DOI: http://dx.doi.org/10.1590/1809-43412016v13n1p071

Too much love: institutional care for old age

Natália Alves Barbieri
Graduate Program in Collective Health, Paulista School of Medicine, Federal University of São Paulo

Cynthia Sarti
Department of Social Science, School of Philosophy, Letters and Human Sciences,
Federal University of São Paulo

Abstract

This paper, which is an exercise in articulating anthropology and psychoanalysis to the study of care for elderly people, is based on an ethnographic case study of an institution caring for the elderly in the city of São Paulo. It seeks to understand the representations of old age, aging and care, and what motivates professionals who provide assistance to the aged. Love, care and attention, understood by professionals and staff as requirements for a good job performance, are designated as donation (gift), regardless of technical knowledge. Recurrent references to both charity (gift) and biomedicine (technique) models, have implications for caring for the aged. For different reasons, both management models converge in a practice in which the elderly appear submitted to the intentions of another. The idea of gift as a supposedly unintentional action reveals care as a power relationship.
Keywords: Care, Old Age, Institutionalization, Biomedicine and Gift, Ethnography, Psychoanalysis.

Amor demais: o cuidado institucional à velhice

Resumo

Este texto, um exercício de articulação entre antropologia e psicanálise para pensar o cuidado a pessoas idosas, baseia-se em um estudo de caso etnográfico numa instituição asilar no Município de São Paulo. Busca-se compreender as representações de velhice, envelhecimento, cuidado e o que move a assistência à velhice. Amor, carinho e atenção, entendidos pelos profissionais e funcionários como requisitos para o bom exercício da tarefa, são concebidos como doação (dom) e independem do saber técnico. Recorrentes referências aos modelos de gestão do trabalho com a velhice baseados tanto na noção de caridade (dom) quanto na biomedicina (técnica) têm implicações para o cuidado; por motivos diferentes, ambos convergem para uma prática em que o velho aparece submetido às intenções de um outro. A ideia do dom como uma suposta ação desinteressada evidencia o cuidado como uma relação de poder.
Palavras-chave: Cuidado, Velhice, Institucionalização, Biomedicina e Dom, Etnografia, Psicanálise.

Too much love: institutional care for old age

Natália Alves Barbieri

Cynthia Sarti

Introduction

Furor curandis was the expression used by Sigmund Freud (1915, 1937) to designate the desire of the analyst to cure. An excess of care – with good intentions – can be abusive, interfering and impeding analytical work, by supposing an overvaluation of the person who offers help. Upon addressing this issue, Freud pointed to a human difficulty in dealing with the questions raised by the presence of the other, which can be manifest in this form of love. The research presented in this paper shows that this type of care – too much love – appears in work with elderly, without it being understood as a problem. To the contrary, this demonstration of love is taken for granted, and is socially accepted and valued.

This issue points to the need to address care as a fundamentally relational human phenomenon, an encounter in which one side is predisposed towards the other. Care thus relates to that which takes place in the relationship between two protagonists – the care provider and the person cared for – each occupying a distinct place. This relationship is marked by an asymmetry, such as that which occurs in the transferential relation between an analyst and the person undergoing psychoanalytic treatment. The asymmetry concerns a difference of positions and needs, in which, in principle, the other is recognized as someone similar. Thus, it does not presuppose any hierarchy of power. The excess of *love, affection and attention*, however, appears, as will be seen throughout this paper, as a form of exalting only one of the sides of this relationship, which will have implications for the care itself and for the elderly that are subjected to it.

Contact with the aging of the other leads to contact with one's own aging. The experience of time marked by finitude permeates daily institutional life (Setllage 1997; Goldfarb 1998). Aging, like death and the fear of dependence, are aspects that are constantly denied in a social context that stimulates the idea of a narcissistic time of youth as a superior value that is associated to the dream of consumption (Messy 1993; Birman 1995; Debert 1999). Aging tends to be considered as a process that always occurs with the other, never with oneself, and professionals who work with the elderly are also part of this culture, which avoids, at all costs, the experience of the passage of time.

To address the specificities of care for the elderly in nursing homes, an ethnographic case study was conducted in an institution in the municipality of São Paulo, Brazil, as an exercise in articulating anthropological and psychoanalytical approaches to the study of care for elderly people. Using anthropological tools for conducting the field study in articulation with theoretical references from both disciplines, we sought to grasp the notion of care found in the way that professionals and employees think of and experience their work. That is, we sought to address care as it is represented in the universe studied, as a "native category". [1]

1 About the possibilities for theoretical and methodological articulation between anthropology and psychoanalysis, see the previous article (Barbieri & Sarti 2011).

This article was written “with four hands”, based on the master’s dissertation of Natália Alves Barbieri (Barbieri 2008), a psychoanalyst, whose initial research problem emerged from her own experience in therapeutic care for the elderly. The work, which was based on an ethnographic method, was undertaken under the supervision of anthropologist Cynthia Sarti, from the graduate program in Collective Health at the Federal University at São Paulo (Unifesp). We sought to discuss the work with the elderly based on the symbolic references implied in the relationship between those who provide care and those who are cared for.

Institutional Care

Care for children, the elderly and family dependents, designated as a predominantly feminine task, came to be a problem when women entered the formal labor market, given that this change was not accompanied by a reformulation in the division of domestic tasks. In these circumstances, families often feel unable to care properly for their elderly relatives at home.

The increase of human longevity, observed since the end of the 20th century, is another factor in this situation. Despite various stimuli for the maintenance of a healthy, active and pleasurable life for the elderly, the advance of age usually involves an expansion of fragility and the advent of chronic diseases, which can compromise the independence of a person in daily life. The rise of new concepts of residence for the elderly has come to respond precisely to the need for intensive and integral care for people who have serious health impairments, given the financial and emotional difficulties families have in taking on this function.

The growing number of private or philanthropic institutions for care for the elderly (Chaimowicz & Greco 1999; Berzins 2006; Camarano 2010) includes both small and clandestine “backyard” facilities, as well as those considered “high standard.” Only 6,6% of the institutions in the country are public or mixed public and private, as indicated by an extensive study conducted by the Institute for Applied Economic Research (IPEA) (Camarano 2010), reaffirming the need for this type of service.

Although institutionalization can be considered an innovative care option – in part because it can allow a broader social life – the search for new collective decisions for housing the fragile elderly who are unable to care for themselves tends to stigmatize the idea of institutionalization, which is accompanied by the “ghost of abandonment” (Sarti 2001a: 94). In Brazil, the term commonly used for this collective housing for the elderly has traditionally been “*asilo*” [*asylum* in English], or *instituição asilar, a sheltering institution*, which originally referred to a refuge for various categories of people such as political exiles during the military dictatorship (political asylum). But in Brazil today, the use of the term *asylum* seems to be restricted to housing for old people, and is still associated with abandonment, poverty and charity.

Not even the new and often euphemistic terminology used in Brazil – rest house, residence, geriatric clinic, long-term care for the elderly or flats – have been able to break with this symbolic association. While these various new terms reflect diverse formats and ideologies, they are often only designated as *asylos*. Or, as Groisman (1999: 01) indicated, all these types of services coexist and compose a “complex and contradictory network of institutionalization of the elderly.” What they all have in common is that *care* is their central focus and *raison d’être.*

To address the specificities of care for the elderly placed in these services, this study was conducted in an institution in the municipality of São Paulo (Barbieri 2008) to investigate *in loco* questions inherent to the foundation of this institutional practice. Without an *a priori* selection of what would be observed, the method chosen allowed addressing professional care for the elderly in the daily life of the institution.

To study the phenomenon of care in *loco* requires the researcher to address important questions, mainly those that refer to the observer-observed relationship, which is a central problematic of both ethnography and psychoanalysis. The questionings proposed by the ethnography guided the presence of the researcher in the field, based on participant observation. The psychoanalytical concept of transference was used as a reference for considering the relations found at the institution. This allowed establishing a parallel among the relationships: researcher-researched, psychoanalyst-analysand and between the professionals of the institution and the elderly residents of the institution.

The methodological choices, therefore, are intrinsically associated to the problem of the study. The dialog between the two disciplines occurred on a methodological level, when conceiving the relationships in the ethnographic fieldwork based on the concept of transference; and on the analytical level, this dialog was always present, given that both disciplines understand reality to be mediated by language (Barbieri & Sarti 2011).

One of the criticisms made of research in psychoanalysis is that knowledge only exists in the experience based on transference, which only takes place in the traditional analytical *setting*: the analyst's consulting room. The concept of transference, however, addresses in a relational manner individuals who speak and interact with each other, no matter where their encounter occurs. (Psycho)analysis is based on the word that interpellates a listening of another. The psychoanalytical experience is established based on this listening to the speech of one (or various people), with this being the field of transference, where the empirical psychoanalytical field of therapy and research come together. It does not involve, therefore, an "applied psychoanalysis" where psychoanalytical concepts would be used as a resource to understand what is seen in the field, but the fieldwork itself is analytical by focusing on transference because this is, beyond the setting, specific to human communication (Althusser 1973).

The study

The questions that motivate this study are based on the complaints presented by families of the elderly who live in nursing homes. Such complaints generally refer to the excessive turn-over of the employees who provide basic care and who spend most of the time in contact with the elderly. The recurring rearrangement is understood to affect the quality of the services provided, even in locations considered to be references in this type of care.

In research on healthcare, the professional is usually not identified as an object of study, with only one of the sides of the care relationship prevailing: the patient, the user of the service or simply the person who is attended (Laplantine 2004).[2] Nevertheless, studies in the human and social sciences (Sarti 2010) show that it is not possible to address institutional care without presupposing its relational dimension, in the encounter between (at least) two protagonists: the one who cares and the one cared for. Following this trend, the population considered in this study includes all professionals and employees who work in the institution, seeking to consider all of the professional and technical categories existing there, encompassing the diversity in the care, as well as the observation of the users of the service. This choice became particularly relevant, because care is normally associated, particularly in medical sectors, to knowledge and action exclusive to the field of nursing, as if doctors cured while nurses provided care (Ayres

2 The model of the Free and Informed Consent Agreement (TCLE) offered by the Research Ethics Committee (CEP) at Unifesp is an example of this trend. Neither the professionals or even the students and teachers are included as "subjects of the research" only "patients" or "users," the population attended by the healthcare services.

2002). In this study, however, care was considered in a broader manner, to understand that it permeates all the institutional levels, and is not restricted to nursing.

The ethnographic work took place over eight months, in an institution indicated as a reference in care by professionals in the field of aging. It is a not-for-profit charitable institution, with capacity to serve an average of 170 elderly people, some of whom pay and others who do not. It was first conceived by a group of church women who decided to create an entity to offer *housing, love and care, as well as support and hospital assistance for needy elderly people*[3]. This initiative, which is nearly 100 years old, was born within a community of immigrants who arrived in São Paulo in the late 19th century[4]. Although it is administered by a board composed only by members of this *community*, the assistance is open to the elderly public in general and not restricted to descendants of the members of the founding community.

The board members work voluntarily, as defined by the by-laws of this philanthropic organization. Daily activities are coordinated by an administrator who is responsible for the administrative sector and by a social worker who is responsible for receiving the elderly, and for the contact and contract with the families. The hired professionals (who have university degrees) also include a geriatrician, responsible for the conduct of health, four nurses, an occupational therapist and a nutritionist. Other employees are people with a lower level of formal education: nursing assistants, caregivers, clothes washers, cooks, kitchen assistants, in charge of cleaning, porters, maintenance staff, the library intern and all administrative staff. According to the institutional records, it is estimated that there are ninety working people in all, as well as a large number of interns and volunteers, with an average of sixty workers frequenting the institution daily, in a not necessarily systematic manner. The nursing assistants and the caregivers (a denomination given to employees without technical training to perform basic care for the elderly, such as monitoring bathing and the taking of meals), as will be seen later in this work, are the ones that are in regular contact with the elderly in institutional routine, and represent the majority of the team.

In relation to the elderly, 70% pay from 4 – 9 minimum wages for individual or shared rooms, an estimate that does not include the costs of medications, diapers and any extra fees that vary according to each person's dependence and need for specific care, for extra caregivers, physiotherapy, speech therapy, and other goods or services. The 30% of the remaining spaces are supposedly free of charge, even though their pensions are retained by the institution and a portion of the funds are used to pay for their expenses, as determined by the Statute of the Elderly (2003)[5].

The first contact was made with the administration of the institution, when the research project was presented. A commitment was made to maintain the names and specific data about the institution confidential, to protect the members of the administration, the elderly, employees and the professionals who granted interviews. The management, in turn, consulted with the directors to see if the field work could be conducted, and the directors agreed. The nursing coordinator was designated as the person responsible for receiving the researcher, because he was also conducting a master's degree and was thus

3 Information found on the institution's Internet page. The address will not be revealed, as well as any information that could identify their origin, because we agreed to guarantee confidentiality.

4 Several communities that settled at that time in São Paulo city built asylums to meet their own elders, such as the Germans, the Japanese, the Syrian-Lebanese and the Jews. We maintain the anonymity of this community due to the established confidentiality agreement with the institution.

5 Law nº 10.741, of Oct. 1, 2003, known as the Statute of the Elderly, and other measures. (Cap. VIII, art. 35): "§ 1º In the case of philanthropic entities, or nursing home charging for the participation of the elderly in the cost of the entity is permitted.§ 2º The Municipal Council for the Elderly, or the Municipal Council for Social Assistance, will establish the form of participation called for in § 1º, which may not exceed 70% of any social security benefit or social assistance received by the elderly."

considered *the most competent*[6] to both evaluate the research project and to accompany the investigative process. This professional was quite receptive and said that he understood the project to be *an important proposal that could help improve the services at the institution*. The fact that the study had the official seal of a university in the field of healthcare, more specifically a school of medicine, proved to facilitate the entire fieldwork process.

The delicate process of negotiation, the sensitivity needed to enter the field and the awareness of the exchanges implied in the research procedures made it possible to build relations of trust with the people associated to the institution – the elderly, their families, the professionals and the employees – during the entire observation period. The presence at the institution was planned with the goal of understanding the work routine. For this reason, at first the visits took place at least twice a week and on the weekend, in the morning, afternoon and at night. The employees' work schedules varied according to their function (and contract) and understanding all these logistics required an intensification of the presence in the field during the study, which helped the researcher to become recognized at the location.

The elderly who circulated in the space were those who proposed a more effective approximation asking: *Who are you? What do you do? Where do you live?* (a question that is directly related to the institutional situation). Meanwhile, the employees and professionals did their work and asked little about the stranger circulating and observing their daily activities, as if they were accustomed to it. Occasionally one or another of the staff would approach the researcher, as in this excerpt from the field work diary:

> The nursing aides go from one side to the other. At this moment I feel like a stunned cockroach, not knowing where to go, what to do, how to behave. [...] I was helped by a nursing aide who I met the last time that I came to the institution, when the [nurse] introduced me. This aide, a young man, approached very calmly asking if I was a volunteer or an intern. I said I was doing a study on caring and he, taking advantage of the situation, asked me to help him take one of the old women who was in the TV room to the cafeteria: So now you begin to provide care. He also seemed to be saying provocatively: 'Come see what it is to care for these people here.' This woman, I realized, was one of those who 'was difficult' – she smelled like urine, she spat on people, walked with great difficulty and spoke an undecipherable language – I felt I was in a rite of passage. This assistance-provocation gave me greater security on this first day alone in the institution and an initial contact with the employees.

Despite having been well received, the researcher found that, some professionals were disturbed with her freedom to circulate in the institution. This was revealed in small exclamations when it was her time to leave: *Are you going already? Why don't you stay here like us?* (which one nurse repeated a few times). Or: *Are you leaving because you are going to spend the weekend at the beach? I'm going to stay here on duty*. These somewhat provocative questions were aimed at a supposed place occupied by the researcher – equivalent to a place of "supposed knowledge" – in contrast to those who had to work. At these moments, the asymmetry in the relationship between the researcher (privileged) and worker (underprivileged) was made more than clear.

The second moment of the study involved choosing professionals and employees for the interviews. Emphasis was given to those who had greater and more frequent contact with the elderly, or even those

6 The terms and words used by the interlocutors of the study will be placed in *italics* to distinguish the "native speech".

who had decisive participation in the care practices.[7] In the case of the nursing aides and the caregivers, there was also a need to establish criteria to decide who would be interviewed, given that frequent rotation was observed in these functions. Priority was therefore given to interviewing those who had been working for more time. Altogether 12 staff members were interviewed: the administrator aged 43 and with a degree in administration; the social worker aged 43; the doctor aged 30; the nursing coordinator aged 33; the nutritionist aged 30; the occupational therapist aged 27; a nursing technician aged 28; three nursing aides, two women and one man, aged 25, 36 and 44 respectively; a cleaner aged 42 and one of the workers called "caregiver" aged 28.

Women predominated among those interviewed (9), as they do in the institution as a whole (besides one nursing assistant, the doctor and the nursing coordinator are the only men). The social difference between the professionals, who have an university degree, and the employees, who have a lower level of formal education, appeared in the considerations over institutional relationships, but predominantly in socioeconomic and cultural differences. Elderly residents are considered by some employees (in general the caregivers and nursing aides) as "privileged" people because they receive *everything* in the institution – unlike what they find in their own lives, which are characterized by difficulties and emotional and financial restrictions.

In relation to schooling, the distinction created between a university or a technical education in the prestigious field of health, with its specific language, was an important factor, appearing as a form of making the contact with the elderly more professional and distant from personal issues. Terms such as *biopsychosocial, interdisciplinary, stimulating self-care, obit* and others are repeated with a certain frequency as a means of professional distinction, even by the employees with a lower level of education. This indicates how the biomedical model of healthcare predominates the institutional discourse.

With the exception of the doctor and one nursing aide, no one else interviewed said that they had chosen in advance to work with the elderly or even in the field of aging. They came to the institution through the mediation of former professionals and work colleagues or by ads placed by professional councils. Most had been unemployed before beginning work at the institution and for many it was their first job after college or a technical course. The institution is one of the destinations for those who are beginning a career, and is easier to enter because it is of low prestige in the medical world. (Singer 2002).

After joining the institution, however, many become concerned with the issue of care for the elderly, perceiving the importance of their role. The fact that they are seen as essential motivates them to remain in the field. Work at the institution thus comes to be considered more than just a job opportunity: by leaving the undesired situation of unemployment they begin to feel appreciated and attribute their "choice" to work with the elderly a result of divine destiny (and not to chance), considering themselves "predestined" to work specifically with this public. This aspect appears in the statement of one nursing aide: *We think that we control our lives, but it is God who controls our life. And he knows our needs and I am sure it was he who placed me here (...).*

The doctor, in addition to his socially valued professional qualifications, is different from the others because he chose to work in the field while still in school, where he had contact with elderly patients: *The hospital where I worked had many elderly people and I had lots of contact at the end of the sixth year. I did an optional internship in geriatrics, which I liked a lot, and that was when I decided to work with the elderly.*

7 During the various phases of field work there was constant contact with the following employees, in addition to the technical professional: doormen, laundry-room personnel, cooks, cafeteria workers, maintenance workers, personnel from the dept. of human resources, administrative personnel, physical therapists (who are sub-contracted), interns (in nursing, aides, physical therapy) and volunteers (professional and recreational).

The supposed growth of a labor market in the field of aging – a promising field still with few professionals – was also indicated as one of the reasons to remain in this area. For some, the first contact with the elderly inspired a search for additional courses and specializations. This point reaffirmed a characteristic of the field of aging: interest tends to be based on practice and not on previous knowledge of a theoretical nature (Barbieri 2014).

Even professionals and employees with specialized technical training tended to base their consideration of aging on their personal experiences rather than on academic theories. Because of this, the meanings of old age, aging and care that guide and influence the care of the elderly transcend geriatric knowledge and gerontology as formalized in educational institutions, reproducing instead socially disseminated representations about these issues.

The hospital model

Originating as a charity run by volunteers, many of them amateurs, the institution began to hire technicians from the field of healthcare in the 1990s to implement more professional procedures. The introduction of a hospital model, characterised by the presence of specialists and by the standardization defined by the regulations in this field of services, is presented as an advance in relation to previous forms of care. They would supposedly guarantee a *better quality of life* for the elderly.

The medicalization of aging came to nursing homes in an effort to improve them, not only by providing better health care, but by creating a structure for care through biomedical protocols, which dominate the entire daily activity. The importance of taking medication and having meals at the correct times is not something to be questioned, due to the high degree of organic limitations of the people attended. But when the entire routine is based on this sole reference, the institution becomes a clinical-medical service and less a pleasant place to live in. This has implications: the care comes to require a technical specificity and the person who provides care must have qualifications to know how to respond to a series of protocols. Those cared for must cooperate and adapt to the protocol of the routines for their *own good*. Thus, an institutional discipline is created that is common to all.

One aspect that can be seen as negative in turning a nursing home into a hospital facility is that not all of the residents require this type of care, and they suffer because some activities that they could continue to conduct on their own are restricted, given that they also come to be considered as *in need of care*. This implies, by definition, that they have limited autonomy. The fact that most of the professionals and employees refer to the elderly as *patients* and not as *residents* reveals this intention of *care*.

The heterogeneity of the people served in this type of service is one of the problems faced: there are those who have no suitable options for residence at this stage of life and who are still *lucid*, seek a form of remaining independent. Others, who are taken to the nursing home by their own family in a state of health requiring intensive and integral care, are necessarily dependent. They all live together, at times in the same room, and are treated in the same way regardless of the state of their health.

The deterioration of lucidity observed is related to this lack of distinction. Despite the best intentions of the care providers, the restriction of autonomy in the carrying out of the daily activities, and the uniformity of the routine in function of the care for the elderly with greater health problems result in restricting the idealization or maintenance of life projects. The impossibility of visualizing future projects (Birman 1995) can lead to the onset of dementia (Goldfarb 2004). This process is exacerbated by putting *patients* in a position of passivity, which is a characteristic of hospital institutions, where biomedical technical knowledge overrides the knowledge of the careproviders (Caponi 2004). Given these institutional

circumstances, it is not possible to ignore that there is much more at stake in the rise of the incidence of dementia than purely organic causality.

In this process, some of the former employees seek training as nursing aides to be able to continue to work; others are substituted and some remain in the function of caregivers, which does not require specific training. The lack of, or the precariousness of a technical repertoire creates insecurity for employees, who believe that they do not know what they should know. The recurring use of technical terms serves as an attempt by caregivers and nursing aides to decrease this insecurity. This was also noticed in relation to the non-medical professionals, as if the use of biomedical terminology would guarantee a command of the task and an inclusion in the symbolic universe of a valued knowledge – the biomedical.

Nursing takes on the central position in this discourse, since the institutional routine is based on the hospital service, which is supposedly exempt from the problems of an *amateur* service based on charity. Among the difficulties faced in this process is the constant rotation of the nursing aides, who regularly resign because they cannot bear the work or because they can earn more elsewhere. During the period of the fieldwork, two salary increases were offered to try to keep people in the institution. But this did not keep some from leaving a week into their contract. In addition to the financial issue, other issues were identified to explain why employees did not stay. The lack of challenges in the daily routine was one of them. The service becomes discouraging in a short time because there is little perspective for professional growth; tasks are *basic* and at the same time *heavy*: giving baths, changing diapers, applying bandages, giving medicine and feeding. In the words of one nurse: *It's cleaning up urine and faeces most of the time.*

The elderly experience the high turnover of these employees as a lack of care. The elderly and their family members complained both of the consecutive absences as well as the internal changes, through which employees are reallocated (from sectors and periods) after creating ties with the elderly. The most lucid say they are disturbed by these changes, because they do not feel well cared for and because they have to explain various times how they like to be cared for. One elderly person commented after not being able to remember the name of an aide: *But there are so many people who come here, people who come and go away that I am not able to remember their names. Whenever they change, I think I should not get attached to them, because I suffer a lot when they go away.*

Between charity and biomedicine

This administrative proposal, based on the concept of hospitalization, came into being as a substitute for a model of care for the elderly, based on a discourse of charity within the Christian tradition in which *giving* is the central element, in detriment to technique (Caponi 2004). Nevertheless, it cannot be said that the substitution was complete. At times we observed peaceful coexistence between them, and at others a dissonant coexistence between references to biomedicine and charity. The coexistence and the impasse between the two models reveals a central question: despite being based on different foundations, the two models of assistance share the notion that the person who provides the care has the knowledge and power over the person who is cared for, because this person is understood as someone who does not know or is not able to decide what is best for him or herself.

This aspect became evident at the institution's anniversary party, which was held at the institution, but to which the elderly, their families and the staff were not invited. The attention, even of the local media, was entirely on the group of women on the board of directors and the 800 outside guests, who received praise for the *charitable actions of taking in the incapacitated elderly*. Because the elderly inmates were not part of the event, it was as if they did not exist; it could be said, at this moment of exclusion, that the elderly and the

workers experience the true "loneliness of the moribund" described by Elias (2001), by being maintained segregated from the normal world.

This action of care is considered benevolent within the symbolic references of charity, in which the charitable person is valued as one who gives without asking for anything in return. Nevertheless, in caring relations, the value of the person who cares (gives) as an uninterested act darkens the dimension of the gift implied in these relations. As Mauss (2003) has shown, the gift implies reciprocity. For this author, there is no uninterested exchange. There is always, somehow, the expectation of something in return, according to the conception of the other with whom one exchanges. The supposed uninterested act, in the case at stake, is related to the idea that the elderly is not in a condition of being able to give; instead, he/she is only able to receive.

So, in the institution, where the work undertaken is considered as an uninterested gift, the possibility of seeing the elderly as being capable of establishing exchanges and participating in decisions about their own situations is excluded: the workers are in the institution for the exercise of the "good action" addressed to the other. These others are conceived as incapable of exchanging, given their limits (of age, social condition, etc.). The discourse of unconditional charity persists, even considering the fact that the residents pay a large amount for the services provided.

The payment establishes a relationship of exchange, but it is not seen as such, because the elderly are placed in the position of being dependent on the generosity of the institution, which offers them shelter. In these conditions, anything that is offered to them is valued by the professionals or employees, who often have difficulty in identifying the reason for some of the residents' complaints, as if they should only be thankful for the care received. In Mauss's terms, the care is seen as the gift given by professionals and employees in exchange for the elderly's gratitude, disregarding other possibilities of exchange in which the latter could be also valued.

Incapacity thus appears as an identifying characteristic of the elderly who seek out or who are taken to the institution, regardless of the condition of their health or financial situation. This representation relates to the rise of institutionalization in Brazil in the nineteenth century, when elderly beggars were taken off the streets to be looked after in this type of institution. Although nowadays such institutions take in fee paying residents and are always full, the old image of the institution as a place destined for the poor and incapacitated elderly remains, as indicated in Groisman's (1999) study.

Doctors, nurses and other employees consider that the elderly enter the institution either because they have succumbed to aging by not fitting the model of an active and successful old age, or because they have been abandoned by their families. These representations thus reaffirm a concept found in the Brazilian law known as the Statute of the Elderly (2003) in which an institutional shelter is seen as the last option for the destination of the elderly. According to the law, shelters are conceived primarily for people who are abandoned, and have no family or financial resources:

> Priority in care for the elderly by their own family, with precedence over institutionalized care, except when they cannot or do not have the conditions to look after themselves (art. 3°, § único, inciso V).

The Statute establishes that the elderly have a right to decent housing with their own family or with a substitute, and when unaccompanied by their family members, in a public or private institution:

> Complete assistance in the modality of a long-term stay entity will be provided when it is found that there is no family group, house-home, abandonment or a lack of their own financial resources or of the family (art. 37, §1°).

The Statute thus follows a format that seeks to shift the responsibility for aging and the elderly from the state, placing it preferentially on the families (Neri 2005). It can thus be perceived that incapacity does not only refer to a situation of fragile health of the elderly or to a family that is incapable of providing basic care, but is presented as a condition that is inherent to the elderly, who will live in the institution regardless of the reasons that led them there.

Technical care x Humanized care

The benevolence in the face of this predetermined mark of incapacity is also present in the discourse of the employees and professionals. The donation as "gift" is manifest as an essential characteristic of working with the elderly, taking precedence over merely technical knowledge[8]. This aspect has been addressed in the healthcare field due to the development of biotechnologies, which are leading to a crisis of assistance, because emphasis on techno-scientific progress takes precedence over humanized attendance (Ayres 2002). This is not the case of the institution under consideration, where, on the contrary, the care provided, is considered for the most part, *simple and basic*, even though *heavy*.

Many employees at this facility complain of the daily goals established by the new procedures and refer mainly to the number of baths that they must give, as if the institution had become a business where what is important is the mass production of daily tasks. In the management of philanthropic action a clear concern is present for the "efficiency of the company" and the "effectiveness of the assistance" (Sarti 1998: 7), which is revealed in these statements as a criticism of the biomedical model implemented, as if this model was responsible for a bureaucratization of the practice of institutional care.

The statements below reveal an attempt to distinguish that which is considered merely *technical* care from that which is conducted with *love* and *attention*:

> *To care is to provide affection. (...) Because caring for the elderly is not just cleaning the elderly. There are people who think that to care is just to clean, change diapers, wipe them and that's it. To care is to give them attention. An elderly person is not an object, you can't just show up and give them a bath, put on their clothes and leave. This is not care. There must be something more.* (nursing aide)

> *To care is to treat well, provide attention, affection... provide what the person needs. (...) I always care with attention, affection, with responsibility in the treatment that I give them.* (doctor)

> *There are people who say that this is caring, but this is being technical: 'I have to take the man from the bed'; 'Change him and that's it, on to the next one'; I think that to care is for you to go in, talk, you are able to meet the person's real needs, then, yes you are caring. (...) And instead of you having just another patient, just another client, what do you have? Another friendship, another friend. This is the difference.* (nursing aide).

These statements highlight the definition of care as a *non-technical term* that should be provided with *love, dedication and affection:*

> *With dedication, affection, respect...* (nursing aide)

> *With love, dedication, with affection. (...) It's about care, right? But I think that when you do it with love, with affection and dedication I think that you care better.* (social worker)

8 About this see Molinier (2014) and Debert (2014).

It is striking that these sentiments, considered to be essential, do not refer to characteristics related to the healthcare professional, whose formal role is to provide the care technically in a mechanical way. Yet a nutritionist distinguished clearly between "personal" and "professional" aspects: *to care is to love, care is respect. It's very easy to be here, to be a nutritionist, to have a number, produce paper. (...) To not just present my professional (side) but to present my person [all side]*.

These statements express the notion that professional care excludes consideration of the subjectivity of the person who is cared for; this can only be accessed (and valued) through a *personal* characteristic – that is one that is affectionate, respectful and concerned – of the person who provides care. It is up to the *professional* to know how to deal with the necessary discipline to organize work with the large number of people who must be served. For this to occur there cannot be space for individual desires. This reveals a concept of care that assumes a gap between the realization only of the *technical* (bureaucratic) and the *humanized* (personal). As indicated by Bonet (2004: 11), in education in the field of healthcare, the cognitive dimension tends to remain separated from the emotional dimension. Nevertheless, this separation is not found in practice and reveals the tension found in the education and practice of biomedicine between "the search for knowledge and the feelings triggered in this process."

Sacrificial Task

Working with the institutionalized elderly, most of whom are in a situation of *dependence* or *semi-dependence*, is fraught with difficulty. In addition to repetitive and *heavy* work, relationships with the elderly are not easy. Some residents oscillate between expressing feelings of submission and impotence (*I cannot do anything here inside...*) and making imperative requests (*Call my family! Do this because I pay your salary!*). This proximity tends to provoke reactions either of proximity to or distance from the elderly which might recall experiences with one's own family:

> *There was an old man who reminded me a lot of my grandfather, so I began to think of my grandfather. You have to be careful: 'No, he's not my grandfather.' Some things you want to do, but do not agree with what the family does, but you are not the son...these are our limits and you have to deal with this and its quite hard.* (occupational therapist)

One nursing aide said: *Working here is a lesson in life and in humility.* She described a scene that was constantly repeated in her relationship with one of the old women: this woman was not able to get out of bed alone and usually called her every day to ask for a glass of water. When the aide entered the room with what she asked for, the woman said that she did not ask for anything. The next moment, the same woman *complained* to other people (employees, the elderly and family members) that this aide never does what she asks for and that she is very *badly treated*, because they ignore her requests. The aide said she did not know how to respond in these circumstances, because the woman in question does not present a condition of dementia and thus believes she is a *bad* person: *I ask myself what she did to be here, because she is well cared for and even so creates these situations where we don't know what to do. I speak humbly: what should I do in this case with her?*

Physical aggressions committed by the elderly are constant; this aspect, present in some relations, however, is considered as something foreseen in the work with people with dementia, and therefore a difficulty inherent to the care:

I've been hit a lot. Now not so much, but I have been hit a lot. What can you do? (...) I chose this profession, we know that they don't do this on purpose, right? It depends on their dementia. (...) I've been hit with a cane in the throat, I have a mark until today from a patient who scratched me, I take it in my stride, you have to maintain a line, hold the pose... maintain your class as well, your posture. (nursing aide).

In the situations described above, to put up with physical aggression or *provocation* is understood both as a sacrifice, as well as a condition of the work. *To maintain class* aims to sustain the experience of these events without getting personally harmed, because they are part of one's professional duties.

The specificity of care for the elderly

When asked about the existence of the specificity of care for the elderly, professionals and employees offer different responses. In general, they mention the relational dimension of dealing with the elderly, whether because some do not accept any form of care, or because of behaviors that require considerable attention. In this sense, a statement by the doctor is illustrative, because it indicates the difference in treatment between older and younger people:

The majority of the elderly, mainly those who go to a doctor's office or those who live here in the institution, have an emotional need much greater than the average younger person. So, they need much more affection, care and attention than a younger person would need.

To have *patience* and to *give lots of attention* to the elderly were also aspects raised by other members of the staff. While some believe that attention and care must be the same for people of any age and who present different pathologies, others argue for specificity. Others compare elderly people with children, either noting similarities or differences. The latter can be summarized in this statement of a social worker:

To care for a baby is the most wonderful thing in the world, it's very different. An elderly person is someone who got old, who has limits, you see yourself tomorrow. The baby is the future. Right? (...) I think its ridiculous when people compare the elderly to a child, I'm sorry, I think this is a lack of respect for the elderly (...) When you clean a baby's behind you want to bite the baby's behind, and with the elderly you don't do this. But there are retarded people, who do this, who sniff. I think it's a lack of shame, a lack of respect for the elderly.

Other professionals also contrast the smell of urine of a child and the strong smell of urine of the old, due to the quantity of medications, as well as the difference between the *soft skin* of a *baby* and the *thin dry skin* of an old person.

In addition to these issues, which deal directly with physical contact, there was a reference to the relational dimension, in which aspects experienced during life can interfere in the practice of care, like the difficulty some family members have in caring for their parents if they were often poorly treated by them. In these cases, they indicate the institution as a care option. On the other hand, some employees say that the care for the elderly is similar to that for a child because of the fragility present in the two cases. The difference mentioned is that the child is developing and the aged are not, as one caregiver stated: *They have already lived, it's as if he is a developing child, but in the case of the elderly the tendency is to get worse.* When the caregiver refers to the elderly as someone who has *already lived*, she indicates a conception in which the present and the future are not part of the institutional experience, an aspect observed in another statement:

In reality, they live in the past (...) they think they are here because they are very sick and that they will go back to their home. But in reality this is their home, they will stay here with us. So it is sad. (...) We are their family. (nursing aide)

Considering the elderly person as someone *who lives in the past* removes their possibility of believing in the existence not only of a possible future, but of a present, even within the limits imposed by fragility. There is no perspective of a future project: he *already* lived; therefore, there is no present either. The past, in turn, also brings the mark of the stigma in two representations presented often during the fieldwork: either the elderly must have done something bad during their lives to live their old age far from the family, alone in a nursing home; or going to the institution is the consequence of family abandonment due to conflicting relations among members of the family:

At times it passes my mind, we comment, we all comment: (...) either she wasn't good to her family or the family is not important to her, one or the other. (caregiver)

Family abandonment is the most common representation of the presence of the elderly in the institution. This became evident when those interviewed said that they could not imagine someone in their own family living in an institution. This would be a sign of abandonment:

> *If one day my mother and my father, if they reach old age, I think that I would not stuff them in a nursing home, I will care for them.* (nurse technician)

> *No, I wouldn't place anyone from my family. (...) Because here they are not abandoned because they have us to look after them and if they didn't?* (caregiver)

> *I can't imagine this as an option, this option is the last of the last for placement* (occupational therapist).

Nevertheless, when talking about their own old age, many professionals and employees say that they have imagined the institution as an option for themselves later in life, either because they do not want to give work to their relatives, or because some see the services and care offered as something that they never had before. The institutionalization is thus not something that they see as bad for themselves, and is a possibility, even if they recognize the difficulty in accepting care from someone unknown.

To address how the professionals and employees justify the presence of the elderly in the institution is particularly important for indicating how they understand the subjects with whom they are relating, and therefore, how they see their own roles. To blame the family for a supposed abandonment is not only in keeping with a known social representation – which is even found in the Statute of the Elderly – but can also be understood as a way to preserve a relationship of complicity with the elderly, by attributing to a third party the negative factor (the abandonment). By blaming the families, they value what they do. The professionals, specifically, report that the institution would never be the same as the family environment, but that this does not release them from the effort of creating the best conditions of care. This aspect was also indicated by Debert (1999: 107):

> "entrance in the nursing home is first represented by the residents as an option that is capable of allowing their independence and the revival of a multiplicity of social roles, of an intense social life that would be threatened or in a clear decline outside the institution. And it is the impossibility for this revival that makes the experience in the institution a deception and gives it a particular dynamic. This is also one of the factors that complicate the work of the technical personnel, who tend to think of the ideal nursing home as that capable of offering the closest possible substitute to family life".

Some, in this attempt to make the institutional environment more familiar, come to establish a link outside the situation of work with the elderly. They may do this by satisfying small desires of the residents,

like making special meals for those with whom they are closer and taking treats from the street like cookies and candy, given that the elderly rarely go out of the building. These small kindnesses can be understood as an attempt to erase the impersonality found in the daily life of the institution.

Professionals and employees, in general, evaluate their relationship with the elderly as being good, and report a lack of complaints about the work they do. They complain that the time with the elderly is limited by the onus of administrative or bureaucratic functions.

In some cases workers refer to the institution as their own family, in the sense that they take responsibility for caring for the residents as if they were young relatives:

> *I am here and it is as if they, the elderly, were my children. (...) Given that I am not a mother, at least I have one side complete, that I take care of them with lots of care, as if they really need me.*
>
> [about a resident] *He is a big baby, he is not an old man. He is a big baby and it doesn't disturb me at all to take care of him. They are all very beautiful* (nursing aide).

The affection and concern for the residents is clear; however, it is perceived that this concept of care includes the personal involvement of the employee, who tries not only to fulfill the needs of the elderly, but their own needs as well. When the need to care prevails in the person who cares, there must be someone in the place of the needy: one has a lot to give and the other is missing something. It should be emphasized that the valuation of the gift (mainly as a personal donation) in the practice of care, is not accompanied by an explicit negative intention of the employee who provides care; to the contrary, care as a donation is understood as a *good*, an action realized for the other, and care *with love* as a practice that is valued in society. The criticism that is made in this work does not refer to the presence of affection (*love*) in the relations, but to how, under its justification, relationships are established in such a way that the person cared for comes to occupy a place of subjection precisely for being (or remaining) cared for.

Final considerations

The representation of *abandonment*, as a characteristic associated with the institutionalized elderly, reinforces the sense of donation of the professionals and employees, who described care as an *act* of *love*, *caring* and *attention*, something that is not part of *technical* knowledge. In this concept of care a split was revealed in the institution between what was considered to be *technical* work, usually seen as both a bureaucratic obligation and comforting service. In other words, the affection and respect for the particularities of the elderly are not included in technical knowledge.

The separation between the technical and the comforting has been defined as a crisis in assistance in the healthcare field (Ayres 2002). Nevertheless, the etymology of the word technical (from the Greek word *thecné* and the Latin *ars-artis*) refers to knowledge about a certain process or method combined with a reflection about this action, that is, the intention of the action is accompanied by a relationship of commitment to the other. The technique is not limited to doing something efficiently, but includes the commitment to this doing, its consequences and its social valuation, and is thus related to the field of ethics (Barbieri 1990).

In this sense, the two management models – the charitable and the biomedical – which permeate the representations of the professionals and employees, raise implications for the practice of care, given that a trend was observed for the professionals to assume for themselves, personally, the responsibility for all the actions that concern the elderly, without their participation in the decisions about their daily activity.

Therefore, the supposition that guides the charitable thinking in which the caregiver does that which he or she considers best for the other, by following the precepts of Christian charity of help for the needy, is also presented in professional practice, when they separate the *donation* from the *technical*.

The hospital mode of operation reproduces the question present in relations based on charity. As in a hospital, where it is impossible to have the participation of the patient in determining the therapy prescribed by the doctor, the professional has the prerogative about the conduct of treatment, while the elderly resident in the institution must adapt to the daily life guided by the procedures and regiments of nursing, whether they are sick or not. In the discourse of charity, the elderly are considered to be incapable and to need complete support: in the biomedical discourse, they are considered as those who should respond to the procedures prescribed for them. For different reasons, these procedures end up converging on a single type of practice that denies the agency of the "patients.".

This is not the result of a deliberate intention on the part of professionals, employees and top management to place the elderly in a situation of subjection. To the contrary, the actions are "well-intentioned". Nevertheless, it was found that they end up extinguishing, even if inadvertently, the other's condition as an active participant or, without considering the need that moves the benefactor to do good, regardless of the implications for his acts on those involved in the relationship.

Moreover, both models are far from the concept of solidarity, which can be understood as a tie between people who see themselves as equals, in which the action of helping does not stimulate dependence of one in relation to the other, but foresees the existence of dialog as a mediator of the relationship (Caponi 2004).

The issues faced by the workers are therefore difficult to address because they constantly refer to the relational aspect found in care, by relating to the very experience of the process of aging and the references of the family and the person cared for. The way that the work is conceived and conducted does not leave space for these workers to describe and elaborate on the idiosyncrasies experienced with the elderly and the various feelings that they generate. The limited participation in the daily decisions made by the administration at the institution and the predominant role of the doctors also influence the work that often ends up restricted to the carrying out of bureaucratic procedures. It is important to note that the interviews raised questions and reflections for those interviewed, indicating the need for spaces for reflexive exchanges about institutional work with the elderly.

The criticisms made of the institution focused on in this study reflect aspects that are common to other institutions, as indicated by Moraes (1977) and Debert (1999). In the same way, many of the representations belong to the broader social field, and assume specific proportions in the practice of institutional care. In this sense, it is reasonable to suppose that these discourses are present in other similar institutions, whether public or private, and among those who conduct home care. This latter type of assistance, although it is defended by the professionals as the best care option, is also subject to relationships in which the concept of care based on charity in detriment to solidarity prevails.

These questions point to the search for models of management and care that allow the elderly, family members and employees to participate in the dialog about daily decisions. They suggest that a relational approach can contribute to improving relations of care for the elderly, opening space for working with the human difficulty of dealing with issues raised by fragility.

Translated by Jeffrey Hoff

Received 31 March, 2015, approved June 1, 2015

Bibliography

ALTHUSSER, Louis. 1973. "Sur le transfert et le contre-transfert". In: *Écrits sur la psychanalyse*. Paris: Éditions Stock/Imec. pp.173-189.

AYRES, José Ricardo C. M. 2002. "Tão longe, tão perto: o cuidado como desafio para o pensar e o fazer nas práticas de saúde". In: T. Saeki, M.C. B. M. Souza (org.), *Cuidar: tão longe... tão perto...* Ribeirão Preto: FIERP/ Escola de Enfermagem/ USPRP/ CNPq. pp.13-26.

BARBIERI, José Carlos. 1990. *Produção e transferência de tecnologia*. São Paulo: Ática.

BARBIERI, Natália Alves. 2008. *O dom e a técnica: o cuidado a velhos asilados*. Dissertação de mestrado, Programa de Pós-Graduação em Saúde Coletiva, Universidade Federal de São Paulo/Escola Paulista de Medicina - São Paulo.

______ 2014. *Doença, envelhecimento ativo e fragilidade: discursos e práticas em torno da velhice*. Tese de doutorado, Programa de Pós-Graduação em Saúde Coletiva, Universidade Federal de São Paulo/ Escola Paulista de Medicina - São Paulo.

______.; SARTI, Cynthia Andersen. 2011. "Psicanálise e antropologia: diálogos possíveis". *Revista Latinoamericana de Psicopatologia fundamental* [online], 14(1): 57-69.

BERZINS, Marília Anselmo Viana da Silva. 2006. "Instituição de longa permanência para idosos. Envelhecer com dignidade: um direito humano!". *Portal do envelhecimento*. Disponível em: www.portaldoenvelhecimento.net/acervo/pforum/ilpis. Acesso em 31 de janeiro de 2015.

BIRMAN, Joel. 1991. "Apresentação: interpretação e representação na saúde coletiva". *Physis: Revista de Saúde Coletiva*, 1(2): 7-22.

______ 1995. "Futuro de todos nós: temporalidade, memória e terceira idade na psicanálise". In: R. Veras (org.), *Terceira idade: um envelhecimento digno para o cidadão do futuro*. Rio de Janeiro: Relume Dumará. pp. 65-78.

BONET, Octavio. 2004. *Saber e sentir: uma aprendizagem da biomedicina*. Rio de Janeiro: Fiocruz.

BRASIL. Lei nº 10.741, de 1º de Outubro de 2003. Dispõe sobre o Estatuto do Idoso e dá outras providências.

CAMARANO, Ana Amélia (org.). 2010. *Cuidados de longa duração para a população idosa: um novo risco social a ser assumido?* Rio de Janeiro: IPEA.

CAPONI, Sandra. 2004. *Da compaixão à solidariedade: uma genealogia da assistência médica*. Rio de Janeiro: Fiocruz.

CHAIMOWICZ, Flavio; GRECO, Dirceu B. 1999."Dinâmica da institucionalização de idosos em Belo Horizonte, Brasil". *Revista de Saúde Pública*, 33(5): 454-60.

DEBERT, Guita Grin. 1999. *A reinvenção da velhice*. São Paulo: Edusp.

______ 2014. "Arenas de conflito em torno do cuidado". *Tempo Social*, 26(1): 35-45.

ELIAS, Norbert. 2001. *A solidão dos moribundos, seguido de, envelhecer e morrer*. Rio de Janeiro: Jorge Zahar.

FREUD, Sigmund. 1915. "Observações sobre o amor transferencial (novas recomendações sobre a técnica da psicanálise III)". In: *Obras completas*. Rio de Janeiro: Imago. vol. XII. pp. 207-21.

______. 1937. "Análise terminável e interminável". In: *Obras completas*. Rio de Janeiro: Imago. Vol. XXIII. pp. 239-87.

GOLDFARB, Delia Catullo. 1998. *Corpo, tempo e envelhecimento*. São Paulo: Casa do Psicólogo.

______. 2004. *Demências*. São Paulo: Casa do Psicólogo.

GROISMAN, Daniel. 1999. *A infância do asilo: a institucionalização da velhice no Rio de Janeiro da virada do século*. Dissertação de mestrado, Universidade do Estado do Rio de Janeiro - Rio de Janeiro.

LAPLANTINE, François. 2004. *Antropologia da doença*. São Paulo: Martins Fontes.

MAUSS, Marcel. 2003. “Ensaio sobre a dádiva: forma e razão da troca nas sociedades arcaicas”. In: *Sociologia e antropologia*. São Paulo: Cosac Naify. pp.185-314.

MESSY, Jack. 1993. *A pessoa idosa não existe*. São Paulo: ALEPH.

MOLINIER, Pascale. 2014. “Cuidado, interseccionalidade e feminismo”. *Tempo Social*, 26(1): 17-33.

MORAES, Maria Lucia de Gusmão. 1977. *A sala de espera: um estudo da ideologia do velho asilado*. Dissertação de Mestrado, Universidade de Brasília – Brasília.

NERI, Anita Liberanesso. 2005. “As políticas de atendimento aos direitos da pessoa idosa expressas no Estatuto do Idoso”. *Revista A terceira Idade* (SESC), 16(34): 7-24.

SARTI, Cynthia A. 1998. “A assimetria no atendimento à saúde: quem é o “necessitado”?” Anais do XXII Encontro Anual da ANPOCS. pp. 27-31. Mimeo.

______2001a. “A velhice na família atual”. *Acta Paulista de Enfermagem*, 14(2): 91-6.

______2001b. “A dor, o indivíduo e a cultura”. *Saúde e Sociedade*, 10(1): 3-13.

______ 2010. “Corpo e doença no trânsito de saberes”. *Revista Brasileira de Ciências Sociais*, 25(74): 77-90.

SETLLAGE, C. F. 1997. “Transcendendo a velhice: criatividade, desenvolvimento e psicanálise na vida de uma centenária”. *Boletim Pulsional*, X(101): 56-74.

SINGER, Diana. 2002. “Psicoanálisis y gerontología”. *Revista Kairós Gerontologia*, 2: 12-35.

Natália Alves Barbieri
Graduate Program in Collective Health, Paulista School of Medicine, Federal University of São Paulo
Av. Ipiranga, 200, apto C271 Consolação 01046-010 São Paulo- SP - Brasil
nabarbieri@hotmail.com

Cynthia Sarti
Department of Social Science, School of Philosophy, Letters and Human Sciences,
Federal University of São Paulo
Rua Alagoas, 162, apto 71 Higienópolis 01242-000 São Paulo- SP – Brasil
csarti@uol.com.br