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ETHICAL DILEMMAS IN MEDICAL CARE FOR WOMEN IN SITUATIONS OF SOCIAL VULNERABILITY: BROADENING THE DEBATE ON MARGINALIZED POPULATIONS IN EDUCATION

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ABSTRACT

The present work addresses reflections and discussions on the female figure in the scenario of social marginalization, linked to human rights threats, with a focus on access to health and quality longitudinal follow-up. This debate analyzes the historical process of marginalization and oppression amplified when women are inserted as street dwellers, enhancing the fragilities of helplessness and substance abuse, thus aggravating violence and stigma. It is a narrative literature review, of a reflective nature, associated with a report of educational experience in the construction of a teaching methodology based on a fictitious case that triggers the discussion and resolution of problems linked to human rights violations of marginalized women, in the light of philosophies of law and the study of public policies for undergraduate medical students. The development of the work shows the importance of expanding studies on this theme, focusing on historically invisible people, in a problematizing narrative, using the construction of clinical cases containing not only health needs for a medicalization resolution, strictly based on biological diagnoses, but that challenge the reflective thinking of social medicine, directing the debate to human rights lines, in a context of interprofessional dialogues and public policy studies, as essential in the training of physicians engaged with the guarantee of equity and access to the most neglected population segments in Brazil.

Keywords: Neglected Populations. Social Vulnerability. Family and Community Medicine. Medical Education.

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INTRODUCTION

The construction of Western culture until the end of the sixteenth century was based on the idea of similarity and representation happened as repetition. Such an idea of similarity made it possible to know the visible and the invisible. There is then a contrast between the same and the different, as well as the pattern of invisibilization and visibility. (Foucault, 1999) The development of history, based on Western culture, traces definitions about standards and notions of normality, to the detriment of the knowledge of what would be different. Thus, the story takes place with the development of this relationship with the other, with being different. In classical Greece, the notion that barbarian people were inferior because they did not have language or culture was perpetuated, and these were unknown, inferiorized and at times the target of fear. In parallel, the cult of the perfect body, the perfect forms of beauty and life, is developed, with a metaphor of a beautiful and healthy body aligned with the notion of harmony.

History also shows that, since the beginning of the development of Western civilizations, highlighting the power and social relations established in the Middle Ages, individuals who did not fit the standard of normality established for customs, conventions and local culture, were the target of prejudice, negligence, stigmatized and left on the margins of social life, by sovereign groups and dictators of rules, the holders of power and great social status. These neglected populations, labeled as marginalized, for being different from family standards, personal choices, being female, having some physical or mental disability, being accused of crimes for the notion of criminality and deviations of conduct from the local culture, among other characteristics that did not fit them to the standard of normal within the morals and good customs for the time, were labeled as inferior and thus excluded.

Among these marginalized populations, there is the figure of the homeless, also called throughout history as beggars, homeless populations that migrate between territories, often sheltered in temporary shelters while changing their environment. In historical moments of humanity, these neglected populations were also victims of persecution and imprisonment in long-term care institutions, including psychiatric hospitals, the "asylums", for contradicting the local organization and being linked to the prejudiced imaginary of violence, disorganization, criminality and dangerousness, and this prejudice is potentiated in the female figure, when we talk about women who live on the streets. Thus, society roots stigmatizing labels, building a prejudiced idea around the homeless population, especially when it acquires the female figure. Within the homeless population,

an extremely vulnerable group in society, homeless women stand out as the greatest target of prejudice and violation of human rights. (Santos, 2003; Rosa, 2012; Souza *et al*., 2016)

Substance use, associated chemical dependence, and lack of family and social support are directly linked to the maintenance of drug addiction and prejudice that homeless women suffer. Such a stigmatizing view often prevents comprehensive health care and reception by professionals working in public health for these women. Negligence in the face of numerous cases of rape, sexual violence, physical and psychological violence, which increase the situation of vulnerability of these women and can trigger mental disorders, is not uncommon and evidences a growing lack of preparation of doctors and other health professionals to care for these invisible women. Such lack of critical medical education, with a look at human rights and training that develops competencies and skills for future doctors to approach and support these women victims, contribute to the perpetuation of machismo and derived practices that inferiorize the social role of women.

The issue of the use of psychoactive substances by homeless women is doubly condemned by the fact of being a woman and living on the street, and is often approached with a predominantly police look of dangerousness, labeling the person as a being deprived of rights, dignity and respect, who should be removed from health care and services and his existence is linked to chaos and disturbance of order. The fact that women choose to use drugs and are homeless are not addressed or considered as the result of a means of violence, helplessness, exploitation and suffering followed by previous family problems and patterns, thus having these women neglected their health care and their human rights violated, with a deep-rooted machismo from the first contact with the reception of the health service to medical care. (Cardoso *et al*., 2014).

Women living on the streets, especially when they use psychoactive substances, are associated with the need for control by linking the habit of drug use to crime and violence. Thus, this homeless population, with a past and life history of seeking drug addiction for reasons of social problems, lack of bonds and affection, helplessness, often having large gaps in support since childhood, due to family breakdowns, are treated with negligence, irony or as a case of needs for a strictly psychiatric approach, focused on abstinence, imprisonment and exclusion. This erroneous view, however, still present in the current health scenario, helps to perpetuate the idea of marginalization of the excluded for the maintenance of social order (Cardoso *et al*., 2014).

The propagation of machismo has its roots since the development of a prejudiced Western culture, having in the figure of the masculine the ideal model of strength, superiority and leadership, handing women the role of subordination and inferiority, obeying

orders and being exposed to male wills and punishments. Thus, the conception of men as the protagonists of sexuality and women as the object of satisfaction and the instrument of power of masculinity is established. The idea of female bodies as constructions of the figure of women is shaped by the sexist view and misogynistic discourse, raising a dilemma of feminine definition based on the object and target of male supremacy. By the definition of man, the figure of the woman is understood as a group of attributes to be controlled, an objectification of women, disregarding free will and female identity. (Alcoff, 2006) The construction of the patriarchal nuclear family hides and normalizes physical and psychological punishments of family heads, a role played by men, with women as a target and synonym of weakness, obedience and servitude. The ritual of the man as the holder of decisions, actions and command of family relations justifies with the idea of protection what in reality borders on a process of female silencing, individual oppression, objectification of women at the service of men's wills and the normalization of violence against women as a common goal and the right to be carried out by men. Thus, the idea of the "male provider" and responsible for maintaining the security of the home and the woman justifies conducts that violate women's human rights of power over their own bodies, over decisions regarding women's lives, decision-making and sexual freedom, and the power to deny obedience to male orders. Traditional gender values are normalized and perpetuated, even with the constant and current struggle for sexual rights and control of women's own bodies and freedom, against machismo, violence and female silencing. (Minayo, 2005)

The fact of being a woman in a current competitive society is already linked to the label and implicit bias of weakness, delicacy, and inferior potentialities to men, both in the intellectual and physical skills spheres, as well as in the talent, organizational, and leadership spheres. Implicit bias is also present in contact with homeless populations, which is enhanced when the homeless person is female. Thus, the popular and common sense imagination labels the homeless woman as an inferior, dangerous being, devoid of voice, freedom, protagonism or rights and that any and all situations of oppression or violation of human rights, when directed at these neglected women, are simply normalized or ignored. When not neutralized, the oppressions suffered by these women are disregarded, such as the neglect of health care, lack of preparation for reception, dignified care and directed to the investigation of the rape case, taking the victim's report into account and initiating guidance on the registration of the occurrence at the police station and women's rights.

The present work aims to carry out a narrative and reflective review of the literature on women in situations of social marginalization, with a study in the light of scenarios of human rights violations, with a focus on health as a right. It also seeks to discuss the

inclusion of teaching on the theme of women in situations of social vulnerability for medical students, through the construction of a fictitious trigger case, inserted in the theme of violation of women's human rights to access health with equity. Debate thus on prejudices and stigmatizing looks associated with the impact of machismo and considering the importance of welcoming and supporting women in situations of vulnerability, especially women in street situations.

METHODOLOGY

This is a reflexive narrative review of the literature, with a report on the construction of a class methodology for medical students based on the creation and debate of a fictitious case, triggering discussion and resolution by the students, which deals with the violation of the human rights of women in situations of social vulnerability, highlighting machismo and medical negligence in the care of women who are victims of violence. Stigma and difficulty in accessing health for vulnerable women living on the streets, users of active substances, as well as the power of implicit bias with a high load of social stigma, acting as barriers in the physical and mental health care of these women, are also problematic. For this literature review, 13 scientific articles, 1 doctoral thesis, 1 theoretical module on alcohol and other drugs and 3 books were used, encompassing the theme and with the objective of expanding the discussion about human rights in the context of women living on the streets, drug addiction, suffering and mental health issues of marginalized populations. as well as the social context of construction, oppression and stigmatization that involves populations in situations of vulnerability.

The present trigger case was built to direct a class on marginalized populations, focusing on the homeless population and the amplification of the challenge associated with "being a woman" and living on the streets, in a perspective directed to access to health. The fictional narrative creates the trajectory of a homeless woman, substance user, victim of violence and rape – Target of machismo, psychosocial prejudice, medical negligence and difficulty in accessing the health system. The complexity of the case is outlined to promote reflection and resolution of the clinical case in the medical education scenario, in order to challenge basic cycle medical students to a critical and reflective look at the influences of the Social Determinants of Health and the discussion of public policies focused on the theme.

FICTITIOUS TRIGGER CASE CONSTRUCTED IN A SCENARIO OF VIOLATION OF THE HUMAN RIGHTS OF VULNERABLE WOMEN

"Homeless women seek care at a Basic Health Unit in the City of São Paulo. In your first contact with the receptionist, you are asked for your identity card and address. The woman reports not having an identification document and says she is homeless. The receptionist of the health unit repeats the request for documents and address data with the street and neighborhood where she lives, reinforcing that without such data she could not be attended. The woman goes into despair and says that she is going through a life-threatening situation because she is hearing threatening voices in her head, with commands to do 'bad things' at the same time that she started shaking her body. The receptionist with an air of irony after a few laughs says that 'it must be the effect of so much drug on the body and that it would solve this problem by putting life in order'. The woman was sent away from the health unit by the employee, but the unit's nurse approaches her and says that she will be able to get a place in reception with the unit's doctor. When she enters the doctor's office and after reporting the reason for seeking care, which consisted of hearing voices with threats, a feeling of fear and panic, as well as tremors throughout her body, she is approached about her social situation and family support. The patient despairs and cries at the appointment, claiming to be homeless after years of physical, psychological and sexual abuse by a former partner, whom she helped with the sale of drugs in the Cracolândia region. She perceives the doctor's expression of fear who says that her problem should be solved by a psychiatrist or social worker and that she should look for a Psychosocial Care Center for Alcohol and Drugs, releasing the patient. The woman goes into despair and reports having been victims of sexual abuse recently in the last 24 hours by other homeless people. The doctor opens the door and says that this must have happened for her to 'learn not to trust anyone out there and to wear more behaved clothes' and that this could also have been avoided if she left the street situation and 'stopped taking drugs'. No other type of counseling or measure was taken, as well as physical examination, support for the woman or other guidance were given to the patient. So she went back to the street without support or care plan."

RESULTS AND DISCUSSION

The fact that a woman is homeless exposes her to several social determinants in health that amplify her situation of vulnerability for the maintenance of health and for the development of a physical and especially psychological illness. Conditions such as poverty, hunger, exposure to precarious structures of itinerant housing, difficulty in accessing

drinking water, among other social determinants, amplify the variety of influences of health inequities for neglected populations. The living conditions of women living on the streets, although varied, converge in motivations that lead them to choices about living on the street, such as oppression and violence in the family nucleus of origin, often since childhood, threats from male figures and silencing, moral and often sexual harassment, with the street and the idea of escaping from this oppressive nucleus linked to the imaginary of freedom. However, the homeless situation is not seen by society as a personal choice, caused by a series of difficulties faced by women, and they are labeled as dangerous, crazy, worthy of maintaining the state of violence, misery and unworthy of health care, especially in the same environment as other people considered normal. (Rosa; Brêtas, 2015; Nardes; Giongo, 2021)

The scenario of the homeless woman is then understood as a fault of the woman who lives on the street, and is not understood as a result of a social phenomenon of omission and inability of governments to address inequalities in income distribution, access to land and individual property, opportunities and expand the reception for women's mental health needs, as well as support for victims of aggression, threats and various types of abuse. It also demonstrates the inefficiency in solving the problem of hunger and the lack of jobs and opportunities, as a result of growing urbanization and migration. Thus, the issue of housing is also not treated as a human right, but as a commodity, linked to the idea of private property. (Nardes; Giongo, 2021)

Due to the extreme invisibility and negligence to which they are exposed, homeless women often question their own value and are unaware of their own rights, believing that they must remain silent and that they do not have the right to dignified health care, as well as the power to denounce physical and psychological abuse suffered throughout their life trajectory. The difficulties of support and access to health care are then normalized and the disbelief of these women themselves in relation to their power of change, of fighting for rights and even of the existence of these rights is amplified. Such lack, lack of support, difficulty in expression and information lead to the amplification of the suffering of women living on the streets. (Rosa; Brêtas, 2015; Nardes; Giongo, 2021)

These invisible women have faced difficult paths since childhood, full of challenges and the search for the street, once a symbol of freedom, is permeated by a prison of violation of rights to their own body, to the maintenance of their own health and to inferiority by socially rooted machismo. Thus, the experiences on the street are transformed into individual and collective survivals for the group of other women who live on it, and the day-to-day life on the street becomes an unpredictable event. These women are exposed to

various forms of oppression and should be a priority in individual and collective actions for women's health and mental health care, but they remain invisible, with a lack of preparation of health units to welcome and care for these women, as well as a minimum group of specialized and qualified professionals to help these women, as well as the Street Clinic teams, in view of the scarcity of resources mobilized for the expansion of these modalities of care for criminals. Aggressiveness against women, harassment and gender violence are common events against women, in the general social reality and especially in the reality of those who live on the street, increasing the condition of vulnerability of this population group and taking their health care to priority levels of assistance, as they are the most neglected. (Nardes; Giongo, 2021) However, such a view of equity still has a lot of resistance to be carried out in the daily practice of medicine and other areas of health, which often require identification and address documents for health care, even for these populations that do not have a fixed address and thus are not registered in any territory or area covered by a health unit.

In the scenario presented, which is nothing more than a reflection of everyday situations faced by women living on the streets, rights violations add up and are often not considered violations by the women themselves, because they do not see themselves as protagonists and because they maintain fear in the face of the hierarchical positions of the male figure and imposition of rules and conducts by many health professionals. Thus, they suffer the direct impact of the social health conditions imposed on the reality of women, by institutions that make them invisible and perpetuate the idea that the individual and health needs of these women are not considerable or a priority for care. (Teixeira; Paiva, 2021; Esmeraldo; Ximenes, 2022) Thus, these women face problems of denial of their rights for a large part of their lives, with total disregard for their human, subjective, singular figure, leading to a dehumanization of care for vulnerable women. (Nardes; Giongo, 2021) In Brazil, there is a growing lack of notifications of violence suffered by women, especially those living on the streets, and in many municipalities the data are non-existent. This fact is often justified by the woman's fear of denouncing the aggressor. These women, due to the great state of fragility that makes them seek housing on the street, often fleeing from family relationships of aggression, commonly carried out by the male figure, identify the street as a symbol of freedom, but punitive relationships, violence and submissions are perpetuated, regardless of the spaces in which these women occupy. Therefore, seeking a false sense of protection, many live an eternal search for new partners and male figures who symbolize and guarantee the idea of security, submitting themselves to new oppressions, especially

sexual harassment and abuse. (Rosa, 2012; Souza *et al*., 2016; Esmeraldo; Ximenes, 2022)

The Harm Reduction Policy (PRD) can be defined as actions in the field of public health that aim to reduce negative effects and consequences linked to drug addiction, consisting of the main pillar of care for users of psychoactive substances, focusing on the psychosocial view. (Silva *et al.,* 2010; Steps; Souza, 2011; UFSC, 2014) However, the care for mental health issues of the homeless population, especially women, must be done in a holistic and integrated way by a multiprofessional team, with the role of joint actions of primary care with psychosocial care centers, with the need to expand the reception and support provided by teams from the clinic on the street, in order to listen and understand all the psychological demands and carry out unique therapeutic projects, aiming to educate and assist in the struggle to maintain the rights of these neglected women. (Fonsêca, 2012; Tondin; Barros Neta, 2013; UFSC, 2014)

FINAL CONSIDERATIONS

With the changes that have occurred throughout history, feminist socialists realized the complex influence of Law, maintaining the condition of women of subordination to the male figure, in which they went through periods in which law had an open role through legislation, but at other times in history, there was an indirect role that legitimized the idea of power, command and maintenance of male supremacy over women, acting ideologically in the perpetuation of the relations of female submission and command of men. (Coombe, 2001) This position of inferiority occupied by women and which leads to the normalization of oppressive attitudes and sexist behaviors is enhanced by the influence of social determinants of health in women's living conditions, in which the greater the number of vulnerability factors this woman has, such as the use of psychoactive substances and being homeless, The idea and social and male normalization that such women do not have rights that should be defended is greater.

In the discussion about the division of the forces of progressive politics into two camps, there is that of redistribution, seeking justice in the allocation of goods, and that of recognition, seeking support for differences, with recognition of sexual minorities, evidencing that the relations between the two camps are conflicting and bordering on tension. Thus, at present, the mobilization in favor of recognition is not aligned with the struggles in the field of redistribution, with feminism and the struggle for women's rights, directly combating the maintenance of the macho culture, a tendency to understand the field of redistribution as a solution to the supremacy and domination of men. These trends

are moving away from trends that look at the field of gender gap recognition. This leads to a greater phenomenon of separation between the politics of equality and the politics of difference. (Fraser, 2007)

In the face of women's social movements against sexism and the violation of women's human rights, it is essential that the members of this historically oppressed group, which are increasingly fragile, especially when exposed to other social vulnerabilities, unite seeking identification and a collective struggle for the rights of their members, but without disregarding the uniqueness and complexity of the life of each individual member of the group. Within this problem, it is essential to debate these themes linked to the construction of theoretical classes with a practical basis in the resolution of complex cases, approaching an interdisciplinary perspective with political and philosophical aspects and dialoguing with theories of law, in a broad view of public policies and historical construction of power relations. Thus, the insertion of the methodology for discussing clinical cases that trigger the theoretical content, based on problem solving, should be aimed at problematizing frequent and neglected themes in the health segment, especially medicine. This change in the way of constructing knowledge and thinking in health, debating priority agendas and directed to marginalized populations, seeks the modeling of the socially engaged professional, against the maintenance of fragmenting medical traditionalism and alien to the understanding of the challenges of access to health with guaranteed human rights, especially for women in situations of vulnerability, associating the study of public policies and human rights within a medical case discussion. The creation of the new approach, based on the construction of a challenging case and with sensitive themes for medical students, contributes to a change in attitude, increased interest and curiosity in deepening knowledge about a topic rarely addressed in the medical curriculum. Thus, the approach of discussing complex cases, involving the theme of marginalized populations, instigates the search for the historical memorial and the investigative look at the origin of problems in health services and in medical training that perpetuate the progressive dehumanization of the physician and maintain the marginalization of the invisible.

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