled and transformed. Furthermore, contradictions illuminate culturally constructed links between gender, power and death.

“Midwives for the dying³⁶,” expression used in England and in the United States to describe a professional category similar to the one of the Brazilian caregiver, are exclusively women, as the name itself suggests. This means that the traditional representation of gender is also present in Palliative Care: men (doctors) make the decisions, dedicate less time with the patients and their families, while women remain closer and more consistently in touch. Since the priority in palliative care is to provide comfort, “nursing” skills are essential. Such activity is more focused on providing care than on healing the ill. Thus, Palliative Care reiterates a rupture between these types of practices. Nurses, psychologists, social workers and other professionals fulfill functions comparable to those tasks of care for the dying performed since long time ago, which did not require any formal training or technical expertise. The goal of people who performed this kind of work in the past was not to heal the patient, but to save his/her soul³⁷.

Several polarities are reproduced in the constitution of this field of expertise: objectivity/subjectivity; decision/assistance; technique/sensibility; reason/emotion;

³⁵ Hallam, 1997; Rodrigues, José Carlos, 1999, p. 89.

³⁶ Albery and Wienrich, 2000.

³⁷ Foucault, 1999, p. 102.

life/death, among others. Masculine and feminine attributes end up conferring legitimacy to each one of those oppositions as in a perfect translation. Therefore, in Brazil, a specialty that is seen as dedicated to the emotions, to religious beliefs and to affection is disqualified by the medical establishment, and legitimacy among palliative care professionals is sought by hegemonic means. Seeking peer validation, one scene is recurrent in conferences and professional meetings: the participation of foreign, especially North American doctors, specialists in pain management, an area that is extremely valued. The association between the presence of foreign keynote speakers and a highly technical approach confer credibility and value to a specialty that is undervalued because it is considered predominantly feminine professional discipline³⁸.

The process of constitution of a new specialty in the medical field is complex and subject to the vicissitudes in each specific context. The Palliative Care approach encompasses widely disseminated images of the body, life and death, and suffering, directed, above all, towards a “humanization” of death. The technology/humanization polarity completes the set of representations found in care projects. In sum, the masculine/feminine dichotomy, associated to the polarities mentioned above persists. On the one hand, it is up to women to “humanize” death with their affection and sensibility; on the other hand, they are at once the subject and object of control, because they are in charge of defining the boundaries of emotional expression. However, as soon as the specialty is recognized as legitimate, men begin to occupy a prominent place within the field, emphasizing technical expertise, which is confirmed in Brazil by the tendency shown in changing the name of the specialty from Palliative Care to Palliative Medicine.

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³⁸ It is worth mentioning the increased valorization of technical expertise in the fight against pain in the end of the XX century. According to Isabelle Baszanger, 1995, the medical establishment long neglected pain and the pain suffered during the terminal stages of an illness. In addition, it is important to consider the contemporary increase in hedonism (Duarte, 1999; 2005).

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