WAYS OF WEAVING RELATIONSHIPS OF CARE IN THE CHRONIC SITUATION OF THE ILLNESS

MODOS DE TECER RELAÇÕES DE CUIDADO NA SITUAÇÃO CRÔNICA DE ADOECIMENTO

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ABSTRACT

Objective: to understand the weaving of "relationships of care" by families experiencing the chronic situation of an illness. Method: study with comprehensive approach conducted as a "study of situation" on three family experiences of care and illness. Results: the analysis allowed us to intuit the relational dimension as the essence of care on which we noted some substantive attributes to the weaving of "relationships of care": accountability, which is the commitment to each other in their needs; and the sharing of care, which corresponds to the desire to provide a common history of care for the other. Conclusion: these attributes need to be built in the relationships so that they become truly caring. Concerning the health professional, some effort to modeling personalized and person-centered practices is required.

Descriptors: Family relationships; Professional-Family Relations; Nurse-Patient Relations.

RESUMO

Objetivo: compreender a tecitura de “relações de cuidado” por famílias que experienciam a situação crônica de adoecimento. Método: estudo de abordagem compreensiva, conduzido como “estudo de situação” sobre três experiências familiares de cuidado e adoecimento. Resultados: na análise, intuímos a dimensão relacional como substância do cuidado sobre a qual evidenciamos alguns atributos substantivos à tecitura de “relações de cuidado”: a responsabilização, que se mostra no compromisso assumido com o outro em suas necessidades; e a partilha do cuidado, que se configura pelo desejo de constituir uma história comum de cuidado com o outro. Conclusão: tais atributos precisam ser construídos nas relações para que elas se tornem verdadeiramente cuidativas. Relativo ao profissional de saúde, demanda-lhe certo esforço para modelagem de práticas pessoalizadas e centradas nas pessoas. Descriptors: Relações Familiares; Relações Profissional-Família; Relações Enfermeiro-Paciente.

RESUMEN

Objetivo: comprender la tesitura de “relaciones de cuidado” por familias que viven la situación crónica de enfermedades. Método: estudio de enfoque comprensivo, conducido como “estudio de situación” sobre tres experiencias familiares de cuidado y enfermedad. Resultados: en el análisis, intuimos la dimensión relacional como sustancia del cuidado sobre el cual evidenciamos algunos atributos sustantivos a la tesitura de “relaciones de cuidado”: la responsabilidad, que se muestra en el compromiso asumido con el otro en sus necesidades; y la división del cuidado, que se configura por el deseo de constituir una historia común de cuidado con el otro. Conclusión: tales atributos precisan ser construidos en las relaciones para que ellas se tornen verdaderamente cuidadoras. Relativo al profesional de salud, se les demanda cierto esfuerzo para modelaje de prácticas personalizadas y centradas en las personas. Descriptors: Relaciones Familiares; Relaciones Profesional-Familia; Relaciones Enfermero-Paciente.
INTRODUCTION

We address here the weaving of "relationships of care" by families who experience the situation of chronicity of an illness. This situation refers to people's own way of experiencing the disease, and the events caused by them are overlapped and intertwined with each other, affecting the different dimensions of life, shaping their ways of living and, in these, the rearrangements for daily maintenance in the presence of the illness. Care can be understood as an existential phenomenon, as it is part of the human nature. It is also a contextual phenomenon because it presents modifications, intensities, amplitudes and various ways and forms according to the context in which it takes place. Finally, it is a relational phenomenon, as it occurs in coexistence with the other.

We assume here these three dimensions of care, placing care in the experience of families going through a chronic illness of one or more of its members. In this statement it is already shown the view that this is existential - the illness is experienced and, along with it, the necessary care; but it is also contextual - it is about very specific situations of each family and their way of life and care; and it is also relational - care is produced within the core of the family itself and among its members, as well as with the people and institutions that are their support networks. These three dimensions permeate the ideas that will be exhibited here, but, centrally, we will entertain the discussion of care as a relationship and on the ways of weaving relationships of care.

Although we assume that care is relational, not every relationship is care, as "it can be self-centered, underpowered or indifferent to the care of others; and it can be even a violent relationship, producer of abuse". Thus, relationships of care are "those identified by the expression of caring behaviors that people share, such as trust, respect, consideration, interest, attention, among others".

In the family, care is designed and produced, as a rule, as something genuine, given the presence of strong ties underlying relations that unite its members, such as membership and inbreeding, it is also where intense flows of material and symbolic resources circulate. Such ties influence the decisions to be taken with regard to health care and guarantee the possibility of fostering the necessary resources for their realization. Care itself, therefore, stands out as an asset that flows through the ties.

Taking the chronic situation as an experience that entails needs of various and long-term orders, some persistent and/or constantly renewed, we realize that the family has the support of close people in a more permanent and effective way. In this situation, the services and health professionals have not acted as a secure source of care over time, when it comes to the kind of care needed in such intensity. Thus, we see that health professionals are timely and eventually present in the weaving of relationships of care that the family promotes, throughout the illness of these people, especially when their presence is even more important.

It is essential to rescue the interaction between the subjects of care, considering the needs of each ill person and of the family who, as the primary caregiver, also needs to be supported and cared for. Thus, we aim at understand the weaving of "relationships of care" by families experiencing the situation of chronic illness.

METHOD

Study with comprehensive approach conducted as a "study of situation" on three family experiences of care and illness, in which senses and meanings woven by them in the daily life are the priority. The approach of this experience occurred through the "study of situation" aimed at understanding the everyday life context and the peculiar situation of illness and care of the person and the family. This allows us to draw some broader inferences from that micro-reality and give relief to the sinuosity of the relations of various orders established during their lives.

We use a Database in Qualitative Research whose collection consists of data and information on family experiences of care and illness undergoing the situation of chronicity so that we select, intentionally, the experiences of families Sonnet, Hope and Resilience. This choice was motivated by terms evidenced in the care needs of the own sickened loved family members who were not, in most of them, visualized and provided by health professionals, demanding from families huge efforts to compensate.
In Sonnet family, sickle cell anemia affected three of its members: Assis, the father and two children, Olavo and Cecilia, whereas the mother, Clarice, had trait for the disease. Before these children, the couple had Cora, who died at the age of one year and a half due to complications of the disease which was diagnosed too late. The Hope family, consisting of Baltasar, Maria and their children Mirra and Belchior, experiencing the illness of the latter by adenoleukodystrophy (ADL), which is a degenerative and progressive, and was diagnosed when the child was seven years old. Finally, the Resiliency family, mental suffering, also progressive, was the injury in question. Are part of this family the mother (Ana), 72, and her four children, among which, two, Ivete and Joseph, were participants of this study.

These experiences were obtained through the use of methodological approach to the history of life and operationalized by interview strategies and careful observation and this material which was organized in the form of research diary, and three research diaries composed our corpus of analysis.

In the analysis, we conducted exhaustive reading of the research diaries, drawing out of the narratives what we believe to be care requirements of the chronic situation. In this effort, we inferred a set of “care scenes” in which every care requirement was located in relation to its context and specific situation. In the face of the set of care scenes of each family experience, our effort focused in deriving some “notions of care” representing them, then, through a “descriptive-analytic diagram”.

The diagram is a visual reflection that embodies a thought through graphics, lines, shapes, words, symbols, arrows or plans. We used this feature to build a palpable speech that facilitates the organization of ideas. We, thus, built a diagram of each family experience and, subsequently, a general understanding of them; With this, it was possible to discern some constituent elements and supporters of the family experience of care, considered thus as “care substances”.

In this study, we look back on the relational dimension of care as its own substance. This dimension tells about the weaving of “relationships of care”, from which, based on familiar experiences of care and illness, we noted “accountability” and “sharing” and “attributes” as important in that weaving, presented and discussed below.

Matrix research that based the collection of the material had ethical approval under nº 307/CEP-HUJM/06 and nº 671/CEP-HUJM/09, with the authorization of the participants, who agreed through the Informed Consent form, which includes the composition of the database with its information and its use in future studies. The collection of each experience, fictitious names for people and institutions are used.

**RESULTS AND DISCUSSION**

As we approach the family experiences addressed here, we realized that the weaving of relations of care is necessary to consider the requirement of certain effort, because to be and to stay with others in the care presupposes assume this other person as a desirable good, reinforcing the ties between people. Some attributes that give substantive aspect to the relationship between the person who needs care and those who provide are also needed to establish a “relationship of care”. In this study, we take accountability for the care of the other and the sharing of care as substantive attributes.

- The accountability for the care of the other

Accountability as an attribute of the relationship of care is demonstrated in the commitment to care for the other person’s needs. In the family experiences studied here, this attribute was evidenced in the sharing of care between their family members. The following narratives portray how, in the Hope family (F. Hope), parents are committed to the care to be provided to Belchior and, therefore, how they are organized to provide it 24 hours a day, whenever he needs “all the time caring for him. Thankfully, my husband also takes good care of him, thank God. One night I sleep with him, the other night he sleeps with him. We alternate nights to sleep with him” (Maria, F. Hope).

Parents changed their daily routine as in a hospital on duty, in order to take care of Belchior in their intense and complex needs resulting from the advanced phase of his illness. They strive to ensure as much well-being as possible to Belchior, sharing the care and, therefore, giving evidence that they are co-responsible in the child care.
Feeling responsible for the other makes people use all their abilities, skills, possibilities and impossibilities to provide care.

The study shows that the family uses resources and knowledge gained from the meanings attributed to their own experience, being able to even specialize in health, to better care for their loved. In addition, family members are attentive to grasp, in the health field, as much knowledge as possible, whether about the disease that affects their loved one, or about the forms of care required by it, and this approach allows them to take an important part on the health care to their loved.

In Sonnet family (F. Sonnet), accountability, which is the care relationship, can be evidenced also in the sharing of the care between parents. Clarice is a nursing technician and is accustomed to carry out technical procedures such as intramuscular administration of medication. However, in the family’s routine, when she is not at home, the father is the one who performs such a procedure, seeking to ensure the administration of the drug at the right time to the diseased children. Still, by considering the difficult accessibility to health services, they do without these services for such administration, most of the time.

When I’m in service, it is him who applies it. You had to see on the first day! This Olavo complained! He said, Mom! You have no idea of what Daddy did to me! (Laughter). Then I said, what my dear? What did your father do to you? Dad took my arm like this, and he spiked like this. (Clarice, F. Sonnet)

Oh, you would get there, people would look at you, and they would leave you like that. How many times we arrived at the hospital São Carlos with Olavo in our arms, walking all around and he crying, and the people would look at us, they did not care. […] And today, well, when he goes into crisis, we always have the rhythm of remedies that can be given from two and two hours. If this does not work, then you have to go … (Assis, F. Sonnet)

The family strives to respond, by themselves, to the care needs of the sick one. They take on the responsibility for the care, to make it happen, ready to acquire skills to enable them to provide the best care, sparing no efforts to achieve skills going sometimes beyond their possibilities. In the author’s opinion, the desire to care for their loved ones blooms with greater force in the family relationship. We inferred that accountability seems to be strengthened in the context of family relationships, motivated by ties, affections and obligations that favor the commitment to create and have the means in order that the care may prosper.

Accountability in the relationship between professionals and the sick people and their families figures as an important aspect to think about the weaving of caring relationships. We know that professional practices are not innocuous because they always have implications for people and their families and thus they affect their lives, whether in the way they are offered and/or organized, resulting in acceptance or not of their health needs, or by their absence. The authors claim that we can create a circle, “virtuous or vicious,” depending on how professional practices bring or not effective responses to the needs of individuals and families. Thus, the professional system entails diversified affectations to the ill person/family by taking or not accountability as an attribute of their practice.

We observed situations that denote lack of accountability of the professional in the search for professional care by families of this study. Clarice reports her negative experience with a professional who, in her opinion, was negligent with the blood transfusion administered to her daughter:

At the time of putting the bag to infuse, she did not test the temperature and then she even came and opened the bottom of the bag, of the blood that my daughter was transfusing, in the infirmary. (Clarice, F. Sonnet)

Lack of attention to the basic principles required in the management of blood transfusion by the nursing professional raised new suffering for the mother, besides those already present in the situation. In professional care, some elements give greater or lesser ability to produce a good practice that may be considered care. Among them:

- the technical competence of the professional - his ability to respond to the needs of people; the ethic attitude of the professional - the way he is willing to mobilize his knowledge to meet in the best...
possible way such needs; and his ability to build ties with those who need care.  

Unaccountability of health professionals to the needs of people results, mostly, on the pilgrimage of families in the search for health services, as could be observed in the Sonnet family, in the search for the essential medicine to ensure the health and welfare of the child. The lack of this medication for more than a month in high-cost pharmacy, with the claim that the State had not made the purchase of it, has consequences for the child such as the experience of severe pain.  

Because it has forty-six days that Olavo stopped taking medication because of the high cost pharmacy does not have the medication. [...] it turned out that we went, there was no medicine, then we waited, at the beginning we kept going, we were always in search, every week, twice a week we were going to the high cost to see if the medication had arrived. [...] So, yes, in this time he had several crises, he cries of pain in the knee, in the joints, legs, he says that his little back is hurting. [...] Because he had already been for seven months, taking the medication. So, this time that he's without the medicine, the treatment goes back. So, he could not do without the medicine! [emphasis]. (Clarice, F. Sonnet)  

We noticed a mismatch of the health service, due to this time-consuming release of the drug that does not keep up with the pace and intensity of the child's needs. The service should be able to meet his needs, assuring the prolonged treatment required in the situation, based on permanence and effectiveness, which would demonstrate a commitment to the health and well-being of the child and the family.  

Ensuring care permanence is crucial in the situation of chronic illness, because this entails continuous, prolonged and constantly renewed needs. However, the subsystem of professional care can not provide the resoluteness desired by the people because it acts still in a localized and fragmentary manner. What is evident is that health services work precariously in the face of care needs that are directed to them, causing considerable damage to individuals and families and interfering negatively in the course of the illness.  

As regards the organizational logic of the practices of the professional care system, we could infer that the flows and protocols are not managed aiming to ensure the necessary modeling to care of people in chronic situation. This fact has contributed for the absent of accountability in the relationship of health workers with sick people and their families. As an example, the fact that the two sons of Sonnet family suffer acute event resulting from sickle cell anemia and both need hospitalization. In this situation, due to the logic of regulation of health services that is guided by the flow of hospital vacancies, Olavo and Cecilia were admitted to different institutions, requiring parents to organize themselves so they could, each one, be with one of the children.  

They were in different hospitals. Olavo was in Samaritano hospital, then he was discharged we and went away in the same day. The next day I went with Cecilia to the Filantrópico. Then I went with Cecilia, one day later, Olavo fell ill and Assis had to go with him at the hospital São Carlos. Then, at the same time, we were with the two of them hospitalized. (Clarice, F. Sonnet)  

By imposing to the family a way of organizing the assistance that very poorly meet its needs, services add them suffering and increase expenditures and wear. In the situation presented, Assis, who was providing for the family, was unable to work due to the need to stay with the hospitalized child while his wife accompanied their daughter. This overload of wear of different orders could be avoided if children were in the same hospital, so that they were accompanied together by only one relative, what could even allow the relay between the parents. This makes us to agree that health services should be organized in order to suit their rules and routines to the health needs of people and not the opposite. It allows us to learn, too, that “the greater or lesser comprehensiveness of care received results, in large part, on how the workers’ practices are articulated in health care”.  

Health care management is carried out in different dimensions, among them the professional, organizational, systemic and corporate dimensions, reaffirming, at various levels, the responsibility of the professional system toward the health care of people. Such management can be defined as “the provision of health technologies, according to the unique needs of each
person, at different times of the person's life, seeking welfare, security and autonomy to continue with a productive and happy life".17:80

Lack of professional responsibility with the care may impose to the family the need to incorporate professional know-how in their daily lives, as said before. Thus, in Sonnet family, the mother, Clarice, a health professional, nursing technician, initially with the sole intention of providing better care to children, given the constant need for invasive procedures, such as blood transfusion, and the ineffectiveness of professional practices.

It would happen this very often, the night would fall and the staff went to sleep, then the serum was lost, we did not know what to do, looking for the girls (referring to nurses and nursing technicians) [collection notes] and wouldn't find them. Then he swelled and he would be like this, you know? And, and us, you as a parent you go crazy in, in, in the hospital corridor, looking for someone to help you and you do not find anyone. So, you know you're there quite often, your child needs quite often and even with all this, it is also something that can be avoided and it is not, because you do not find professionals there, present. And that was where I decided to do this course, not with the intention of go out to field to work, but for me to be able to take better care of my children at home. (The last two sentences have a very emotional speech) [Archive's note]. (Clarice, F. Sonnet)

The lack of professional practices that meet the desired care for people makes families feel even more accountable to the care of their loved who is ill. The set of negative affectations of these practices seems to have driven Clarice to professionalize in nursing as a way of she and her family cope with this poor effectiveness of professional practices, perfecting herself the care of children. This makes it possible to reaffirm the non-harmlessness of these practices, producing many affectations that can even come in the form of sufferings and afflictions.

It is evidenced, by the way, the need for professionals feel accountable for the care of diseased person/family, favoring the desire to make it happen and weaving caring relationships. Thus, the accountability results in the commitment of each professional with the designs of those for whose health they care.19 This author affirms the need to participate in the projects of happiness of people cared for, as an existential project. We join in this understanding when considering that everyone wants to be happy. Health is both, a way, but also the reason of that happiness. Certainly, to weave relationships of care, the ideal would be that professional practices could produce positive affectations in people's lives. For this, the professional care must be involved with family care, acting as a supporter of caring potential of the family, protecting and preserving this as a primary and fundamental unit of care.4

- Sharing the care

Sharing care, as an attribute to the weaving of a relationship of care, represent the building of a "common history" with the other, from the desire to build with this care. The three family experiences many times show how care is shared among family members and their importance through the involvement, of the presence and commitment of/in the family with the care to/of the sick person.

In the Hope family, the sharing daily care between parents enables them to be closer to the child, Belchior; and, consequently, to better understanding of his care needs, as they feel more cable to respond to them promptly. The ADL, which is in advanced stage, prevents Belchior from expressing his needs and because of that, parents find it difficult to delegate the child care to other family members. Baltasar tells how he feels about it:

There were somethings that sometimes we were already used to it, to understand more or less what he wanted, but who was not used to live with him wouldn't know, then that's our concern. Sometimes he was really wanting something and the person did not know what it was, but we, because we were already with him in this situation, we knew more or less what he wanted. (Baltasar, F. Hope)

We believe that the "want to share" the care with the other is necessary; it is not, therefore, an intrinsic attribute to the relationships, but something that is built by the desire to want to be part of the care. In the family, this desire comes with greater force thanks to the mobilizer ties of this
want. We found, in the section below on the Family Resilience (F. Resilience), dedication and willingness of José toward Dona Ana, because even though he does not assume the mother’s daily care, he is always present when needed, getting involved in the care and worrying for her.

I pick her up, take home, absorb a little bit, I’m there with her. Or sometimes even during the week, at night, I go there in their house, right? to stay with her a little. She feels safer when I'm around. (José, F. Resilience)

We stress the importance of the desire to share the care of the other must be also present in health professionals supporting their relationship with the ill person and the family as we identified in the experience of Sonnet family in which a medical professional seeks substantiate his relationship rooting it on accountability and sharing of/with care. In Clarice’s narrative, we realize that the professional can establish links with the family, weaving a relationship of care guided by involvement, permutation and concern with the care needs that are presented:

Who took care of them was Dr. Daniel and, wow, he was like a father, you know? It was cold, it was rain, sun, no matter the time, no matter the weekend, he was giving assistance in the Hematology Center. So, then, it was very good for us! Often too, they were already with doctor Vinicius when I was in the ICU. They were with Dr. Vinicius, Vinicius, caring, following, but Dr. Daniel, when he would be informed, he would go there in the ICU just to see how we were doing, you know? To see if everything was okay, if we needed it something, then we had that bond. (Clarice, F. Sonnet)

For Sonnet family, the weaving of a relationship of care proved to be important in facing the chronicity of the disorder that affects their children from birth, thus over 14 years. The availability of the professional to be and stay with the family,20 in this case, monitoring the children is seen positively by the family who has confidence in this relationship. Their expectations for attitudes of care from the professional were met, who at the moment that shows to care for the children21 encourages and mobilizes the effectiveness in the relationship with the family, allowing himself to share the necessary care to children with the family.

This attitude of remaining close gives also confidence to the family regarding the care provided by the professional. On this, Clarice tells the importance of nursing in the experience of illness of her family:

Ah nursing! I use to say that nursing is the eye. The doctors, they see, they pass before you, they can be there every day, but their assistance is one minute. If you need a physiotherapist, he comes, makes the therapy on your son and goes away. If you need any other specialist, he comes from there, and sees, and goes away. And nursing remains. So therefore, I always say that nursing is the eye, because they are the ones who are 24 hours with you. (Clarice, F. Sonnet)

We realize that the remaining attitude that links the relationship between professionals and the person/family made it possible to preserve the provision of care to loved sickened and provided to families the assurance of their constancy, allowing the professional to create a positive atmosphere for the sharing of care. Thus, we agreed that to take care of one’s health, projects must be considered and built, engendering the “co-possibilities” of subjects in a relationship that is sustained over time.19-27

However, professionals who have the attitudes listed above are exceptions in the experiences of care and illness of the families we approached, as they actually highlighted the little involvement of them and/or their nonchalance in being effective in their practices and in sharing the care with them.

Clarice tells, for example, about the episode in which the daughter had a stroke readily recognized by her, which allowed her to quickly take her daughter to the emergency room; but arriving there, the professional disregarded her experience in the situation, refusing her opinion, resulting in delay in diagnosis and in the treatment that the case required:

When we arrived, then the doctor did not accept the diagnosis. He said this, that she had to wait for the neurologist, because it was a facial paralysis that she had, then I went and said to the Doctor, but my daughter has sickle cell anemia and she may be having a stroke. And he said no, sickle cell anemia does not cause stroke. (Clarice, F. Sonnet)
In the Resilience family experience, Ivete indignantly tells about how her mother was treated by a professional in a query:

_Simply, not even a SUS doctor would assist the way they did. She sat, hi Dona Ana, what happened? What happened? Oh, this medicine did not work out, I’ll get you another. Then she would get out of there with a lot of boxes, in the last visit she returned with a full bag! that’s not right._ (Ivete, F. Resilience)

In the Hope family, Baltasar tells about the refusal of the professional to visit his son when he was asked to. In his opinion, the professional should make the visit to his child, even not being summoned, given the precarious state of the child's health. Disappointed with the health professional, the family questioned the commitment of this with the care of the child:

_If we had the visit, just like you came. Here in the neighbourhood we have the Family Health Unit, I needed the doctor twice to come here to see my son. I called him, he said he wouldn’t come, he sent the nurse. So, I think he has an obligation to visit, especially patients like him, and it was a failure, because if it is a family health unit, then they have to visit the houses._ (Baltasar, F. Hope)

The narrative above demonstrate that there is disengagement of some health professionals to care, even violating the legal and ethical responsibilities governing professional practices. In the situation narrated by Baltasar, such lack of commitment becomes even greater for being a professional who is operating in the midst of "the Family Health Strategy", which proposes the principles, guidelines and foundations of primary care: 'universality, accessibility, bond, continuity of care, comprehensiveness of attention, accountability, humanization, equity and social participation’.22-20 The non commitment of professionals prevents the weaving of a relationship of care with people, which makes us agree that the interaction between professionals and people/families is the most difficult aspect for them to be able to offer a care focused on people,23 and consequently, for its share.

In this context, families find themselves solitary taking care of their own, once that the professionals are willing to share just a little the care with them, offering practices that do not value their knowledge - an own and sensitive knowledge, able to see the details involved in the disease, weaved in the situation. Unlike this knowledge, professional practices have been guided by looking to the disease, not the person.

Such evidence may denote the difficulty of professionals to develop a practical wisdom, which implies sensitivity, willingness and openness to dialogue, to attentive auscultation to the desire of the other, becoming thus a to do involved with each other.19 This openness can enable professionals to weave relations of care, as they overcome the reductionist look turned to people in their practices, personalizing them to meet the singularities of the chronic condition of an illness, so that the care may be centered on people and families.

**FINAL REMARKS**

The family experiences that we approached here show the need for health professionals to want to engineer a personalized care, covering the needs of each person and the unique requirements of each chronic condition. In this sense, accountability for the care of the other and its sharing showed up as attributes that need to be built so that truly caring relationships may be weaved. To be responsible means to take on the production of care to the other with all the person's capabilities and possibilities. Sharing refers to building healthcare projects with people, favored by the presence and supportive and comforting closeness. Such construction demand some effort from the healthcare professional, whether for the recognition of the other in their care needs, or for modeling personalized ways to care for and ways of being/living with the other, demonstrating, thereby, its ability to weave relationships of care with families.

Families proved to be capable of providing such personalized care, by recognizing the sick one and his/her own needs for care and by providing care as a right in the gift circuit, permeated by giving, receiving and giving back, so unique in the context of the ties that unite their members. Still, by taking care as a desirable well, they mobilize all they can in their conditions of possibilities in order to meet with their full potential the needs of their sick loved family member.
In the professional field, the weaving of relationships of care proved to be a challenge to be overcome, especially by the look also reductionist released to people. We point out the need for the professional practice be guided by a sensitive look, in the availability to offer personalized practices in the presence with the sickened person/family and in the readiness to mobilize all their skills in care. It is necessary to tune the professional care to the needs arising from the situation chronicity of an illness. Therefore, the modeling of this care must to take place “in situation,” considering the singularities of the illness and those specific to each person/family. Certainly, the provision of care requires that the professionals want to compose care relationships with people to, then, be careful of references to them.

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