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# Reconstructing medical practice: political-philosophical reflections on care from a Brazilian healthcare context

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**ABSTRACT**

This essay presents a political-philosophical reflection on the need to reconstruct health practices in order to make them more effective and sensitive in identifying and responding to the needs of diverse individuals and populations. To this end, it draws on the experience of health sector reforms in Brazil and the development of the Brazilian Public Health System, focusing in particular on the relevance of three conceptual constructs associated with this process: comprehensiveness, vulnerability, and care. Inspired by philosophical hermeneutics (Gadamer, Ricoeur), the discussion emphasizes the importance of a broader and more integrated understanding of health needs; the use of social markers of difference as indicators of vulnerabilities that require differentiated responses from health services and policies; and the value of a dialogical approach to health practices that is existentially sensitive and informed by multiple forms of knowledge, enabling productive integration of technical efficacy with practical success.

**Keywords:** Philosophy of medicine; Comprehensive healthcare; Social vulnerability; Social markers of difference; Public health; Social medicine; Hermeneutics

**INTRODUCTION**

This study is a theoretical and reflective essay. Its purpose is to present three concepts that, in Habermasian terms, can be described as reconstructive:<sup>(1)</sup> that is, theoretical constructs which, starting from the critique of concretely lived experiences, point toward innovative horizons based on existentially and politically emancipatory ideals for the reconstruction of practices – in this case, health practices. By adopting a hermeneutic-philosophical perspective<sup>(2)</sup> as a foundation and critical reconstruction as a horizon, this reflection seeks to contextualize the setting from which the concepts presented and discussed here arise, as well as the practical interests that motivated both their development and the way they are addressed by the author of this essay, who participated in the movement described.

Therefore, this work represents a comprehensive interpretative movement, an argumentative circle that moves from a totality of meaning serving as a reference for examining the concepts to be discussed – in this case, the ethical, political, and technical context of Brazilian Health Reform – to the parts that one wishes to describe and interpret – namely, the reconstructive concepts – which, in turn, enrich the understanding of that reference totality, configuring the so-called hermeneutic arc.<sup>(3)</sup>

The current state of healthcare in Brazil, which has partially realized the ideals of the reform movement discussed here but still faces significant

challenges, such as the underfunding of the healthcare system, the precariousness of work in health services, and the persistence of structural obstacles to reducing the vulnerability of various population groups, makes the ideals and practical challenges addressed in this essay particularly relevant. It is also believed that the conceptual reconstructions proposed within the Brazilian context may be inspiring and pertinent to other national realities and to the critical global health movement.<sup>(4)</sup>

With this aim, the essay begins by briefly describing the context from which this reflection originated, namely the scenario of Brazilian healthcare reforms and the process of technical and political reconstruction of healthcare policies that followed. It then outlines three conceptual constructs that emerged within this scenario for the proposed reconstruction of Brazilian public healthcare: the concepts of comprehensiveness, vulnerability, and care. In discussing these constructs the essay highlights how sociocultural identities may serve as general guidelines for healthcare insofar as they enrich the diagnosis of health situations beyond traditional biomedical parameters and favor preventive actions, treatments, and rehabilitation that are more appropriate to the needs and interests of the populations concerned. Underlying this line of argument is the restoration of a practical, dialogue-based, and interdisciplinary understanding of rationality in healthcare, proposed as an “antidote” to the conservative and “desubjectivizing” effects that may arise when healthcare becomes dominated by the instrumental excesses of biomedical scientism.

### **Between survival and utopia: constructing Brazilian Public Health System and reconstructing healthcare practices**

Brazil has undergone profound transformation since the 1980s. When the new Brazilian Constitution, the so-called “Citizens’ Constitution”, came into effect in October 1988, a long period of dictatorship was formally terminated.<sup>(5)</sup> This period had begun in March 1964 with a military coup that led the armed forces to take control of the presidency of the republic. Since 1988, a significant process of restructuring social life has taken place in several areas of national life. On the one hand, this process sought to redemocratize practices and, on the other hand, to reconstruct (or in some cases construct) social well-being and development projects that had been denied during the long period of political exception. Healthcare represents one of the most sensitive areas affected by these transformations.

The healthcare field played an important role in the process leading to the end of the dictatorship. The progressive deterioration of living and health conditions among a large portion of the population living on the peripheries of major cities in southeastern Brazil became increasingly evident. These populations had expanded through an industrial development model based on the intensive exploitation of manual labor, characterized by long working hours, low wages, precarious housing conditions, poor nutrition, and limited access to healthcare services and infrastructure. In this context, demands for medical attention became one of the focal points for criticizing the military government and for organizing resistance to the regime.

Alongside other social manifestations, the Health Reform Movement (*Movimento da Reforma Sanitária*) began to challenge the existing political order, revive ideas of active citizenship, and create communication channels between social movements and political parties aligned with these interests. Many of the party leaders who later assumed prominent positions in the political opening process emerged from social movements advocating healthcare improvements or maintained close connections with them.

Health issues also fostered alliances between popular movements and important social agents, including sectors of the Catholic Church, the trade union movement, political parties (some operating clandestinely), student organizations, healthcare professionals, and universities. Within this context, the Brazilian healthcare reform movement emerged. This broad alliance became so strong and cohesive that it came to be referred to as a “Health Reform Party” (*Partido da Reforma Sanitária*).

After a phase characterized by denunciation, criticism, and resistance to the existing order, the Brazilian Health Reform Movement became structured in the 1980s as a technical, scientific, and political field involving influential organizations such as the Brazilian Health Studies Center (CEBES – *Centro Brasileiro de Estudos em Saúde*), the Brazilian Postgraduate Collective Health Association (ABRASCO – *Associação Brasileira de Pós-Graduação em Saúde Coletiva*), and several departments and schools of preventive medicine, social medicine, and public health.<sup>(6)</sup> The movement soon entered a phase of proposing concrete reforms and ultimately helped shape the conceptual matrix of the Brazilian Public Health System (SUS – *Sistema Único de Saúde*).

Brazilian healthcare thinking has faced numerous challenges over the last 40 years. These challenges range from policy formulation to the structuring of healthcare models for implementation across thousands of healthcare institutions throughout the national

territory. Addressing the full complexity of these political, technical, and conceptual challenges goes beyond the analytical scope and objectives of this paper. Instead, this essay focuses on a specific aspect: the task assigned to academics connected with the Brazilian Health Reform Movement to develop a conceptual basis capable of guiding healthcare reconstruction in Brazil in an emancipatory direction consistent with the interests of redemocratization and social justice that informed the techno-political organization of the SUS.<sup>(6)</sup>

Healthcare professionals and researchers involved in this reconstructive process, including physicians, nurses, psychologists, dentists, sociologists, anthropologists, and economists, faced the challenge of responding to urgent and basic needs after years of institutional neglect while simultaneously proposing a healthcare system capable of realizing the “utopia” of a universal, equitable, and comprehensive system capable of addressing Brazil’s healthcare needs.

The close connections between individuals who assumed strategic positions in the formation of the so-called New Republic and the academic sector of the Health Reform Movement – positions often occupied by the same individuals, as in the emblematic case of the Congressman and Professor Sérgio Arouca<sup>(7)</sup> – created a strong relationship between political commitment and conceptual development. Within this context, the three fundamental doctrinal principles of the health chapter of the Citizens’ Constitution, which forms the regulatory basis of the SUS, also became an agenda for knowledge production in Brazilian universities: universality, equity, and comprehensiveness.<sup>(8)</sup>

In summary, the principle of universality establishes that all citizens should have access to the full set of healthcare structures and services available in Brazil. The principle of equity requires recognition that each individual and social group should receive what is necessary for their specific circumstances, implying the unequal distribution of services and resources according to the unequal distribution of needs within the population. Finally, the principle of comprehensiveness raises the challenge of determining both “what” can be done and “how” it can be done within healthcare to respond universally to the specific needs of each individual or population group.

To address this interrelated challenge, a broad consensus has developed that the healthcare system should be integrated, regionalized, and hierarchical. This means that federal, state, and municipal levels should be linked, as well as public and private services operating under the guidance and coordination of the public system (integration). The system should also

be organized according to a regional logic based on municipal administrative structures (regionalization). Finally, services should be structured according to levels of technological complexity, such as primary, secondary, and tertiary care (hierarchical organization).<sup>(9)</sup>

At the primary care level, adequate distribution of healthcare services is essential. Primary care serves as the entry point to the system and should address approximately 80% of the healthcare needs of individuals and communities. From there, patients may be referred to secondary or tertiary levels depending on their need for more specialized professionals or equipment, preferably within services located in their own region. In this way, primary care coordinates healthcare through referral and counter-referral mechanisms connecting users to different services within a given healthcare region. Longitudinal follow-up of individuals, families, and communities ensures continuity and integration across different healthcare actions and services. Primary care also has the responsibility of linking healthcare actions with other sectors, such as education, justice, labor, and culture, that contribute to health protection and promotion at different stages of life and within diverse social contexts.

Among the three fundamental principles of universality, equity, and comprehensiveness, the latter presents the most significant technological and conceptual challenges for reconstructing healthcare practices within the context of healthcare reform, since universality and equity primarily concern access to services and the distribution of healthcare structures. The pursuit of comprehensive care involves organizing patterns of use and interaction among these resources in concrete ways that guide healthcare actions in everyday practice.

Although the principle of comprehensiveness applies to primary, secondary, and tertiary levels of the healthcare system, it assumes its most important operational role within primary care. At this level, healthcare needs are first identified, and responses to these are formulated, or guidance is provided for accessing other services and levels of care, as well as related sectors.

However, an important question remains: what exactly constitutes comprehensiveness? How can it be achieved in practice? How can we assess whether healthcare practice is moving closer to or further away from this principle? The following discussion seeks to clarify how comprehensiveness has been conceptually examined within Brazilian academic contexts and to explore its objectives and possibilities for implementation within healthcare services as an operational framework.

### Comprehensiveness and health: difference as ethical value and technical criterion

An archeological investigation of the concept of comprehensiveness would certainly require consulting multiple sources.<sup>(10)</sup> As is commonly observed with concepts that possess such breadth and ambition, its development does not originate exclusively within the discourse of healthcare. Various influences and reference points have contributed to its historical formation. However, the purpose of this essay is not to undertake a full archeological reconstruction of the concept. Instead, it is sufficient to identify some of the discourses that are conceptually adjacent to comprehensiveness in order to differentiate and delimit its current characteristics, rather than exhaustively reconstructing its origins and historical trajectory.

In this regard, the concept of comprehensiveness resonates with the American concept of “comprehensive care,” which reached Brazil during the 1970s. The notion of comprehensiveness entered the discourse of medical reforms, in which criticism was directed toward the fragmented view of patients that prevailed within a highly specialized medical system, particularly in medical education. Efforts were therefore made to overcome this fragmented perspective.

This notion was invoked by broad sectors of medicine and other healthcare fields interested in restoring a situation in which the subjects of healthcare were considered more positively and comprehensively. This more inclusive and integrative approach to patients or healthcare subjects found favorable conditions within the broader context of healthcare reform, where it echoed and expanded existing practical concerns.

The notion of comprehensiveness was subsequently adopted by participants in the healthcare reform movement, who identified a strategic space within medical care for transforming healthcare practices in Brazil. Motivated by the more radical commitments of the reform movement, the process of valuing comprehensiveness (*integralidade*) acquired features that were more explicitly politicized than those associated with its counterpart, “comprehensive care.” It incorporated the idea of integrating diverse forms of medical knowledge with social knowledge in order to understand patients more fully. This perspective sought not only to enrich the interpretation of individual healthcare needs but also to integrate an understanding of the health determinants and needs of collective social groups within healthcare implementation.

At the same time, the notion of comprehensiveness was incorporated into proposals for intervention, and also for knowledge production, with the immediate aim

of acting collectively on certain population groups that had become politically organized around emancipatory interests. One example is the Comprehensive Women’s Health Care Program (PAISM - *Programa de Atenção Integral à Saúde da Mulher*), which emerged during the 1980s in the context of the country’s redemocratization process and at the intersection between the healthcare reform movement and the women’s movement. PAISM represented an important milestone in the transformation of the concept of comprehensiveness and in the development of its conceptual specificity within healthcare reforms. Its intention to integrate the technical and political dimensions of healthcare practice is particularly evident. In this framework, adequate care in women’s health meant responding in a technically sound and scientifically grounded manner to women’s emancipatory interests. The program addressed both long-standing issues in women’s health, such as contraceptive methods, and topics not previously included in earlier “mother-child health programs,” such as sexuality and sexual and reproductive rights.

The proposed integration extended beyond these aspects. It also involved linking individual and community perspectives. Epidemiology was called upon to support the foundations of clinical practice, while clinical practice, in turn, generated demands for epidemiological research. Individual, group, and community interventions, together with population-level policies, became part of the program’s scope. Integration also occurred between biological and social dimensions. Gender perspectives informed the interpretation of healthcare needs and the development of responses. Working with women’s health within primary care required understanding the social roles and power relations involved in issues such as maternity, sexuality, reproductive choices, patterns of illness, and the use of healthcare services.

During the 1990s and the early 2000s, this expanded understanding of comprehensiveness became widely disseminated in Brazil. Through the reconstruction of medical care practices and public health programs, these integrative approaches, linking individual and collective, technical and political considerations, and biological and social factors, became strongly embedded in the research, teaching, and extension agendas of major university centers associated with the Brazilian Health Reform Movement. Different institutional contexts adopted different terminologies, such as healthcare program actions at the *Centro de Saúde da Faculdade de Medicina da Universidade de São Paulo*; the expanded clinic at the *Universidade de Campinas*; healthcare surveillance at the *Instituto de Saúde Coletiva* of

*Universidade Federal da Bahia*; and comprehensiveness as a healthcare policy at the *Instituto de Medicina Social of Universidade do Estado do Rio de Janeiro*.

The principle of comprehensiveness, as incorporated into the constitutional text, initially referred in general terms to the obligation of the Brazilian state to provide healthcare responses to the diverse needs of its citizens. This represented a departure from the idea of differentiated “packages” or the so-called “minimum basket” of services offered to individuals unable to pay for care or maintain private health insurance. However, within the social dynamics of constructing the SUS, this principle evolved into a powerful driving force for emancipatory efforts aimed at reconstructing healthcare practices during the 2000s. Paradoxically, the multifaceted and counterfactual nature of the discourse on comprehensiveness has made it a polysemic and sometimes imprecise concept. Depending on the practical context of its application or the academic traditions of different institutional groups, the concept may acquire multiple meanings. However, it is possible to organize its principal meanings along four major axes.<sup>(8)</sup>

A) Axis of needs: This axis refers to the quality of listening to, receiving, and responding to healthcare demands. The central objective is the capacity to identify needs in a non-fragmented manner that is not decontextualized and not reduced solely to the morphofunctional aspects of the biological basis of disease (while still recognizing the importance of these aspects).

B) Axis of purposes/goals: This axis refers to the integration of actions related to health promotion, disease prevention, treatment of illness, and rehabilitation or social reintegration. The underlying objective is to create synergies that optimize healthcare actions both in terms of rational use of resources and outcomes, and in terms of convenience and accessibility for individuals, families, and communities.

C) Axis of articulations: This axis refers to the degree and forms of integration between interdisciplinary knowledge, multiprofessional teams, and actions across different levels of the healthcare system and service sectors. The goal is to create the most favorable conditions for providing effective responses to healthcare needs from the expanded perspective described in axis A.

D) Axis of interactions: This axis refers to intersubjective interactions within everyday care practices. The proposals associated with this axis aim to establish effective dialogue-based relationships among participants in healthcare encounters, whether between

individuals, between healthcare teams and communities, or between managers/policymakers and the populations targeted by healthcare actions and policies.

As demonstrated, the range of meanings encompassed by practical discussions and proposals related to comprehensiveness is broad, making it difficult to define a single set of actions or evaluation criteria capable of guiding its operationalization.

For this reason, comprehensiveness can be understood as a guiding principle for healthcare actions and policies. In the face of the dynamic and plural contexts that challenge the consolidation and improvement of healthcare practices, this principle helps ensure that the democratic and emancipatory values that underlie the SUS remain central. Although there is considerable diversity in the paths toward comprehensiveness, other experiences, sometimes developed independently of this principle, have also converged toward similar directions. The conceptual framework of vulnerability, discussed in the next section, represents one such example.

## VULNERABILITY AND HEALTHCARE

The public health landscape was profoundly affected worldwide in the early 1980s by the AIDS pandemic. Globally, the re-emergence of an infectious disease of such serious magnitude and consequences had a significant impact on healthcare institutions and practices. Traditional epidemiological tools and preventive strategies were challenged and criticized for being insufficient to address the complex determinants of the epidemic. Moreover, the uncritical reproduction of stereotypes and prejudice often aggravated the inability to produce effective responses to control AIDS.<sup>(11)</sup>

In Brazil, within the scenario described above, studies based strictly on probabilistic risk analysis and preventive strategies focused primarily on individual behavior were soon perceived as at least inadequate, if not potentially harmful, to the reconstructive processes underway within Brazilian healthcare reforms. The increasing politicization of healthcare epidemiology issues and the growing recognition of relationships between illness and social determinants, such as gender, race/ethnicity, age, social class, beliefs, and religion, appeared to be reduced to simplistic interpretations, often summarized by the formula “misinformation=infection.”

Earlier experiences, such as the PAISM and mental health programs focused on deinstitutionalization and psychosocial reintegration of individuals with mental illness, offered alternative models. In addition,

the critical tradition of Brazilian epidemiology, largely resistant to reducing epidemiology to a purely auxiliary technical instrument for biomedical research, contributed to shaping a differentiated response within Brazilian public health in relation to the AIDS epidemic. At the same time, the expansion of popular participation during the years of the country's redemocratization enabled individuals directly or indirectly affected by the epidemic to organize collectively and advocate for their rights as human beings and citizens.

This context helps explain why the perspectives of vulnerability and human rights became central paradigms for analyzing the determinants of the AIDS epidemic and for guiding responses aimed at preventing new cases and providing care for affected individuals within the Brazilian context. It also helps explain why this conceptual framework advanced significantly in Brazil, both in terms of its incorporation into public policies and its implementation within healthcare services.<sup>(12)</sup>

In the context of the AIDS epidemic, the vulnerability framework emphasized the need to incorporate categories and methods derived from the human sciences, particularly anthropology, into healthcare research and intervention. Through this perspective, the dynamics of the distribution and progression of infection and illness were shown to reflect underlying social inequalities. These inequalities were linked to historical processes and entrenched relationships of domination and oppression within Brazilian society.

Homosexual identity was among the first and most visible contexts in which the relationship between oppression and vulnerability to the AIDS epidemic became evident. This group was among the earliest to be affected in epidemic proportions in Brazil, and stigma and discrimination associated with socially perceived "deviant practices" contributed to patterns of neglect in public policies and healthcare services addressing the seriousness of the epidemic.

More than four decades after the first case of AIDS was detected in Brazil, large-scale media campaigns directed consistently toward this population group remain relatively limited. Within healthcare services, sexual orientation often remains an invisible identity dimension that does not effectively guide the organization of care capable of responding to issues such as sexual rights. Individuals within this group frequently experience physical and psychological violence, and in many situations invisibility becomes a strategy for survival. Such conditions produce a cycle that hinders public recognition and the promotion and protection of rights. Consequently, despite the advances achieved

by the Brazilian AIDS control program, homosexual populations continued to be disproportionately affected in the 1990's, with HIV transmission rates among younger individuals remaining particularly concerning. An example illustrating these challenges is the veto by the National Congress, driven by evangelical representatives, of initiatives aimed at distributing educational materials designed to combat homophobia in Brazilian schools during the administration of President Dilma Rousseff. These debates were later reinforced during the presidency of Jair Bolsonaro, under pressure from conservative political actors.

Studies on vulnerability have also contributed to understanding the limited effectiveness of AIDS prevention and treatment policies among women. When epidemiological indicators were analyzed according to sex distribution, the impact of universal access to antiretroviral therapy and preventive strategies was not uniform. While the growth rate of the epidemic began to decline among men at the end of the 1990s and early 2000s, this decline was less pronounced among women. Similarly, the reduction in AIDS-related mortality during this period was significantly smaller among women. Gender-focused research has highlighted several contributing factors, including lower perception of risk, delayed access to diagnosis and treatment, prioritization of care for partners and children over personal health needs, cultural and relational barriers to negotiating safe sexual practices, including situations involving physical violence, and the limited integration of sexual and reproductive rights within primary healthcare services.

Similar patterns of vulnerability have also been observed in relation to race/ethnicity. Research indicates that Black populations in Brazil, particularly Black women, experience heightened exposure to the epidemic and encounter greater barriers to protection and healthcare access. More broadly, Black communities remain vulnerable to numerous health challenges associated with the long-term social consequences of slavery and the historical absence of comprehensive policies promoting social inclusion and equity.<sup>(13)</sup>

Adolescents and young adults living with AIDS also face significant challenges. This generation, sometimes described as one that "should not have survived"<sup>(14)</sup> but whose lives were extended through antiretroviral treatment, now confronts new forms of social inclusion and life-course challenges. Many continue to live within social conditions shaped by the same factors that contributed to their initial vulnerability, compounded by the persistent stigma associated with the disease.

The potential of the human rights framework as a reference point for identifying social differences that translate into inequality and oppression is, therefore, evident. At the same time, it offers guidance for developing policy strategies aimed at addressing and overcoming such inequalities.<sup>(15)</sup> A human rights perspective also seeks to promote equality when differences lead to discriminatory practices while protecting diversity when demands for uniformity suppress individual or collective identities.<sup>(16)</sup>

### CARE WITH A CAPITAL C

Interest in dialogue between healthcare practices and social markers of differences is not limited to diagnosing situations of vulnerability or defining public health policies and actions.<sup>(17)</sup> As already indicated, implementing the principle of comprehensiveness and incorporating vulnerability and human rights into concrete actions depends on the reconstruction of healthcare processes.<sup>(18)</sup>

Transformation perspectives on healthcare needs by considering different socially shaped identities and

relationships generates tensions with traditional ways of organizing healthcare, which are predominantly based on biomedical interpretations of health-disease processes.<sup>(19)</sup> As discussed earlier, these tensions require space for integrating the various purposes of healthcare work. This integration involves linking different forms of knowledge, agents, and service sectors, and, very importantly, developing new forms of interaction between healthcare providers and recipients of care. It also requires renewed understandings of clinical practice. The reconstructive proposal for the technical core of healthcare discussed here is referred to as “Care” with a capital C, in order to distinguish it from other established uses of the term in everyday language.

Care is proposed as a regulatory idea rather than a fixed technological model of care technology. It may be summarized as the search for healthcare actions constructed through dialogical interactions, with an active interest in the practical meaning<sup>(20)</sup> of individuals’ experiences of health and illness. Such interactions aim to generate a shared understanding of objectives and strategies for healthcare.<sup>(21)</sup> This change in perspective is illustrated in the following diagram (Figure 1).

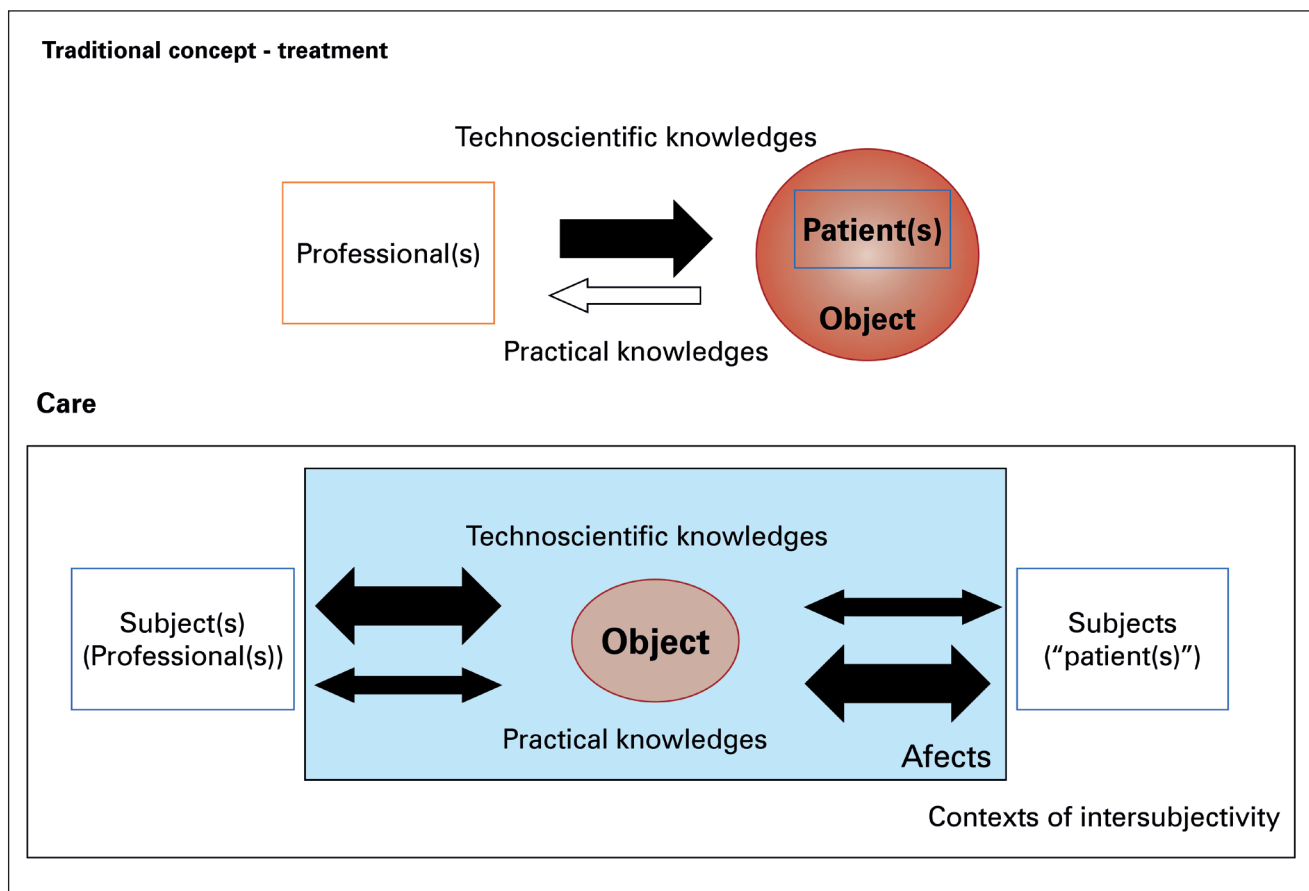


Figure 1. From the traditional model of treatment toward the care approach

Several important aspects are highlighted in this diagram. First, it emphasizes that, despite the structural differences and asymmetries that may exist between participants in healthcare relationships, the care proposal seeks to recognize that beyond the positions of professionals and service users, both are subjects who interact through and by means of technical practices. This recognition carries several implications that should not be overlooked. Recipients of healthcare actions are not merely individuals presenting morphological or functional abnormalities who seek treatment or prevention. Rather, they are people with histories, values, experiences, and social relationships that shape their identities. These identities influence not only the specific characteristics of their healthcare needs but also the ways in which they request, interpret, and accept the healthcare actions proposed to them.<sup>(22)</sup> These dimensions confer practical meaning to healthcare needs and responses and form the central core of care. As subjects, individuals do not passively accept being reduced to objects of knowledge or intervention, even if healthcare professionals sometimes assume such reduction implicitly.

Healthcare professionals themselves are also subjects shaped by sociocultural experiences, values, and personal histories. These elements influence their professional practices and shape the ways in which they interact with both technoscientific knowledge and with the individuals seeking care.

Following this reasoning, and drawing on the reflections of Ricoeur<sup>(23)</sup> personal identities shaped by sociocultural experiences are not expressed as the continuation of a single stable core of the self (sameness), but rather as an ongoing construction of identity (ipseity). From this perspective, attention must also be given to the relational character of identities as they emerge in encounters with others within care practices. Physicians, nurses, psychologists, and other professionals are not defined solely by stable professional identities; rather, their identities are continually reconfigured through interaction with the individuals who seek care. In this sense, it is the dynamic nature of intersubjective encounters, rather than pre-established professional or personal identities, although these remain influential, that shapes the character of care within healthcare actions.

Within these intersubjective contexts, which are also shaped by the affective dimensions present in any interpersonal encounter, knowledge circulates and organizes interactions by establishing normative and objective standards that guide decisions regarding what should be done and how it should be done.

In conventional healthcare practice, biomedical technosciences generally maintain a hegemonic role in defining the objects of intervention and the purposes and means of action. In contrast, the concept of Care proposed here seeks to promote complementarity between different forms of knowledge.

Such knowledge is frequently introduced into healthcare encounters by professionals, but not exclusively by them. Service users also possess substantial forms of knowledge about their own experiences, and access to information continues to expand through digital and electronic media. In this context, technoscientific knowledge must diversify and become open to interdisciplinary dialogue in practice, particularly with the human sciences. As discussed earlier, biomedical knowledge must be situated within the concrete realities of individuals and communities.

However, Care also requires forms of knowledge that are not strictly technical. Practical knowledge is necessary so that decisions made are not only technically effective but also wise and ethically grounded in their purposes and means. Knowledge derived from everyday life, experiences, and cultural traditions, often treated as secondary or even as irrelevant, should instead become an integral component of care practices. This knowledge provides access to what may be described as the existential meaning attributed to healthcare needs and to the ways in which individuals seek to address them. Such meanings connect healthcare actions with people's aspirations and possibilities and wills as human beings.

In summary, Care can be understood as a combined construction of biomedical and humanistic knowledge, integrating technoscientific and practical forms of understanding. It unfolds through a shared search for responses to healthcare needs rooted in people's everyday lives and informed by the practical meanings associated with their "projects of happiness" (Figure 2).

Within this framework, the two poles between which healthcare practice operates, technical efficacy and practical success, become productively interconnected when patients' ethical values, moral commitments, and concrete life interests (their "projects of happiness") are considered as normative horizons guiding healthcare decisions. These horizons emerge from the constructive integration of diverse forms of scientific and experiential knowledge.

## FINAL COMMENTS

The guiding role of social markers of differences within care becomes sufficiently clear within the scope and

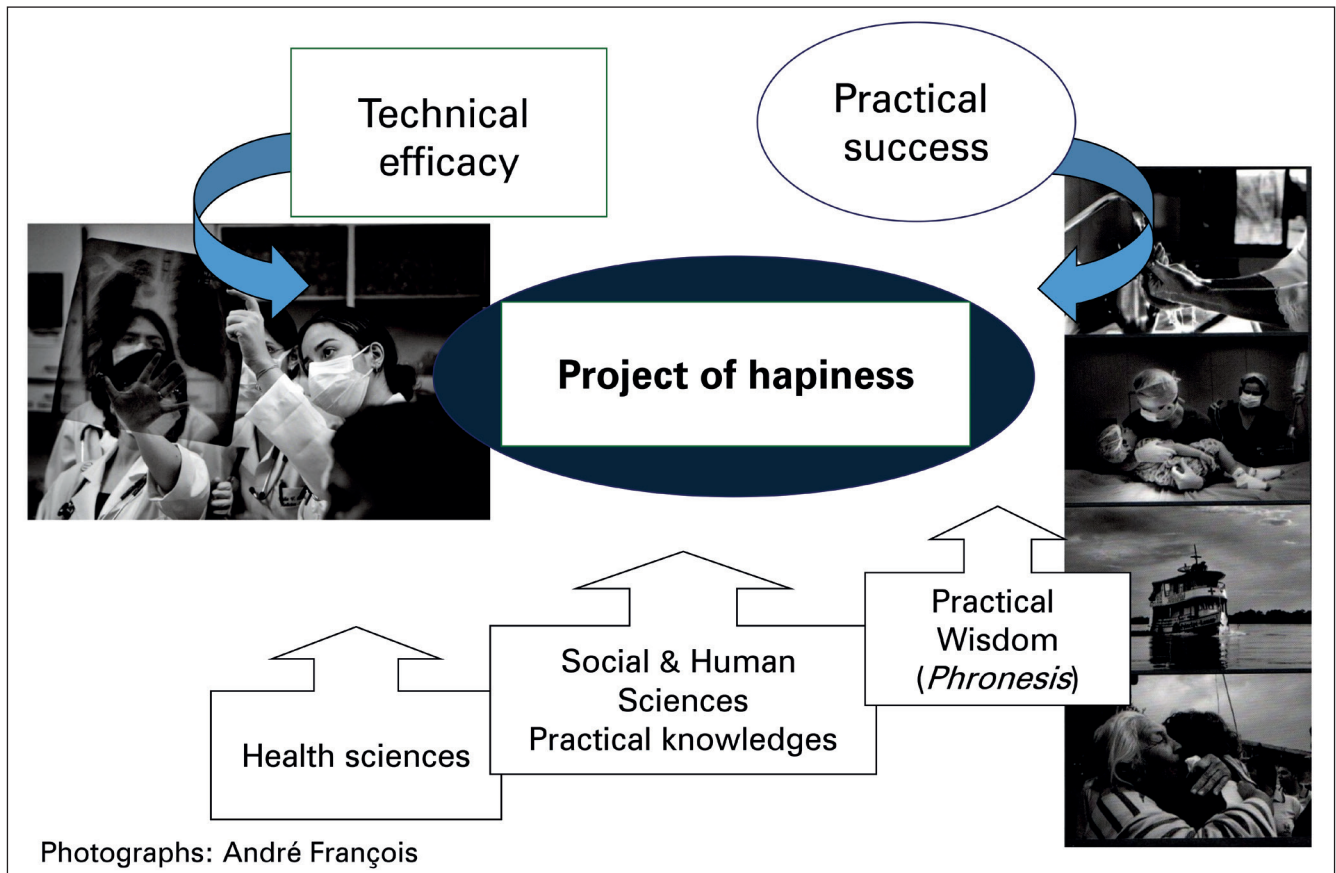


Figure 2. The existential horizon and articulation of the structural components of care

limitations of this study, which does not aim to provide a comprehensive overview of the topic. In both the diagnosis of vulnerabilities and the development of proposals for prevention, treatment, and rehabilitation, whether at the macro level of policy formulation and programmatic actions or at the interpersonal level of clinical practice, these markers shape identities in ways that not only indicate the concrete living conditions of specific population groups but also reveal the normative patterns underlying prevailing healthcare practices, thereby enabling critical reflection on their validity.

When social markers are incorporated into healthcare practices, they can function as analytical tools that help synthesize possibilities for technical efficacy and the requirements for practical success within diverse care contexts. The set of reference points mobilized in this process, which relate to relatively generalizable forms of social organization and action, together with their physical, mental, cultural, and institutional dimensions, supports the integration of healthcare needs and demands as dynamic and provisional totalities of meaning. In this way, reflection on healthcare knowledge and practices also requires

continuous consideration of their purposes and normative orientations.

However, this important function may be undermined if the approximate, provisional, and contextual nature of these broad categories, such as gender, age, or race, is not taken into account. When such categories are treated as absolute or as direct expressions of a supposed “substance” of social life, the pursuit of Care may become as problematic as the rigid application of absolutized categories derived from biomedical technosciences.

For this reason, and consistent with the broader concern regarding the reconstruction of healthcare practices guided by the philosophical horizons of comprehensiveness, vulnerability, and Care, it remains essential to pose critical questions within different practical contexts: What does it mean, in ethical and political terms, to adopt perspectives based on gender, race/ethnicity, or age when reflecting on or acting within healthcare? How can the differentiation produced by these perspectives be incorporated into concrete healthcare processes? And what impacts do these processes generate for health, for individuals, and for social groups?

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## DATA AVAILABILITY

All underlying content is included within the manuscript.

## AUTHOR CONTRIBUTION

José Ricardo de Carvalho Mesquita Ayres: conceptualization and development of the philosophical argument and drafting of the initial and final versions of the manuscript (including revisions following peer review).

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