

# **Rethinking Brazilian Public Healthcare Practice: Dialogue and Collaboration**

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## **Background**

Public healthcare in Brazil has been going through a significant transformation during the last twenty years. The Brazilian government has considered new paradigms in its attempt to transform the long-term public health crisis. In 1990, Brazil initiated a new National Healthcare System called the Unified Health System or Sistema Único de Saúde (SUS). This initiative called for a significant change in healthcare delivery. In this new system, the delivery of care is based on principles of integration of services, universality, comprehensive care, decentralization, social participation and the equal right of access by all citizens. This new system requires a major restructuring of Brazilian healthcare as it has been operating to date. Specifically, proposals to connect levels of care, provide more focus on clients, and increase efficiency in service delivery have been central. In an attempt to respond to these proposals, political strategies have emphasized the importance of a broader understanding about the process of health and illness as opposed to viewing health and illness as static features of individuals and communities.

In other words, we could say that there has been a significant push to take a more ecological perspective toward health and illness, focusing on a wide range of issues including economics, relationships, community, family, school, work, social class, and local resources. The goal is to understand health and illness in its broadest context thereby facilitating more effective and efficient healthcare delivery. In addition, attempts are being made to create an interconnected web among all aspects and resources for

healthcare. As a result, enormous importance has been given to interdisciplinary work and the creation of a more interactive relationship between health professionals and the communities they treat. In so doing, the goal is to develop an overarching healthcare system for Brazil, but one that is sensitive to the vast diversity of regional and local practices.

In an attempt to implement this mandate, efforts have been made to connect the system of healthcare at all levels (primary, secondary and tertiary), integrating and organizing the system, thereby providing more efficient services. To acquire these aims, focus has been placed particularly on the first level (Primary Health Care) which is considered the entrance to the National Health System. At this level, healthcare delivery occurs within the community. Locating the “first contact” within the community emphasizes the relationship between health professionals and the specific communities they serve. This emphasis affords an interesting opportunity for collaboration that is now less focused on traditional technical healthcare issues and more centered on the ways in which health professionals and communities can engage in revising healthcare together.

The work described in this article centers on the ways in which communication, and specifically dialogue, can assist in transforming public health in the Brazilian context. Our approach to communication is described below but it is worth noting here that “the difference that makes a difference” as Gregory Bateson says (1972, p. 272 ) is an understanding of communication as a *social process*. This view of communication is radically different from the popular understanding of communication as a means for conveying information and/or persuading others – a view that is referred to as individualist or monologic (Sampson, 1993). When we consider communication as a

social process, we begin to ask questions about what sorts of worlds we are creating with others when we interact. For the Brazilian Healthcare System, this question seems resonant in that it allows us to explore how health and illness, treatment and cure are understood within the diverse communities and regions of the country. In effect, understanding communication as a process of social construction invites us to take the ecological perspective mandated by the new National Healthcare System.

We have had the privilege of participating in collaborative activities with psychologists and healthcare professionals at the University of Sao Paulo in Ribeirao Preto, Brazil since 2002. Our work has centered on primary healthcare, specifically on the creation and study of dialogic processes as they inform healthcare practice. We have focused on creating collaborative, dialogic processes for healthcare delivery and use. Central to this focus is an exploration of what we call conversational resources for transformative dialogue.

We have been curious about the resources available for changing or improving a person's health. Our common interests have generated explorations of professional-to-patient, as well as professional-to-professional conversations that place an emphasis on the collaborative construction of understanding, diagnosis and treatment. Examining the ways in which patients and professionals can jointly participate in the healthcare process promotes the development of practical resources for managing care and health education. This view positions the professional as one who can be most effective when she or he understands the complexity of the patient's relational network as well as the complexity and variety of meanings the patient, family, and community members give to health and illness. To us, privileging the relationships that, in obvious yet often unnoticed ways,

contribute to a patient's understanding of his or her health is not a peripheral aspect of the healthcare process. Rather, the way in which meaning is created within significant communities and how that meaning relates to one's health and illness should be an issue of central concern for all. The overall effect is a healthier, more informed public concerning healthcare issues.

From this orientation, an important question emerges: **How can we train professionals (in the current case, primary health professionals) to become “experts” who can use their professional tools, techniques, and forms of analysis while simultaneously placing primary emphasis on their relationships with their patients (and colleagues) and the ways in which those relationships generate meaning?** Anecdotally, we recognize the desire to help humanity through healing that serves as inspiration for many students entering the field of healthcare. Yet ironically, by the time training is complete, most think of the body as a machine and find routine interview protocols more efficient for dealing with high patient demand. There is an urgent need to return primary healthcare to a basic focus on communicating with others. This argument has been made forcefully by healthcare practitioners (Kleinman, 1988; Charon, 2006; Frank, 1995) and communication scholars (Harter, Japp, and Beck, 2005; Zoller and Dutta, 2008), alike. This is the focus of our continuing collaboration.

We draw upon communication, dialogue and social construction as useful resources for the development of training programs in universities for healthcare professionals, as well as the development of trainings in hospitals and community health centers. We have been engaged in a project aimed at supporting the growing work in this

area and have developed a collaborative program integrating our research interests in dialogic transformation.

### **Where We Begin: Dialogue**

Julia Wood (2004), drawing on the work of Bakhtin (1981), says, “Genuine dialogue depends less on self-expression and other transmissional aspects of communication than upon responsiveness . . . [which] arises out of and is made possible by qualities of thought and talk that allow transformation in how one understands the self, others, and the world they inhabit” (p. xvi). If we are responsive to others – particularly to others who have views that are incommensurate to our own – then we are open to critical reflection of our own commitments and beliefs. Our work in Brazil is about the responsiveness of dialogue in the healthcare context. The incommensurate world views at play might best be cast as the subtle opposition between healthcare as a science and healthcare as human engagement. Is it possible to dissolve this dichotomy by creating opportunities for the sort of *responsiveness* that dialogue offers?

For many, the ideal strategy for dealing with incommensurate views is to work toward consensus among those who hold oppositional stances. Yet, being responsive, we argue, does *not* mean choosing between consensus or one view overriding its opposition. The sort of responsiveness required by dialogue implies allowing the *rationality* of the other. This sort of change clearly has nothing to do with winners or losers, nor with building consensus. Instead, it focuses on making space for multiple rationalities.

**What is Dialogue?** To Bakhtin (1981), dialogue is a responsive activity. Therefore, it is not limited to self-interest, psychological or relational improvement, or to crafting cooperative, conflict-free ways of living. In dialogue,

(1) communication is . . . a fluctuating, unpredictable, multivocal process in which uncertainty infuses encounters between people and what they mean and become, . . . (2) interlocutors are immersed in a process that shapes and forms them even as they shape and form it and one another in ways that are not entirely predictable or finalizable, . . . (3) tension is inherent . . . and integral to (the process) . . . (4) (there is no attempt to) idealize or seek common ground, . . . and (5) (participants) are realized in the *process* . . . (pp. xvii-xviii)

Yet, we must be clear. Bakhtin's responsivity should not be interpreted as assuming that participants enter into interaction as equals with the same or comparable values or status seeking equal outcomes. To Bakhtin, as to Buber (1970), dialogue occurs when conditions of curiosity are fostered, despite differences in values and beliefs. Participants in dialogue engage with one another with respect and curiosity.

Bakhtin (1981), as well as Sampson (1993), would describe the common, understanding of communication<sup>1</sup> as monologic. Monologism is characterized by a focus on what Sampson (1993) calls the *self contained individual*. In monologic relations, an individual only need focus on him/herself – his or her motives, beliefs, intentions, and cognitive abilities – to understand. There is no attempt to understand the other “from within.” The other, in monologism, is a “serviceable other” (Sampson, 1993); there to

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<sup>1</sup> The common understanding of communication is that it is a *means* (i.e., vehicle) for conveying information, for persuading others. This view sets up a “us vs. them” world view, where if I feel unsuccessful in “communicating” (i.e., convey my information *on* you), either I have failed (am flawed), you are flawed in that you can not understand me, or there is some problem in the context that prevents us from achieving understanding. This view is focused on individuals and their competencies (or lack thereof).

service my needs.<sup>2</sup> In short, monologism prioritizes the individual and his or her reasoning abilities with little to no consideration for the other as a reasoning being.

Dialogism, on the other hand, offers us a very different understanding of human interaction. As Sampson (1993) says, in dialogism “*the most important thing about people is not what is contained within them, but what transpires between them*” (p. 20, italics original). Further, Sampson tells us that in dialogue, the “emphasis (is) on the idea that people’s lives are characterized by the ongoing conversations and dialogues they carry out in the course of their everyday activities” (p.20).

However, much of our interaction – whether in healthcare contexts or others – takes a monologic form. For example, health professionals often make quick assessments of a person’s physical condition without waiting for patients to answer questions or tell their stories. This monologic stance centers our attention on ourselves, our competencies, and our values. There is little concern for what Buber refers to as “the otherness of the other” (1970). The monologic focus is on the individual and his or her private meanings, feelings, and motives. There is no concern for the ways in which conversational partners make meaning together. It is a “mentalist” (or individualist) approach where the assumption is that one must “get their ideas out on the table” (where “out” refers to “out of the private recesses of a person’s mind”) in order for any sort of coordination to transpire.

It is interesting to recognize the connection between popular models of professionalism and the “self possessive” (Macpherson, 1962) stance of monologism.

We tend to consider someone a professional or an expert when s/he “dispenses”

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<sup>2</sup> A good illustration here is the patient who only wants the doctor to diagnose and treat. If they treatment fails, the doctor is deemed incompetent. Similarly, a doctor can act toward a patient as a serviceable other looking only to the body of the other as the instrument allowing the doctor to do his or her job.

information. The doctor is professional when she or he can diagnose and treat an illness. A teacher is professional when she or he can effectively convey important concepts and theories to students. However, what these expectations of professionalism omit is the unique, local, and situated aspects of all interactions. Healthcare (and education) does not adhere to a “one-size-fits-all” technique. To be a useful professional requires technical skill and disciplinary knowledge *as well as* the ability to engage the other (patient, colleague, student) in his or her local rationality. In fact, to be a professional requires more than this. It requires an appreciation for the relational ways in which values and beliefs (meanings) are made.

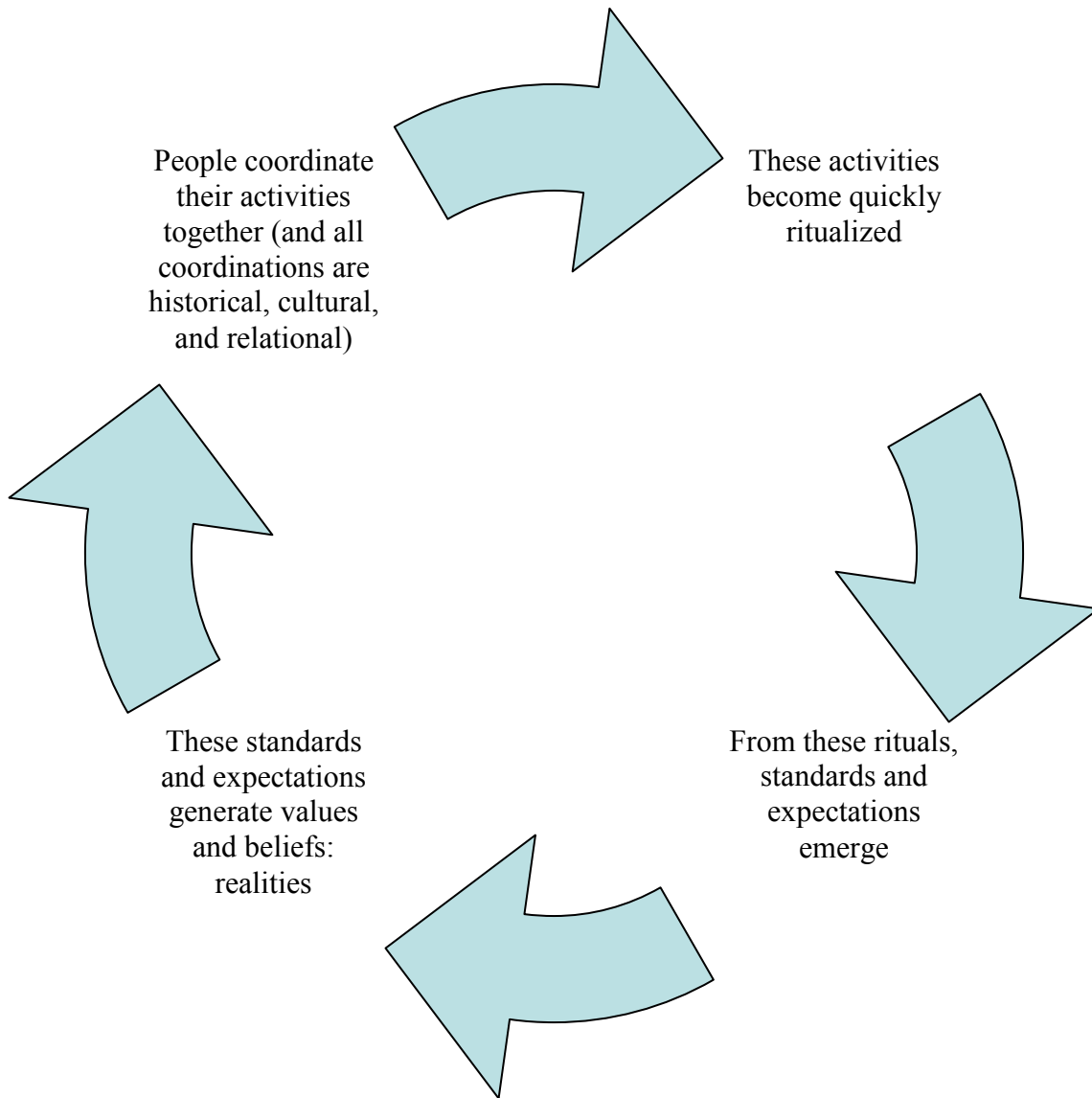
Monologism is, unfortunately, our taken for granted mode of interacting and it emphasizes individual capabilities over collaborative achievements. It is also seen in the realm of public deliberation where it is an individual’s reasoning abilities that are at stake. Dialogue, by contrast, is mistakenly seen as a “feel good,” conflict-avoidant form of practice. Our individualist, monologic tradition is our default mode of operation precisely because it holds individuals accountable for their own private meanings and intentions and this is how we unquestioningly assume things should be. Yet, the dialogic understanding of meaning that Bakhtin, Sampson and a host of others propose, far from being centered on feeling good, is concerned first and foremost with appreciating the complex process by which our worlds are made.

This process starts with people coordinating their activities with others in interaction.<sup>3</sup> We might think, for example, of the first encounter between a doctor and a patient. As the doctor enters the examination room, both patient and doctor understand

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<sup>3</sup> We would like to emphasize that the *starting* point is the coordination of participants, **not** “self contained individuals” who come together to coordinate. There is a significant difference between starting with relational coordination and starting with two (or more) separate, cognizing individuals.

that the topic of conversation is focused on the patient's health. The doctor questions; the patient answers. From these coordinations, patterns and rituals quickly emerge. Some doctor-patient relationships include conversations about family and home life so that when the patient arrives at the doctor's office, s/he anticipates discussing topics beyond the health issues that brought him/her to the medical context. These rituals generate a sense of standards and expectations which we use to assess our own and others' actions. Thus, if the doctor fails to ask about the patient's family, the patient might feel slighted or disrespected. Similarly, if the patient fails to answer the doctor's questions, the doctor would feel that the expectations for the situation had been violated. Once these standardizing modes are in place, we see the generation of values and beliefs (i.e., social realities). That is, we are left with an unquestioned set of assumptions about, in this case, "how a medical encounter should go." This process is illustrated in the diagram below.



Thus, from the very simple process of coordinating our activities with each other, we develop entire belief systems, moralities and values. What is interesting about this model is that we can recognize the social/relational locus of meaning. If a person's values and beliefs emerge from his or her coordinated activities with others, then can we locate responsibility solely within the individual? Is effective healthcare simply the result of a healthcare professional applying the correct diagnostics? If we are blind to the relational, situated, and often times very local processes within which we craft our

understandings of the world, we can easily mistake meaning, intentions, values, moralities, and all that is meaningful in our lives to the private world of the mind. And, in so doing, our attempts to move toward more collaborative, ecological ways of living (in this case, of providing healthcare and health education) is thwarted because the decisions about how we should work, the decisions about what policies should be in place and about what counts as equity, will remain in the hands of those in positions of power who are granted the ability to make these complex decisions because they *know* how to preserve the *right* values and the *right* actions. But, the question must be asked: *by whose standards are we determining the right values and actions? What are the standards by which those in power claim their position?* What about the very unique ways in which local communities coordinate their activities concerning health and illness?

It is not our attempt to claim that dialogue will solve all problems. Dialogue, as Anderson, Baxter, and Cissna (2004) describe, "exists in moments rather than extended states,... cannot be lionized,... cannot become business as usual,...and cannot be planned precisely or made to happen" (p. 15). It is perhaps useful for us to distinguish between dialogic moments and the broader issue of creating meaning. Whenever people come together, meaning is created. But if the participants to an interaction have diverse beliefs and values, how do we adjudicate which values and beliefs should apply? Do the healthcare professionals' beliefs and values dominate because they are professionals? There is good reason to hand authority over to professionals. But might there not be more generative ways of operating if we move beyond the either/or binary of monologism and find ways of coordinating diverse beliefs and values so that the

healthcare professionals' expertise can be interwoven with the local community's beliefs and vice versa?

We see dialogue as an opportunity to engage more voices in crafting the values, beliefs, and meanings by which we shape our lives. The application of dialogic practices to the Brazilian healthcare context serves, in this article, to illustrate the ways in which a relational understanding of meaning can transform our ideas about what counts as professional healthcare practice and what part community members and professionals can play in that transformation.

To engage in dialogue, as we are talking about it here, is not to retreat to our own worlds, seeking solutions to our own problems. Dialogue requires that we extend our curiosity about the profuse and diverse realities that emerge when people come together and coordinate their activities. We must extend that curiosity to those who are “different,” who are “oppressed,” and who are “oppressing.”

Penman (2000) writes about the ways in which various types of interaction and communication allow for genuine participation, and how they influence the well being of participants – whether that wellbeing refers to their private lives or issues of broader public concern. She discusses “good communication” from a dialogic orientation as necessarily implying a morality: communication is “good” when it is human and good to people, *not when it is clear and concise*. This last statement distinguishes a dialogic understanding of human communication from a popular, technique-oriented approach to communication – an approach associated with a modernist, individualist, monologic understanding of communication and meaning.

Penman’s idea of “good communication” is dialogic. Interaction must acknowledge those present and the values and beliefs they bring to the conversation. The most important aspect of any conversation is the *interactive moment* – what those present are doing now and the histories, cultures, and traditions they bring with them. Second, any conversation must remain open to the possibilities that emerge within the interactive moment; there is no prescribed route toward a pre-determined goal. In other words, dialogue is not focused on any particular technique or content. In dialogue we are more attentive to *what we are doing together*. Third, good communication is marked by openness to diverse understandings which are the by-product of coordinations among participants (note earlier diagram). Finally, no meaning, no conversation is ever ultimately complete. Meaning that emerges within an interaction is always open to further supplementation and thus to the construction of new understandings.

By defining “good” communication in this way, our focus shifts from the content of what people are doing and saying to the *processes* in which they engage and *how their actions* invite each other into particular rituals and relationships. This is not to say that content does not matter. Of course it does – particularly in the world of public policy and healthcare. However, the dialogic focus we are proposing here encourages a “pause” if you will, in our attention to content.<sup>4</sup> To emphasize dialogue is to be attentive to the ways in which we might *build conversational domains where people can talk in different ways about the same (old) issues*.

This means that our first task is to explore ways of creating a context (physical, relational, and personal) that *invites* participants to talk differently about “the same old

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<sup>4</sup> And we should think about what this means for healthcare practice. In the world of healthcare, the notion of “pause” appears antithetical to being a professional. What a shame that efficiency has been equated with rapid treatment and assembly line-like modes of operation.

topic.” This does not mean (as critics presume) that participants must self disclose in deeply personal and self-interested ways. Nor does it mean that difference of opinion, conflict or discord of any kind must be suppressed. This also does not imply that differential power positions are ignored nor that professional expertise is put aside. Rather, to be in dialogue is to engage in the tensionality produced when one holds one’s own position while simultaneously remaining open to the (often very oppositional, contradictory) position(s) of the other(s) (Stewart and Zediker, 2002).

This understanding of dialogue is significantly different from the “happy talk, no conflict” interpretation so many hold. The risk of holding one’s own position while allowing others – often with diametrically opposing views – to do the same, and to be open and curious about the *coherence* of those very different positions, creates a very unique relational context. It is a context, we believe, that is more democratic and concerned with broader issues of human and social wellbeing. It is, in other words, a useful process for public deliberation, policy formation, and social equity, particularly in a large country like Brazil where access to healthcare and health education has been historically unavailable to the majority of the population.

It is with this particular understanding of dialogue that we now turn to an exploration of the Brazilian healthcare system and the nature of our work in that context. The healthcare system in Brazil has undergone extensive reform over the last decade. One major aspect of this reform is the attempt to humanize services, thereby creating a better environment for professional-patient interaction. The assumption is that an enhanced provider-client relationship will contribute significantly to personal, community, and ultimately, national well-being. Thus, many efforts are underway to

explore professional-user relationships and new practices and methods for healthcare delivery.

In the remainder of this paper, we will describe the relationship of dialogic practice and healthcare in the Brazilian context. In this work we can see a small illustration of the effect of creating, within a variety of health services and communities, opportunities for professional-user and professional-professional dialogue about health issues. We are particularly interested in showing the potential for dialogue to transform the professional/user relations that facilitate healthcare. The ways in which dialogic practice transforms professional to professional relationships, thereby shifting the way users and professionals think about healthcare in general, is discussed elsewhere (Camargo-Borges, Mishima, and McNamee, 2008). We hope to open discussion on the ways in which dialogue – if adopted on a broad-based scale as a common stance in public health – might be usefully employed to enhance collaborative, democratic practices of personal, community, and national health.

In the remainder of this paper we describe one of three different venues within which we have introduced a dialogic sensibility to one Brazilian community's healthcare services and practices. Our focus in this article is on one illustration of health professional and user (patient) collaborations in a family healthcare program. The remaining two venues where we have created dialogic contexts that transform understandings of healthcare include work with (1) healthcare teams and (2) regional health service administrators. Both groups struggle with their own professional diversity and the concomitant issues of power and authority that emerge within the traditional institutional context of healthcare.

Looking at the collaborative activities of healthcare professionals and patients in a family healthcare program, we draw on Camargo-Borges's (2007) doctoral research. This research centered on a specific group within a community healthcare center in Ribeirão Preto. Camargo-Borges's analysis entails an exploration of how a dialogic approach to community healthcare, which centers on a relational understanding of meaning making, can improve and transform the process of healthcare delivery by transforming the professional/client relationship.

Brazil's newly adopted Family Health Program (which is part of the National Healthcare System) requires a strong relationship between health professionals and the communities within which they work. Yet, despite this new mandate, little to no guidance has been provided concerning how health professionals and administrators might build professional-community and/or professional-professional relationships that facilitate preventative healthcare. To set the context for our work, it is necessary to provide some background on mandated healthcare reform in Brazil and its relationship, as we see it, to dialogue.

### **Healthcare Reform in Brazil**

Clearly, this is a large project. In an attempt to explore the possibilities and constraints of the National Healthcare System's revised goals, emphasis has been placed on the primary healthcare level as the nodal point connecting all levels within the system and also connecting the community to the professional healthcare levels. With primary care as the central focus for realizing the national healthcare goals, efforts have been placed on the Family Healthcare Program (PSF) since this program embodies the confluence of multiple levels and issues concerning healthcare. This program is

grounded in the heart of communities where each health team (which includes 1 general physician, 1 nurse, 2 assistants, and 5 communitarian agents – akin to the notion of community volunteers in the USA) is responsible for a clearly defined geographical area. Each health team covers an area that includes 600 to 1000 families. The aim has been to promote a health system that is coherent and coordinated with the local history and culture of each of Brazil's diverse communities and regions (Pan American Health Organization, 2005).

The health team gets to know the families and visits each, once a month, whether they are ill or not. The families are seen as a dynamic system which the health professionals should treat with the broadest of understandings about the health/illness process. This suggests that topics that are apparently unrelated to a person's health might be worthy of consideration and discussion, given the values and beliefs of the local culture. Therefore, the family within its community is the fundamental unit of focus (WHO, 2003).

A large part of the team's work emphasizes health promotion and prevention. However, clinical issues are addressed as well in the local health center. At the Center, there is more of an emphasis on community based healthcare and its form of care delivery is more collaborative. **When we say collaborative, we are referring to the attention given to developing forms of health-related intervention *with the involvement of the entire community* that are, consequently, coherent with local values, beliefs, and practices.** Through this collaborative process, more interaction focusing on quality of life between health professionals and users is encouraged. Clearly,

the aim is to represent the National Healthcare System to each community in a manner that helps construct an integrated and effective approach to public health in Brazil.

The goal is to establish relationships that facilitate the process of care, thereby creating a collaborative work environment, fostering an atmosphere of cultural sensitivity and promoting a sense of attachment, participation (Camargo-Borges and Japur, 2005), and relational responsibility (McNamee and Gergen, 1999). **However, this goal creates some very different requirements and expectations for healthcare professionals.**

Specifically, health professionals must establish good relationships with the community in which they work in order to create and maintain an “open door” policy (Brasil, 1994).

In order to realize the goals of a more collective and collaborative Family Healthcare Program, there are some mandatory activities that each team should develop within its working community. One is the development of group activities. Specialized group activities are an important focus of each health team. Some specific groups are created based on epidemiological issues. For example, it is likely within almost any community that there would be groups organized around topics like hypertension, diabetes, and diet. These are typically the first to be organized at any local healthcare center. Usually these groups serve a largely informative function and involve limited encounters. The aim of these groups is to help participants (i.e., community members) develop more knowledge about the disease or topic and create a sensibility for self-care (Brazil, 1997).

However, since the most common tools for helping users with health problems is the health professional’s medical expertise, the ultimate goal of *collaboration* among professionals and community members does not “automatically” contribute to what we

would call a dialogic, relationally sensitive opportunity for equal participation in healthcare issues. Professionals tend to rely on a technique-oriented approach, dispensing their medical expertise in the same manner that they have been using within the former healthcare system. Rather than create a participatory, relationally sensitive context for healthcare, the same traditional ways of working continue – modes of work that privilege hierarchical and fractured relationships within rigidly structured, clinical contexts. Although the objective is to be more dialogic,<sup>5</sup> it has been difficult to change the traditional individualistic paradigm that dominates healthcare. The delivery of care is still centered on hierarchical interaction focusing on isolated aspects of healthcare and not on the integrative, interdisciplinary mode proposed by the new national program<sup>6</sup>. In large part, this is the result of local “delivery” groups and their own very particular interpretations of the new national mandates. Specifically, most communities examined the new mandates and focused their discussions on how *what they were already doing – the modes of delivery they already had in place – could be described as meeting (unchanged) the new national guidelines.*

Traditionally, change has always focused on the structural and/or financial aspects of healthcare. What is so startling about this latest reform in Brazil is precisely its focus on a more fully integrated understanding of health. Thus, the current healthcare reform has created the opportunity for health professionals and administrators to consider the interaction between the health system and the population. The byproduct of has been a focus on broad community participation. Specifically, when the new national healthcare reform was introduced, most healthcare professionals and administrators interpreted it as

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<sup>5</sup> Dialogic according to the assumptions described here.

<sup>6</sup> It should be noted that the national reform articulates a relationally-sensitive, collaborative mode of healthcare delivery but offers no concrete notion of what such a program would or should look like.

a reform to infrastructure (at the economic and structural levels). Yet, some might reframe this latest reform as focused on *relationships*. Specifically, attention is placed on creating collaborative, working relations among healthcare professionals (in all contexts and professional disciplines), communities, families, and individuals. This is particularly the case in the development of the Family Healthcare Program. This program was established purposively to foster close relations within each community, mandating group activities as well as home visits to bridge the gap between professionals and users. Fostering these collaborative relationships places the emphasis on resources for continued healthcare that emerge from *both* professionals and the communities they serve.

For these reasons, we believe that relational forms of practice – particularly forms of practice that we consider dialogic – can assist in the transformation from the traditional understanding of healthcare to the new system conceptualized by the government. *How can healthcare professionals learn to move beyond their analytical and practical skills (content) and develop sensitivity to more collaborative and relational modes of practice (process)?* There is a gap between traditional training in techniques and skills, such as diagnosis and treatment, and training in understanding the complexity of human communication processes (Camargo-Borges and Cardoso, 2005).

### **Health Professional – User Collaborations in the Brazilian Healthcare System**

We want to return to the value of understanding as responsive and complex (Wood, 2004; Bakhtin, 1981). And, we want to focus on the context of the Family Healthcare Program in Brazil, especially in group practices where health professionals and users work together. These activities offer opportunities for participants to create a space where incommensurate discourses can co-exist, allowing (and encouraging) users

and healthcare professionals to engage in a vast array of topics – many often not “allowed” or valued in traditional healthcare venues. For example, is it possible to value community members’ home remedies along side the medical professional’s scientific treatments? This kind of “dialogic tension” can be useful when we are talking about a health team working within a specific community. By locating a healthcare center within the community, a culture shock of sorts is created by virtue of connecting extremely diverse backgrounds – specifically, medical/technical expertise vs. folk wisdom, local knowledge, and home remedies. The distinction can be seen as a clash between science and common sense. The challenge becomes one of approaching each side of this culture divide with respect and curiosity for each community’s coherence.

Camargo-Borges (2002), in her study of one community healthcare group, argues that the involvement and participation of all social actors in *dialogic moments* is a central feature in the transformation of the traditional, hierarchical healthcare system. Her research demonstrates that the critical ingredient for maintaining community member/professional involvement in healthcare has little to do with content and is, instead, dependent upon creating a conversational space wherein *all* participants – professionals and healthcare users – can remain engaged in dialogue.

Further extending this work, Camargo-Borges<sup>7</sup> followed the meetings of one healthcare group located within a Family Healthcare Program. This particular group – the hypertension group, which we will examine closely below – had been identified, by the health professionals, as an extremely successful group. It had been meeting consistently for three years, while other similarly organized groups (e.g., a diabetes

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<sup>7</sup> The research we describe here is part of Camargo-Borges PhD research.

group, a diet group, a women's group) disbanded as soon as the healthcare professional had provided all of her/his professional knowledge about the group's health concerns.

The hypertension group was initially created to help people suffering from the chronic disease of hypertension. Interestingly, it quickly transformed into a group focused on general, daily issues. Any subject of interest to the members was engaged by all participants, regardless of the topic's connection to traditional health related issues. For example, it was not at all unusual for this group to organize parties and meals for the community as a whole, to practice and perform dance, or to plan a cooking class where participants could learn how to prepare a nutritious and tasty meal for under one Brazilian Real (approximately 57 cents). Thus, despite the intent of meeting for purposes of informing patients about their disease and medications, this specific group met regularly and became legitimated by the community who began inviting all users of the local health care program to participate, despite their affiliation with the formal purpose of the group.

The group established a pattern of "open conversation," letting the desire of the group – in concert with the health professionals – create together and, in the moment, the topic for discussion at each meeting. The group maintained their identity as the "hypertension group" by taking blood pressure readings collectively at the end of each meeting as well as by following each person's treatment needs. Regardless of one's health record, the reading was taken, with everyone – the professionals and participants together – using the appropriate measurements.

Not surprisingly, this group, now the oldest functioning group at the center, is recognized as a group where any new information within the broader community (as well as within the health center) can be discussed. Advice about setting up new activities for

the community are frequently sought from this group. It would be fair to say that people – professionals and community members alike – come to this group when they have information, ideas, or questions that might potentially effect the entire community.

Camargo-Borges (2007) explored the features that function to make this group a success. She examined this group in an attempt to understand not only what features enable dialogue but also to explore the very practical ways in which participants work together to create the opportunity for dialogue.

It is interesting to look briefly at Camargo-Borges's transcript of this group (below) given our argument that dialogue requires a focus that is less centered on any specific content and more attentive to the relational aspects that enhance and invite participants to respectfully engage in the process of meaning making. We believe that the investigation of this group's conversational practices could assist future participants in the design and facilitation of dialogue in a wide range of contexts. We also believe that understanding how this group succeeds in creating a dialogic process offers important information concerning (1) the role of professionals and, in the present case, (2) the promotion of health. The central dialogic focus of this case is on the *responsivity* of group participants (professionals and users) to each other. For example, the "striking" difference in this group's interaction is the way in which the professional (a pharmacist in this case) positions herself in relation to the group members. She is both expert *and* learner. To that end, we might say that dialogue is about significant social reform – in the present case, reform of the professional's "all knowing" position as well as reform of the patient's lack of knowledge and expertise. This kind of social transformation is achieved through participants' mutual responsivity. In these group meetings, both health

service users and health professionals learn and expand their understandings about health, the local community, and the best way to serve the needs of this specific population. Dialogue is also about the transformation of status differentials between professionals and users that all too often create a chasm in health treatment and prevention.

If Brazil has a policy that requires a very different set of relationships among community members and healthcare professionals but no specific model or mode for making this shift, what can we learn from this one group that has succeeded in operating in a manner that can be clearly distinguished from a traditional, hierarchical model of professional-client communication? Examining this group in detail offers some interesting ideas about healthcare in any context. More pointedly, it offers some useful models for implementing a dialogic healthcare policy in Brazil.

### **The Hypertension Group: The Responsivity of Dialogue**

For purposes of creating reflection about dialogic practices in the field of health care, we will give an illustration, in the context of the Family Health Program, of one moment within the hypertension group that we consider to be a fresh form of dialogue. This group meets at a Health Center that is part of the University of São Paulo, in the southeastern Brazilian city of Ribeirão Preto. This group is coordinated by the nurse and her assistant. In addition, there is always a student participating (e.g., medical student, nursing student, pharmacology student, etc.). It is also not unusual to have guests – experts from other fields – depending on what the group wishes to discuss. The group members can be hypertension patients or not. Anyone from the community who shows up at the Center on the group's meeting day is invited to attend. Often, participants bring

friends. As we can see, one feature that permeates this group is a flexibility concerning membership.

A transcript of a brief interaction that took place during one meeting will help us illustrate the features of this group that we see as illustrative of dialogue in practice. This excerpt is from a meeting attended by 10 users/patients and 4 health professionals. One of the health professionals is a pharmacist, invited by the group, to talk about medications. Prior to this meeting, the group had been discussing the varied problems they each experienced with their medications and how they each coped with their difficulties initiated by different medications, doses, and various combinations of prescriptive drugs. These discussions prompted them to invite the pharmacist to offer her expertise on these issues. At a certain point in the meeting, the topic of home remedies emerged.

Cissa (USER) – I went back to the old days, you know? Because  
the doctor told me to use an anti-inflammatory cream to treat  
an irritation, right?

Laila (PHARMACIST) – Yes.

Cissa (USER) – It was really painful. A very sharp pain. The  
cream burned my whole heel! The skin was coming off!  
You should have seen it! Well, then I stopped using that  
cream. And do you know what I did? My mother used to  
use this remedy. She made an alcohol solution out of  
grain...no...it was grain alcohol with “cloves” and pepper.  
The one ... the whole clove, you know?

Donna (USER) – And how about your skin? Didn't this mixture irritate it?

Cissa (USER) – No. Not this remedy.

The pharmacist, who was facilitating the meeting, adopted a non-judgmental stance within the group, letting the patient talk about how she managed the situation. With just only one word, “Yes,” she has been responsive to the Cissa's story and has encouraged her to continue with her description of her mother's “common sense” treatment. The pharmacist's listening position seemed to give room for other stories to emerge. Group members started to offer their own stories about home-made remedies. They felt free to talk about healthcare treatments that are very much part of their local culture yet are alien to the culture of modern medicine.

Cissa (USER)- Listen, after that, my knee started to hurt.

Donna (USER) – What? (expression of astonishment)

Cissa (USER) - I took a book that I have at home. Avocado with grain alcohol. I put the prescription the doctor had given me aside and then started to use this home remedy on my knee. It got better! Now, I can't take the medicine. I can't take the anti-inflammatory medications. I can't put any of this on my knee. That is it!

Jane (USER)– Is it the one with avocado?

Laila (PHARMACIST) – The alcohol....the alcohol. It is...in fact....it is going to help in the healing process.

Jane (USER)– The avocado that you cut, was it ripe? I have done this as well.

Cissa (USER)– No. You have to put the avocado in the sun and take the brown skin off. Then you cut it all and put it inside a glass .

Laila (PHARMACIST) – Some people use the avocado’s seed. They put it in alcohol and leave it there until it softens. Then they use the solution – the alcohol with residue from the avocado seed – on the problem area.

SOMEONE – Really?

CISSA (USER)– Wow!! It really gets better...

Jane (USER) – We have to cut it when it is green like that, when you just pick it from the tree.

Laila (PHARMACIST) – Will you remember to do some research about the avocado seed to find out how it can be used to treat rheumatosis? (Asking the student of pharmacology who was attending the group that day)

Jane (USER) – Listen. Do you know about a weed that grows around the sidewalk that is good to use for high blood pressure? I have a book that talks about this. It is written by a nurse and she talks about this weed.

Here, we see the pharmacist adopting an open stance. She opens the conversation to all participants, allowing more interaction among the group and allowing

them to bring and share stories about how they have “treated” their own health problems. They feel free – even in the presence of a pharmacist – to exchange stories of their own home remedies and the success they have had using them. By allowing the group to share their knowledge, the pharmacist does not need to abandon her own scientific knowledge. As a form of collaboration, she explains the healing process of alcohol to the group and asks her student assistant to conduct further research into the healing powers of the avocado seed.<sup>8</sup>

(...) Laila (PHARMACIST) – Listen, the next time I come here,  
do you know what we can discuss? Let’s talk about home-  
made medicine. I think that would be interesting.

Cissa (USER) – Nice!

Celiane (RESEARCHER) – So, is it a deal?

Laila (PHARMACIST) – Home-made medicine!!!

In this short excerpt, we note that the pharmacist, in her invitation to extend the group’s conversation in another meeting, was being responsive to the contributions of the participants. She was illustrating her curiosity for the members’ local ways of making sense of their own healthcare. As the “expert” or “scientist,” the pharmacist was open to the comments of the users. By making space and legitimating the discussion of the participants’ non-traditional health treatments, the possibility for future collaborations

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<sup>8</sup> Our argument here is not that healthcare professionals should give up the medical or scientific discourse that allows them to diagnose and treat illness. In this illustration, we see the pharmacist “holding her own” (i.e., she is the professional) while being open to the understandings and local practices of the other. This is an illustration of the tensionality of dialogue (Stewart and Zediker, 2002). Neither the professional nor the patient has the “truth.” Rather, they all have coherent stories and the challenge is to coordinate those stories so that health is promoted.

were crafted. Users became curious about each other's remedies and apparently comfortable to share their own knowledge with professionals.

### **Implications of Dialogic Collaboration**

We identify this excerpt of the group as an example of dialogic process based on the collaborative way in which they have and continue to create a strong sense of relational connection, participation and belonging among themselves as well as to the broader community. They have found a way to maintain an “open door” policy that invites others from the community to join their activities thereby maintaining a fluid and constant relationship between the community and health professionals. One central feature of their success seems to be their focus on the *process of their conversation and their relational connection*, rather than on the purported *content* (i.e., hypertension).

We see this group coordinating multiple beliefs and values. There is no attempt to determine whether the expert's information or the community members' remedies are the “best” answer. The group manages to let these multiple realities co-mingle with no attempt to come to consensus or a decision of one method over another. It seems that they have, over time, successfully created a context where “the same old topics” (in these case, healthcare treatments) can be discussed in a way that differs dramatically from the typical medical encounter.

Clearly, other medical contexts demand very different forms of practice. There are times when a healthcare professional does not want to consider the folk wisdom of the patient because doing so would endanger his or her life. However, the dialogic process we are describing here is still significant. A patient who has been able to tell his or her story, to share his or her beliefs, folk wisdom, and fears with a medical

professional and experiences that professional's *responsivity* to his or her stories, is more likely to be responsive him or herself when the professional offers an alternative understanding of the situation.

In dialogue, there is no apparent attempt to avoid conflict or difference of opinion. Persuasion is replaced with responsive listening, curiosity, and self reflexivity. Admittedly, this specific group is not gathered to confront a difficult difference of opinion. Yet, typically, these health groups function in a more traditional manner. The health professionals usually operate as coordinators of the groups, seeing their role as "experts" who dispense medical advice to community members. This dynamic has established a somewhat conflicted context since the health professionals see their visits to these groups as an imposition on their very busy schedules and do not feel that the community members "cooperate" with their medical treatment. The users, on the other hand, stop attending these groups reporting that the professional information given by attending experts does not connect with their specific circumstances. In turn, the health professionals identify these communities as resistant to medical advice.

Returning to our diagram of how meaning – entire belief systems – emerge in communities, we could see that dialogue centers not on determining which set of coordinations generate the correct values and beliefs. Rather, dialogue asks how we can open curious conversation about the coherence of these very different meaning systems. Thus, we believe that dialogue can facilitate the creation of a different relational context – one that respects differences while simultaneously providing an opportunity to collaboratively construct a successful mode of healthcare within each particular community group. To us, the tension of dialogue, to which Stewart and Zediker (2002)

refer, offers a model of how the various levels of expertise (professional and lay) might inform each other and subsequently improve the process of healthcare in Brazil.

Dialogue, as a process, can help in the realization of the country's new healthcare requirements. Opportunities for dialogue can generate new forms of relating within communities and with health professionals and can invite health professionals to move beyond the reproduction of the technologies that prevent them from being spontaneous and fully present to the people they are committed to helping.

The group in this illustration does not exclude the voices of all group participants – professional and community user alike. Nor does this group seek to find one answer to a medical ailment. They work instead to respectfully learn about the various ways in which their ailments can be relieved.

This group, by some standards, could be seen as a dysfunctional group because their conversations are not focused on hypertension and any possible changes in patients' behaviors, as they relate to hypertension. However, from a dialogic perspective, this group can be seen as creating an important conversational space where diverse understandings of health and treatment are equally respected. The dialogic tension between holding on to one's own position – whether that be, in the present case, a belief that home made remedies are better than modern medicine *or* that modern medicine offers solutions to health problems – creates a context where lay people and professionals can become curious about each other's diverse beliefs.<sup>9</sup> Through this process, the

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<sup>9</sup> It is important to note that the group members invited the pharmacist to join their group because they were keenly interested in having the expert inform them on the science of various medications and their proper use. The excerpt we have included, therefore, illustrates an interesting departure from the explicit purpose of the group meeting and yet, it is a departure that the expert seemingly facilitated and welcomed. Moreover, the pharmacist indicates that she, herself, would like to learn more about these very different (non-medical) forms of treatment.

expertise of the professionals is respected as is the “local” expertise of the community members. There is no attempt to develop consensus about what each group understands about health. Rather, the goal is to create an environment where professionals and community members can continue in dialogue with each other, finding alternatives to deal with their health and creating common modes of treatment, even when professionals and users differ in their opinions.

We believe that in operating in this collaborative way, professionals are able to create modes of action that are responsive to specific communities, as well as to construct specific practices that can be usefully extended to other levels of healthcare expertise. In other words, it is not only a collaborative model engaging users and professionals but one that creates collaborative possibilities among the diverse levels and disciplines relevant to public health, in general.

In this context, the importance of dialogue is directly responsive to the National Healthcare System’s requirement to create a strong sense of community and a strong connection between users and health professionals on the daily bases. We suggest that the dialogic process developed within the hypertension group could work to inform a new mode of healthcare delivery. This group offers useful ideas for developing health practices based on a relationally sensitive process of communication and negotiation between health professionals and users. Dialogue among the hypertension group created a different relational context, which subsequently transformed the relationships among all participants. They successfully achieved the construction of a context where all participants felt connected to the healthcare center and were able to gain whatever support they needed as they negotiated the complex process of health/illness.

While this case illustration may seem insignificant, those in the community as well as those working at the health center have recognized this group as successful. Their success is visible in two ways. First, it is the only group that is enduring and well attended. Second, it helps to strengthen the relationship between the healthcare Center and the community. Thus, in a small but significant manner, the dialogic mode of operating within the hypertension group offers generative ideas for addressing the new National Healthcare mandates.

This kind of intervention is not about therapeutic process in the sense of working to change the way users think or feel, nor is about changing their undesirable behaviors. It is about the possibility of creating a coordinated pattern where together they can realize the goals of the National Healthcare System and how to go on together, negotiating their needs. Those goals require collaboration and more community member (user) participation in the crafting of preventative healthcare. To do so, health professionals must be open and curious to the different values and beliefs within local communities. These differences must be negotiated and legitimated (not excluding modern medicine). This example shows us that dialogue is not just about individuals but is about transforming healthcare practices, helping to create ways for the solidification of the Brazilian healthcare system as well as energizing new ways of building community/professional relationships.

## References

- Anderson, R., Baxter, L. A., and Cissna, K. N. (Eds.) (2004). *Dialogue: Theorizing difference in communication studies*. London: Sage Publications.
- Bateson, G. (1972). *Steps to an ecology of mind*. New York: Ballantine Books.
- Bakhtin, M. M. (1981). *The dialogical imagination* (M. Holquist, Ed.; C. Emerson and M. Holquist, Trans.). Austin: University of Texas Press.
- Bird, J. (2000). *The heart's narrative*. New Zealand: Edge Press.
- Brasil/Ministerio Da Saude (1997). *Saúde da família: uma estratégia para a reorganização do modelo assistencial*. Secretaria de Assistência à Saúde. Coordenação de Saúde da Comunidade. Brasília: o autor.
- Brasil/Ministerio da Saude. Leis, Decretos (1994). Portaria MS n.692, de 29 de Março. *Diário Oficial da União*, N° 060, 4572.
- Buber, M. (1970). *I and Thou*. (W. Kaufmann, Trans.) And. New York: Scribner.
- Camargo-Borges, C. Mishima, S. M and McNamee, S (2008). Da Autonomia à Responsabilidade Relacional: explorando novas inteligibilidades para as práticas de saúde. *Geraios. Revista Interinstitucional de Psicologia (accepted to be published)*.
- Camargo-Borges, C. (2007). *Responsabilidade Relacional como ferramenta teórico/prática na promoção de novas possibilidades na atenção à saúde: uma análise de processos conversacionais entre trabalhadores e usuários*. Phd thesis. College Nurse. Department of Public Health. University of São Paulo.
- Camargo-Borges, C. and Cardoso, C. L. (2005). A Psicologia e a Estratégia Saúde da Família: Composto Saberes e Fazeres. *Psicologia & Sociedade*. v. 17, n. 2, p. 26-

- Camargo-Borges, C. and Japur, M. (2005). Promover e Recuperar Saúde: Sentidos Produzidos em Grupos Comunitários no Contexto do Programa de Saúde da Família. *Interface-Comunicação, Saúde, Educação* v. 9, n.18, p.507-519.
- Camargo-Borges, C. (2002). Sentidos de saúde/doença produzidos em grupo numa comunidade alvo do Programa de Saúde da Família (ESF). *Dissertação de Mestrado*, (Psicologia) Ribeirão Preto: Faculdade de Filosofia Ciências e Letras, Universidade de São Paulo.
- Charon, R. (2006). *Narrative Medicine: Honoring the Stories of Illness*. New York: Oxford.
- Cloud, D. L. (1998). *Control and Consolation in American Culture and Politics*. Thousand Oaks, California: Sage Publications.
- Frank, A. (1995). *The Wounded Storyteller: Body, Illness, and Ethics*. Chicago: University of Chicago Press.
- Gergen, K. J. (1999). *An invitation to social construction*. London: Sage.
- Gergen, K. J., McNamee, S., and Barrett, F.J. (2001). Toward transformative dialogue. *International Journal of Public Administration*, 24, 7/8, 679-707.
- Harter, L., Japp, P., Beck, C. (Eds.)(2005). *Narratives, Health, and Healing: Communication Theory, Research, and Practice*. New Jersey: Lawrence Erlbaum Associates, Inc.
- Holzman, L. and Mendez, R. (Eds.) (2003). *Psychological investigations: A clinician's guide to social therapy*. New York: Brunner-Routledge.
- Isaacs, W. (1999). *Dialogue: The art of thinking together*. New York: Doubleday.

- Kleinman, A. (1988). *The Illness Narratives*. New York: Basic Books.
- Macpherson, C.B. (1962). *The Political Theory of Possessive Individualism*. London: Oxford University Press.
- McNamee, S. and Gergen, K. (Eds.)(1992). *Therapy as Social Construction*. London: Sage Publications.
- McNamee, S. and Gergen, K. (1999) *Relational responsibility: Resources for sustainable dialogue*. Thousand Oaks, California: Sage.
- McNamee, S., Gergen, K., and Barrett, F. (2001). Toward transformative dialogue. *International Journal of Public Administration*, 24, 7/8, 679-707.
- McNamee, S. and Shotter, J. (2004). Dialogue, creativity, and change. In R. Anderson, L. Baxter, and K. Cissna (Eds.), *Dialogic approaches to communication* (pp. 91-104). Thousand Oaks, California: Sage Publication.
- Monk, G., Winslade, J., Crocket, K. and Epston, D. (Eds.) (1997). *Narrative therapy in practice: The archaeology of hope*. San Francisco: Jossey-Bass.
- Newman, F. and Holzman, L. (1997). *The end of knowing: A new developmental way of learning*. London: Routledge.
- Newman, F. and Holzman, L. (1996). *Unscientific Psychology: A cultural-performatory approach to understanding human life*. Westport, Connecticut: Praeger.
- Pan American Health Organization. (2005). *Brazil Health System Profile*. Pan American Health Organization.
- Penman, R. (2000). *Reconstructing communication: Looking to a future*. New Jersey: Lawrence Erlbaum Associates.
- Peters, J. D. (1999). *Speaking into the air: a history of the idea of communication*.

- Chicago: University of Chicago press.
- Sampson, E.E. (1993). *Celebrating the Other*. Colorado: Westview Press.
- Schudson, M. (1999). What public journalism knows about journalism but doesn't know about "public." In T. L. Glasser (Ed.), *The idea of public journalism* (pp. 118 – 133). New York: Guilford.
- Stewart, J. and Zediker, K. (2002). Dialogue as Tensional, Ethical Practice. *Southern Communication Journal*, 65(2/3), 224-242.
- Tonn, M.B. (2005). Taking conversation, dialogue, and therapy public. *Rhetoric and Public Affairs*, 8(3), 405-430.
- Waldegrave C ( 2005) “ ‘Just Therapy’ with Families on Low Income” *Child Welfare*, (Child Welfare League of America) Vol 84 (2), March/April, pp265 – 276.
- White, M. (1995). *Re-authoring lives: Interviews and essays*. Dulwich Centre Publications.
- Winslade, J. and Monk, G. (2000). *Narrative mediation: A new approach to conflict resolution*. San Francisco: Jossey-Bass.
- Wittgenstein, L. (1953). *Philosophical investigations*. Trans. G. Anscombe. New York: Macmillan.
- Wood, J. (2004). Foreword: Entering into dialogue. In R. Anderson, L. A. Baxter, & K. N. Cissna (Eds.), *Dialogue: Theorizing difference in communication studies*. Thousand Oaks, CA: Sage.
- World Health Organization. (2003). *Primary healthcare: A framework for future strategic direction*. Global Reports. World Health Organization.
- Zoller, H. and Dutta, M. (Eds.)(2008). *Emerging Perspectives in Health*

*Communication: Meaning, Culture, and Power.* New York: Routledge.