

### The power of the bond for Healthcare production: what guiding users teach us

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This article discusses the findings of a research on production of care in healthcare networks in a municipality in the South of Brazil, regarding the power of the bond as a tool-concept to reorganize work processes of healthcare teams. The methodology was a cartographic approach that consisted in following the experiences of three “guiding users” in order to provide researchers with a perspective that is closer to that of users. We considered mutual acknowledgment and symmetric relationships, associated with a shift in the positions of recognized knowledge, as an ethical condition to the development of bonds. We argue that the construction of bonds is a powerful strategy to transform daily healthcare practices, based on an ethical-esthetic- political project that focuses on users’ demands and health needs, taking into account their singularities, and established through symmetric relationships.

**Keywords:** Interpersonal relations. Professional practice. Comprehensive healthcare. Bond. Health needs.

## Introduction

This article problematizes findings related to the production of bonds in healthcare practices, collected in an investigation carried out with guiding users. It aims to give visibility to issues that tension the strategies used by professionals of Brazil's National Healthcare System (SUS) when they organize their care practices.

According to Cecílio and Matsumoto<sup>1</sup>, the bond is one of the operational components that compose users' health needs. Its production was viewed as a technical and assistance guideline in many municipal experiences<sup>2-7</sup> of implementation of the SUS in the 1980s and 1990s. It is possible to find a version of the concept in some ministerial documents related to Primary Care and published in the end of the 1990s. In these documents, it is called "responsibility bond" and "commitment and co-responsibility bond" and it is defined as something produced by a continuous interaction, with potential for "[...] solving individuals' problems and maintaining their health"<sup>8</sup> (p.15). Documents from the beginning of the 2000s refer to it as an operational guideline for the materialization of the principles of the SUS<sup>9</sup>. In the directive that approves the *Política Nacional de Atenção Básica* (PNAB - National Primary Care Policy)<sup>10</sup>, the term is understood sometimes as a principle, sometimes as a foundation and guideline for Primary Care, and has a more precise definition: the bond "[...] is the construction of affectivity and trust relationships between user and health professional. It enables the intensification of the process of co-responsibility for health that is built over time, and carries in it a therapeutic potential."<sup>10</sup> Furthermore, the directive mentions that the bond is a device required for the coordination of care:

Longitudinal care presupposes continuity of the clinical relationship, with the construction of bonds and shared responsibility between professionals and users over time and in a permanent way, with professionals monitoring the effects of health interventions and other elements on users' life, adjusting conducts whenever necessary, avoiding the loss of references and reducing the risks of iatrogenesis deriving from ignorance of users' life histories and care coordination<sup>10</sup>.

Summoning the understanding expressed in the PNAB to the debate without considering it the sole truth about the theme, the bond implies knowledge of users' life histories and constitutes something that needs to be permanently constructed between professionals and users - something that implies mutual trust and that, we propose, constitutes the expression of the event of care, viewed here as production in the intercessional meeting<sup>11,12</sup>.

Brunello et al.<sup>13</sup> carried out a review about bonds in healthcare in Brazil and concluded that the establishment of this type of relationship between teams and users might, in fact, improve professionals' knowledge of the real problems of the assisted population and motivate them to search for solutions, together, for the problems and for an improvement in the services. Garcia Jr.<sup>14</sup> approaches the power relations that the bond production practice engenders among care subjects and states that this practice can be established "[...] despite the differences they have in translating and reassembling, based on the exchange of experiences, an ethos of care."<sup>14</sup> (p. 129)

We believe that the bond will be developed or not in the context of health work depending on the way in which relationships among workers with different educational

backgrounds occur, as well as relationships between workers and users. The nature of health work is that it is live and produced in the act in the several encounters between worker and user, in which both of them practice self-government and bring with them their values and life histories<sup>15</sup>. The meaning that will be impressed on health practices and, consequently, the uses that will be given to the protocols and norms employed by health professionals are under intense negotiation and dispute. This process occurs in arenas crossed by forces politically and socially implicated in disputes of projects, imposing purposes on the care production process that, sometimes, may not be cure and health promotion<sup>16</sup>.

Thus, we ask: What is the power of the bond as a tool-concept<sup>17,18</sup> to reorganize teams' working processes? Would it be possible that, on behalf of the bond, health professionals also commit iatrogenesis, interdictions and daily micro-violences? What ethical and moral values have sustained the construction of bonds in the daily routine of health work? We invite the experiences lived with guiding users<sup>19</sup> in the fieldwork carried out in a city located in the South of Brazil, and the learning that resulted from them, to this debate.

## Methodology

The experiences analyzed here were collected in the research entitled "National Observatory for the Production of Different Modalities of Care in the Context of Implementation of Thematic Healthcare Networks in the SUS: An assessment of those who seek care, those who provide it, and those who use it", carried out nationwide from December 2013 to December 2016 by 52 researchers in the interinstitutional research line "Micropolitics of Work and Healthcare"<sup>20,21</sup>. The research aimed to analyze care production in the healthcare networks of 17 cities from all the Brazilian regions, based on the understanding that, beyond professional and institutional norms and hierarchies, care is also a production conducted by workers in their micropolitics, in the different projects they dispute<sup>19,22</sup>.

The analysis presented here refers to care production experiences observed in monthly encounters that lasted two to three days per month, with teams from three primary care units and one emergency unit. It also refers to encounters with workers from other services.

The research was carried out through a cartographic approach. This approach aims to produce knowledge from affections and intercessions experienced by individuals in the investigation process, including the researchers, and its objective is to give visibility to the tensions present in these encounters, giving voice to what was felt but had not been said yet<sup>23-25</sup>.

Thus, based on the encounters among researchers - those who were external to the services and those who, besides the role of researchers, were also protagonists of the care production process (users, workers and managers) -, it was possible, together with the guiding users, to extract the scenes presented in this article.

The tool-concept "guiding user" departs from an ethical-methodological bet in which the centrality of the experience lived by the user shifts the investigator's view so that he assumes the user's perspective, in the government of himself, as the reference to the meanings that must be given to health practices. In other words, it is a bet on the

professionals' adherence to the life of the other as ethics, shifting the other from the position of object to that of co-producer of knowledge<sup>20,21</sup> and care. In this study, we followed the guiding users Sueli, Ricardo and Rosa. The names are fictitious.

The study complied with the ethical principles of the Declaration of Helsinki of the World Medical Association and with Resolution 466/2012 of the National Health Council for the obtention of participants' informed consent, and ensured data confidentiality. The investigation was approved by the National Research Ethics Committee under no. 560597/2014.

## Results and discussion

The results that were considered central to the reflection proposed in this article are brought in the form of "scenes" that occurred while the researchers were following the three guiding users. They are presented in this section intertwined with the discussion.

### Mutual acknowledgement as a condition for the construction of bonds

Sueli is a 47-year-old woman who begins her journey across different points of the health network in 2014, referred or by herself, with recurrent complaints of headache, dizziness and blurry vision. After many fruitless passages in the network, she is diagnosed as having a benign frontal lobe brain tumor with a diameter of approximately seven centimeters. She undergoes a surgery to remove it, not without difficulties to obtain such intervention, even after the diagnosis had been made. In one of our visits to the Primary Care Unit of Sueli's catchment area, the team responsible for her care invites us to visit her.

When we arrive at her home, an unexpected scene takes place: the team workers are prevented from going in. Sueli kindly states that the problem has already been solved and she does not need the unit anymore. She reveals that she intends to acquire a private healthcare insurance, as she no longer wants to depend on the public system - she had an experience that she considers bad. At this moment, we reach the climax of the scene when we watch, astonished and helpless, the whole team - physician, nurse, nurse technician and community health agent - remain there, in front of the gate of Sueli's house, claiming their right to enter and discussing, in loud voices, that this refusal derives from an alleged mental confusion and cognitive difficulties caused by the tumor. Finally, we go away. The team members were visibly revolted by what had happened and someone suggests she should be interdicted. (Fragment from the field diary)

If we take the concept of bond expressed in the policies, we can think that, if a bond had been established at some moment of the relationship between Sueli and that team, it did not exist in the witnessed scene. In this scene, similarly to what happens with so many Suelis we assist on a daily basis, the door was closed and the bond was not produced. But what led her to give up the possibility of establishing a bond with the team? It seems that this is a key point to reflect on the events of Sueli's trajectory.

When she fails to receive the care she needed, she no longer sees the team as a reference. The team, in turn, searches for an explanation to Sueli's behavior within a given repertoire of knowledge: "she is confused, she had a tumor extracted from her head and this has affected her reasoning". Thus, when the team argues that Sueli allegedly has an incapacitating condition, they question her autonomy. However, Sueli upsets them precisely because she refuses to adhere to a project outlined without her participation and does not accept to lose control over her body and life as a condition to the establishment of the bond. A mismatch is established and the only alternative that remains to the team is an immediate and radical interventionism on the health problems<sup>26</sup>, grounded on the guideline of assuming responsibility at any cost for the user's care, even if they have to construct the bond "by force". But is it possible to construct bonds unilaterally, exercising control over the other's life?

It is possible to notice the repetition of an instituted expectation about the user: the desire that they should be "lamb people"<sup>27</sup> - docile, obedient, easily handled and controlled. However, lamb people do not exist. Even if, during the day, they let the "master" think he is in control, at night they take the wool off and the hypertensive lamb person smokes the cigarette she swears she does not have anymore, the diabetic lamb person hides away to eat candies, etc. Some lamb people brace themselves and take the wool off in the light of day, lock the master outside and do whatever they want. And when they cease being a lamb, they really annoy teams that do not have opportunities to reflect on their practice and assume the responsibility for prescribing how the other should lead his life.

The findings of this study suggest that the bond is something that can be constructed, but it can also be deconstructed or never be achieved. Therefore, it must be cultivated. Thus, the bond is something that can only be constructed if the other also wants it, if both consider themselves "valid interlocutors", that is, if they assume the ethical posture of seeing the other in the relationship as someone with whom it is necessary to establish pacts<sup>26,28</sup>, someone who has needs, desires, expectations and a type of knowledge that, in the majority of times, is different from mine - and this enriches my practice<sup>27</sup>. Based on this acknowledgement, it becomes possible to share therapeutic projects in the space between the desires of users and workers<sup>29</sup>.

It is clear that operating this concept in the complexity of the daily routine of the health work is neither simple nor natural. Furthermore, when we present this scene, we do not intend to disqualify these workers nor stigmatize their practice in a Manichean way. In fact, we witnessed that they assumed responsibility for Sueli and for many other users of that service in countless situations.

### **Symmetry as ethics and condition to the production of bonds**

In November 2014, the researchers contacted the workers of an Emergency Unit and asked them to make a narrative about a user that had affected them in some way - due to success, to some difficulty or to failure. Ricardo, the chosen user, was a 37-year-old man diagnosed as having alcoholic neuropathy. He was bedridden and lived in a house without piped water or electricity that was known by the neighbors and the Family Health team (FHT) as "oca", a reference to indigenous dwellings in Brazil. Ricardo lived with his family - five brothers and sisters, three nephews and the father - of

Paraguayan and Indian origin. There were many bottles of spirits in the house, a strong smell of marijuana and inhalant drugs, and several signs of violence were invariably perceived by the team. Ricardo did not walk, rarely talked or moved his arms and, in the first encounters, repeated the sentence insistently: “I need to be hospitalized, will you do this for me? No one takes care of me here, only Ana, when she can. If I continue here, I’ll die”.

After weekly visits, the FHT decides to request the assessment of the physiotherapist of the *Núcleo de Apoio à Saúde da Família* (NASF - Family Health Support Nucleus), who recommends daily sessions. However, it is not possible to schedule the sessions due to hindrances in the services: there is no place, the patient does not have the adequate profile, there is no transportation, there is no patient sitter. The team feels their hands are tied and define Ricardo as a problem, a complex case.

In the first encounters, it was visible that there were many barriers to his treatment. However, there were workers like Lia, who Ana, Ricardo’s sister, called “the one who falls and stand up with us”. During the 24 months of research, we perceived that Lia, the FHT worker who conducted the research team to the “oca”, knew that family’s history in detail: the thing we call *bond* had been constructed among them.

In Ricardo’s story, as well as in Sueli’s, the construction of relationships between interlocutors who consider themselves as mutually valid also emerges as a necessary condition to the construction of the bond. When Lia views Ricardo as a “[...] subject who lives a complex life, has knowledge and desires, with whom the team needs to talk in order to produce, in a shared way, new possibilities of handling problems and sufferings”<sup>26</sup> (p.1802), she validates his and his family’s existence and the ways in which they relate to life. Ricardo and his family, in turn, feeling acknowledged in their difference - even though, at that moment, their demand was not met -, also perceive the interlocution with Lia as valid, which allows them to establish a relationship based on mutual acknowledgement.

Thus, the differences between the subjects involved did not constitute an asymmetry between them and did not produce, neither in the worker nor in the user, a feeling of repulsion against each other; rather, it produced a feeling of symmetry. In these relationships where the individuals involved, despite their differences, consider themselves valid interlocutors, it is possible to establish a relation of “symmetry”, not as harmony and equality, but as dissolution of frontiers between interlocutors<sup>30</sup>. There is not a denial of singularities and no one overlooks the fact that there are differences. The univocal subject/object relation is deconstructed and it is understood that the encounter between a user and a worker is not a simple encounter of different individuals; many times, it is an encounter of distinct worlds. This requires actions in relationships of symmetry, of equivalents - symmetry between the self and the other as an ethical and political bet on a certain mode of relationship<sup>31</sup>.

### **Our movements while we search for symmetric relationships**

Our first encounter with Rosa occurs when we listen to the narrative constructed by the FHT. They present her as a case that they considered difficult but succeeded in terms of articulating the various health services involved. We then start to outline our “provisional profile” of Rosa, understanding this profile as something incomplete,

transitory, open to movements of dismantling and remodeling caused by new intensities generated by the encounters<sup>32</sup>.

Rosa was introduced to us as a child who suffered abuses in her childhood. When she was 14, during a nursing consultation, she reported this situation and was instructed to go to the *Centro de Referência de Assistência Social* (CRAS - Social Assistance Reference Center) to file a complaint. After this, she was expelled from home and was included in the child and adolescent protection network. However, as she does not see the care provided in the network as something meaningful to her, she runs away from the shelters. On the streets, she builds her life in the midst of prostitution and drug use. Subsequently, her mother dies of AIDS. She acknowledges the healthcare unit as a place where she obtains support for hygiene actions and, sometimes, food. (Fragments from the field diary)

The encounters with this user were difficult to the research team. They disorganized the team, defied their certainties and imposed shifts from the place of wise people to a place of openness to an individual who is very different from them. In the search for other angles of Rosa's provisional profile, other narratives were found:

Her health deteriorated in the last years due to her condition of homeless and drug user. As a consequence of this reality, she became a resistant and reactive person who does not accept and does not adhere to the suggested proposals of therapy. She refuses contraception, for example, mainly the use of injectable contraceptives when necessary. She had three risk pregnancies in this period. In spite of the difficulties, the team provided prenatal assistance, diagnosing and treating syphilis. (Fragments from workers' narratives)

According to a FHT worker, Rosa cannot raise her children. She cannot afford it and her life is too disorganized for her to be a mother. The first daughter is taken away from her when the health team detects a condition of neglect. They request sheltering for her. Subsequently, they tried to ensure that the next children did not leave the hospital with her and went directly to the shelter. In the last pregnancy, in addition to the sheltering of the daughter, they ensure that she undergoes a tubal ligation. (Fragments from the field diary)

In this relationship, the researchers experience a certain "disarrangement", a "discomfort" with what sounds a strong capture of actions in the area of health, when they meet the user, due to the focus on their own logic of a morally operated knowledge. They view the other as their object of action, a reaffirmation of the health professional's knowledge over the other's, a reinforcement of what is considered the 'correct' way of leading life. These are movements that transform differences into inequalities of knowledge and forms of living, where there is asymmetry between the knowledge/power of some in relation to the others<sup>11</sup>. But why is it that, when the worker we have in us meets another person that is very different from himself, he produces effects of control over the other's life? Or can it be that we walk through this choice almost un-



consciously, in a scape from the tensions that symmetric encounters between mutually valid players can generate?

The bet that emerges from the analyses of our research is a movement of inversion of the action that controls and dominates the other's life, which occurs precisely in the field of soft technologies<sup>33</sup>, a territory of deterritorialization that generates noise and can be the driving force of a self-analytical process related to the daily production of care, enabling other relationships. For example, the creation of spaces for symmetric encounters with Rosa. In fact, this is also what is experienced while we walk with Rosa across different spaces of care, when other narratives emerge:

At another moment of life, after the last pregnancy, Rosa starts to make several movements to recover her daughter, trying to meet the criteria presented by the judge responsible for the sheltering. She looks for a job, leave the streets and starts sharing a room with her cousin. She is able to stay abstinent and visits her sheltered daughter. The changes in Rosa's life are noticed by the CRAS professionals, who, at this moment, start suffering with her, when they perceive that the barriers are too complex to be overcome. (Fragments from the field diary)

At this moment, therefore, some CRAS workers put themselves in a position of symmetry in relation to Rosa, walking with her and experiencing events from within the movements of her life. The possibility of understanding Rosa's profile as provisional, constructed in an intensive moment of relationship with the user, enabled the team to see her as a multiplicity under constant production: Rosa starts to be considered a valid interlocutor to speak about herself, her desires and her trajectory. At some moment, the opening to the encounter with the other, considered as someone who is very different from us, happened, potentializing us for acting together with her, producing other possibilities of care<sup>32</sup>.

### **Researchers under (self) analysis: what do the guiding users teach us about bond production?**

We usually look at the processes we experience, either in the daily routine of health work or as researchers, from the outside, as if we mastered the secrets of the other's life. At some moments of our experience with each of the guiding users presented here, we felt the sensation that we had the formula to those teams' action, that we would be more skilled in the production of bonds and shared therapeutic projects<sup>26</sup>. We also made prescriptions and judgements, and it was necessary to deconstruct this place.

In our encounters with the user, we also felt lost at many moments; sometimes we caught ourselves establishing a relationship with the user as the object we wanted to transform, ignoring his/her story; other times - and these were very frequent -, we faced our non-knowledge, as we exemplify below, in our relationship with a guiding user:

Ricardo succeeds in obtaining our adherence to his request of receiving care outside his home! Our actions produce other movements and he finally goes to an asylum, which also made us uncomfortable - after all, we contributed to his "institutionalization". There, he becomes more talkative and feels better. Other



movements happen and we and other individuals involved in the process shift places and, somehow, gradually adhere to his new repeated phrases: “*I want to walk, I know I can walk*”. (...) We gradually realized that, while the workers and we focused on our knowledge - although it was an emancipatory knowledge related to not hospitalizing the patient -, nothing happened. (...) not only focused on our knowledge and formal protocols, but on the extent to which we, health workers, were paralyzed by the familiar representation of that user, so distant from a standard of family “structured” around work as the central element, organized from a dwelling belonging to a fixed territory, considered “a social problem”. Because, being paralyzed, we did not explore the possibilities of production of therapeutic projects based on encounters. We were stuck where users do not fit and lives remain neglected. (Fragments from the field diary)

Little by little, in the encounter with the other’s life and action, we gradually felt in our bodies the sensations that the teams experienced in the relationships they built with the user, feeling the same impotence, the same discomfort. And it was due to the recognition that our knowledge would not be capable of producing care in that situation that we opened our hearing to the proposals that Ricardo made, searching, based on the possibilities of symmetry that were constructed in each encounter, for other logical matrices to provide us with clues. In this movement, together with him and other workers, we saw that penetrating his world contributed to the construction of his shared therapeutic project. It is in the encounter with the other that we can realize that we need him to construct good solutions.

It is likely that, to many workers, admitting this place of “non-knowledge” involves a sensation of professional failure. We prefer to deny it. But our “non-knowledge” can be linked to the insufficiency of the tools that are available to us and that are recognized by science and health organizations as adequate to intervene in situations where the other has to fit in criteria, protocols and assistance flows that are not very flexible. Many authors<sup>6,29,32-34</sup> have already shown the insufficiency of the technologies present in organizations that propose to produce healthcare.

We bet that the point-of-departure for the production of symmetric relations is the discomfort of perceiving our “non-knowledge”, of “feeling displaced, deterritorialized, with a sensation of “I don’t know what to do or what to say”. Obviously, it is not possible to predict what we will do; it is a production that will happen in the act at the moment of the caregiving encounter, which is full of uncertainties<sup>28,33</sup>. In these situations, one solution is to ally with the other (user or worker) to produce possibilities.

Thus, we have brought the concept of symmetry to problematize this situation, which repeats itself in the daily routine of the health services, and reiterate: symmetry does not cancel difference<sup>35</sup> (p.141), but it is possible as a result of difference. However, assuming that this difference does not generate inequality a priori in the relationship, how can we take the other into account, with his way of living, which, many times, causes indignation and repulsion in us? Is it possible not to make judgements and not to have prejudices at the first encounter with an Other who is so different from me? How can we consider his knowledge, place him as a valid interlocutor, and build with him relationships of affectivity and trust, according to the public policy<sup>10</sup>, so that he also acknowledges me as a valid interlocutor and the intercessional encounter takes place?

We also propose that, when we talk about bonds, we often trivialize this concept when we intend to operate it in the daily routine, and we run the risk of producing more barriers than care; more guilt attributed to the user, according to Merhy, “producing subjectifying serialization in the way of desiring and producing life”<sup>35</sup> (p.295).

We propose a shift from the idea of “user’s adherence to the treatment” to the perspective of “team’s adherence to the other’s project”, to focus on the needs identified by the other based on his world and his perspective of how he desires to live.

## Final remarks

The interaction with the guiding users Ricardo, Rosa and Sueli, whose scenes we chose due to the radicalness of the experienced situations, reveals the challenge faced everyday in situations of many intensities and differences related to thinking/feeling in the area of health.

Another common issue in the scenes are the power relations present in the encounter between health worker and user when the latter is a “rebellious” user, that is, he does not have the same project of life that the worker has. Therefore, it seems that symmetry is, beyond an ethical positioning, a political bet, related to changing meanings/proportions of forces in the relationship, and an esthetic bet, as it summons us to open ourselves to the pulsations in front of us during the encounters. It is no surprise that symmetric relations are hard to construct.

Another point is that we tend to desire a standard user, ideal, submissive, who accepts the life we have outlined as the best for him. People who open the door when requested, who open their lives to be thoroughly investigated, who are not rebellious, who follow prescriptions to the letter, who do not interfere, do not question, who adhere to therapeutic plans that were unilaterally outlined<sup>29</sup>.

When they say how they want to be treated and when they resist the instituted offers that are imposed on them, Sueli, Ricardo and Rosa disclose the tensions produced in the services. When we consider that both the worker and the user bring to the encounter their ways of being and understanding life, we can suppose that resisting the “framing” would precisely be the expression of their power and desire to maintain the government of their own life<sup>32</sup>. After all, my resistance is my capacity to decide what I desire for me.

When the Other is looking for help, he already brings with him, between the lines, a proposal, but we rarely stop to listen to it and ask: “What would you like us to do to help you?” When the individual establishes symmetry by acknowledging the other as a valid interlocutor and allows to be affected by the multiplicity of life in potency, he opens the possibility of producing other existential territories based on the desire of walking again, of being a mother, of having other options of care: the bet is that producing bonds means producing more autonomy to subjects, in symmetric relationships and respecting differences.

We propose to think about care management devices that consider workers and users as valid interlocutors in symmetry relationships, disclosing tensions and difficulties in the engendering of transformations. We propose that this is not produced from external norms and orientations; the experience and the reflection on it are the factors that can transform these daily practices and generate new concepts to sustain

symmetric encounters among workers, managers and users. The process of a collective of workers analyzing their practice in the daily routine of the work is conflictive, with different perceptions about what was lived; therefore, it is tense. Due to this, it is necessary to have management devices to strengthen and support workers in this task.

Although the concept of bond in healthcare is, many times, massified, it can be fertilized by an ethical-esthetic-political project that never ends, that puts the focus of the health practices on the health demands and needs of lives respecting their differences, and that potentializes the choices of each user - those that are meaningful to them. It is necessary to avoid making moral judgements, criminalizing the other's desires and choices; it is necessary to escape from the place of knowing what is best to the other, recognizing our non-knowledge and the need of an active action in the attempt to share the production of care among workers and with the user, in a live, symmetric and singular way.

### Authors' contribution

Clarissa Terenzi Seixas, Rossana Staevie Baduy, Kathleen Tereza da Cruz, Maira Sayuri Sakay Bortoletto and Helvo Slomp Junior contributed actively and in an equivalent way to the conduction of the study, discussion of the results, draft of the manuscript, critical review of the content and approval of the final version of the manuscript. Emerson Elias Merhy contributed to the development and coordination of the research and participated actively in the discussion of the results, in the critical review of the content and in the approval of the final version of the manuscript.

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**Translator:** Carolina Siqueira Muniz Ventura

Submitted in 10/27/17.  
Approved in 02/28/18.