

Solidarity, alliance and commitment among healthcare professionals in the practices of the Brazilian Health System (SUS): a bioethical debate

Doris Gomes^(a)

Flávia Regina Souza Ramos^(b)

^(a) Soebras/Funorte (Associação Educativa do Brasil/Faculdades Unidas do Norte de Minas). Rua Rafael da Rocha Pires, 3913, Sambaqui. Florianópolis, SC, Brasil. 88051-001. dorisgomes@bol.com.br

^(b) Programa de Pós-Graduação em Enfermagem, Universidade Federal de Santa Catarina. Florianópolis, SC, Brasil. flavia.ramos@ufsc.br

Taking a bioethical standpoint, this paper aimed to analyze the social need for solidarity, alliance and professional commitment as a challenge within the practices of the Brazilian Health System (SUS). Through a qualitative study of descriptive and exploratory type, 30 subjects were interviewed (nurses, doctors and dentists) in a metropolitan region in southern Brazil. The results were analyzed from a bioethical standpoint through discursive textual analysis. The liberal-contractual framework that is reflected through public assistance reveals social vulnerabilities and gives rise to problems regarding the quality of services, thus suggesting that there is a relational construction preceding the mere contractual relationship: an alliance between equal subjects; a benevolent commitment towards other people who are different and/or vulnerable; and solidarity engaged in constructing a new state of dialogue, in the form of collective clinical excellence. For this, clinical bioethics needs to incorporate these values so as to transform the quality of attendance, which is still contractual and of rationalist, abstract and impersonal type, into new practices of dialogue.

Keywords: Ethics. Bioethics. Health professional.

Introduction

The transformations arising from the restructuring of the world of work have created a new perception of the right to health as one of the achievements of the movement in favor of citizens' rights: there has been a profound breakdown in the concept of the essence of work; and social protections are challenged, daily, by market relationships. The ambiguous treatment given by the State to social policies in the neoliberal context, especially in the 1980s and 1990s in Brazil, clearly reduced the sharpness of definitions in the model for healthcare: the fact that the purely liberal model for healthcare was not feasible translated into the constitutional achievement of the

SUS [Brazil's National Health System], but this has been historically overcome by a greater role for private interests while serving the public interests – in the form of passing through of funds, and management responsibilities, to the private sector.

The dispute between differentiated logics and objectives in this public-private mix is evidence of a duality: one health project – the public system, designed to serve every citizen – coexists with another, that of the insurance industry and of the traditional medical-industrial complex, constantly challenging the role of health as a 'duty of the State'. This can be seen as a process that reflects the broadening of the ascendancy of capital over labor, and the continuous sub-financing of the system, and on which has made the quality of public-sector healthcare into a problem.

The investment in the humanistic repertory of ideas as a policy of the State, especially as from the HumanizaSUS in 2004, aimed to transform this quality into a positive involvement with technological advances: for the professionals it was to mean an exchange of knowledge, spaces for creation, participation as co-managers, and improvement in working conditions¹. This strategy was used to increase the degree of co-responsibility of the various factors of the System, giving priority to non-material over mechanical technology.

However, this new *modus operandi* that calls for new ethical-political positionings on the part of the professionals in taking of decisions and implementing of actions, continues to be 'under construction', as it faces opposition from approaches which, although their aim is to be beneficial, ground themselves on a contract-centered attitude, an instrumental rationality. The contract of the 'liberal-economics' type, which has never been so strongly present as an intermediating factor in human relationships, and is so closely linked to the principle of egotistical individualism, latent conflict and coercion, still prevails widely as the sole possible relationship between individuals – keeping private interest above the mutual respect resulting from cooperation and communicative competence², this also being reflected in healthcare in the public sector.

Social vulnerabilities – marked features of Latin American society, and an indelible presence in the construction of relationships – amplify the problems facing co-production of a dialog-based relationship. When tensions and conflicts are built up between the attitude of dialog and the attitude of instrumental rationality, bioethics is called in to debate a common ground, a point of reference that tends toward the universal and at the same time is beneficial, taking into account those people who are vulnerable, in actions to protect and intervene in a way that expresses solidarity and is sustainable. This article, thus, investigates the social need for solidarity, alliance and professional commitment as possibilities in the practices of the Brazilian national health system (SUS) – looking at these factors from the point of view of bioethics.

Methods

This is a qualitative survey of the exploratory-descriptive type, using semi-structured individual interviews with 30 subjects (doctors, nurses and dentists) who have experience of work in both the public and private sectors of healthcare, in the metropolitan region of the city of Florianópolis, in the South of Brazil. The region has 22 municipalities, the largest population group in the state, and one of the highest qualities of life in the whole of the country. It is a region where there is a strong intersection between the public and private systems in healthcare, including healthcare of high and medium complexity, and is an area where eight municipalities that have a hospital have management by the State (of Santa Catarina). There is a clear zoning of urban space by income levels: Florianópolis, capital of the state of Santa Catarina, attracts populations of a higher income level, followed by its contiguous municipalities – São José, Palhoça and Biguaçu.

The contacts with professionals to seek the initial authorization for interviews were first made with people linked to a Municipal Health Department (*Secretaria Municipal de Saúde*) of the region. Since selection of participants gave a certain priority to people with the characteristics necessary for the knowledge that was being sought, subsequently the interviewees were mainly chosen by the 'snowball method' – where one initial interviewee recommends another, and the process is repeated until saturation is reached. The central objective of the interview was to collect data that refer to the ethical aspect of life as lived by the professionals who were interviewed.

It was in the interests of the study that the institutions studied should be the most varied possible, expressing dynamics and questions that are common to the professional experiences in multiple health services. They covered: 11 experiences in public-sector odontological/polyclinical specialty centers and private clinics/consultancy offices/hospitals; 12 in a basic health unit and a private consultation office/clinic/hospital; 2 in an Emergency Care Units (UPA) of the public sector and a private clinic; and five in public hospitals and private hospitals/clinics.

For analysis of the results, the technique of Text-based Discourse Analysis³ was used – in which the basic approach is to analyze the subjects' depositions into basic units and formation of categories (with the help of the ATLAS.ti software), capturing new elements as they emerge, and combining the meanings expressed into a meta-text, followed by a cycle of critical analysis and validation. The project was approved by the Ethics Committee – CEPESH/UFSC/2461. Participation was voluntary under a Free and Informed Consent Form, and obeyed the conditions for autonomy of CNS (National Health Council – *Conselho Nacional de Saúde*) Resolution 196/96. To guarantee anonymity the participants are characterized by the letter P plus a number.

Results and discussion

“... in the private sector the people who seek your care are usually those who are better informed and more aware - they ask more questions about the diagnosis and treatment, and they demand more - you have to elaborate your replies more, your clinical reasoning. In the public sector the difference that I see is the general public's overall level of real neediness – lack of resources – often even ignorance. They very infrequently question the care and solutions that you provide, they are satisfied by the simple fact of having actually received attention on that day: often people don't want to wait for you to give an explanation – this comes from the patient him/herself – because that person has already waited in line for between four and six hours, so he/she doesn't even question you; the patient adopts what you say as the truth”. (P20)

This line of verbal reporting reveals the assumption of logical premises in daily work that differ between the public and private sectors – in which the professional works with different degrees of autonomy, scientific rationality, coercion and control, based on a particular professional-patient sphere of decision, which goes back to a historic interface between power, knowledge and values. The interlocking involved in the duplication of public and private healthcare service in Brazil creates a relationship of competition in the dispute for the network of services. Among other factors this increases prices, and makes contracting of human resources in the SUS more difficult.⁴ It also causes a change of paradigms in production itself. The professional's often assumes a stance in discursive-relational terms that is foreign to the social dimension of the work, and this directly results from serious structural problems of the system.

“... the lack of time available in the public system makes me very anxious: they keep on asking me for quantity, and sometimes I am not able to say everything I want to. My patients accept my orientations, they return, they do everything just right, they obey me, so much so, indeed, that a patient here who is disobedient or inattentive doesn't come back to me, she will get such a talking-to for having given a four year old boy Danone baby food – such a rap over the knuckles for doing something wrong – that the mother doesn't even dare to come back. Here, I see that there are patients who are badly looked after, not because the professional does not have the capacity, but because he does it just any old way, whereas in the private sector he does it with more zeal, more care”. (P17)

In this verbal report one sees a stance on the part of the healthcare professional that is considered to be of an excellent clinical standard according to the biomedical model in the practices of the SUS: she sees patients at the right appointed times of day, she asks for more time for consultation, she requests tests, and obedience, and she prescribes. This is a clinical typology still linked to a knowledge-power mechanism, in which the connection signifies domination: the truths

contained in the scientific statements operate with effects of power. Following this same biomedical model, another stance is revealed – considered to be clinically distorted by the reported lack of zeal and care – which also exists in the practices of the SUS: the professional who attends, and prescribes, very little, if at all. Both stances sum up one of the main challenges in the construction of the health system: The need for a new relationship of dialog between the various subjects of the health-illness process.

Merhy⁵ says that the attempt to establish the 'SUS utopia', and on life as an inalienable right of each person, is related to the way in which the 'other' is listened to/treated: as an object, or as a subject. Santos et al.⁶, are of the opinion that the commitment of the professional in the construction of the link and of the autonomy, and in the sharing of knowledge and activities, and also in the perception of the reach of the daily practices in emancipation and co-allocation of responsibility, still fall short of needs in actual daily professional working life. Gastão Wagner⁷ deals with the importance of a clinical activity that is widened to meet social needs, and indeed the desires of the patient/user and vulnerable groups, combining the objectivity of the clinical and of epidemiology with a practice of listening to the singularities of the lives of subjects, groups and collective entities.

These new propositions contrast with the persistence of a manner of listening on the part of the professional that is based on knowledge about the patient in which the only thing of interest is what the professional wants to hear, thus laying bare an ethos of free public service rooted in a social reality of enormous inequities, with a focus on class: The 'SUS/dependent/poor' patient/user has less culture and knowledge of his/her rights, and thus has less power of pressure and possibility of access to the courts, a simpler understanding, does not need to be heard, does not want, or only 'obeys' under the coercion of urgency, lack of options, or the waiting line.

"... in the public hospital it seems that the families are more passive, they accept everything that's being offered, it's only in a few cases, which are exceptions, that family members take any position at all. We perceive that the majority of people is content with what is offered, it just seems that there is a great deal more to offer. In the private system, family members are more demanding, they want faster results". (P22)

"In the public system, most usually, it's a person of low income". (P4)

"The patient of a private clinic has a better purchasing power, consequently most of them a better education, they have a better culture, so they also have a different level of demand". (P15)

"In the public system the patient is less demanding than in the private system". (P18)

“It’s clear that there is always that difference that money cannot avoid producing, the person in the private system has a very different vision of everything”. (P10)

Opening up to a differentiated way of listening would seem to have a direct relationship with the demands on the professional’s decision: demands for results, questioning, personal or family pressure, associated with cultural status, and the ‘fetish’ of payment.

Within the concept of a contract, there is a transition to an ethical civility that respects the autonomy of the subject-patient, with a different way of listening to his/her needs/interests. However, the type of listening that is associated with hyper-individualization and market interests confuses the limits between autonomy and purchasing power; pressure from private or family interests; access to knowledge and information; and desire for consumption as a need, creating ethical problems and moral pressure for the professional.

“...in the private system, you have this difficulty that they read on Google and think that they know more than you do, they ask you for a doctor’s certificate for absence from work much more than they do in the SUS, where you can just say no and that’s it. In particular they think that they are paying and they can ask what they want and you have the obligation to provide it”. (P11)

Bioethics is called in to debate problems arising from new social-historical perceptions and experiences. An example would be those related to the utilitarian play of interests, which under market ethics, can now exert some coercion on the professional decision. Based on structuring of bioethics principles in the field of research with human beings as early as the 1970s, these principles in relation to aspects of the professional-patient relationship – autonomy, benefit, justice – are being re-thought. It appears that these principles when operated by clinical bioethics in the format of an individualized contract do not seem to be enough to deal with healthcare in the public-sector environment, which is guided by collective and social values.

Seen under this focus, the allocation of more value to the patient as a co-participant in the relationship goes beyond a simplified paradigm of autonomy as an absolute principle, in the sense of its construction in the relationship, in: (i) a movement between the individual and the whole, contextualized in the contemporary processes of construction of new needs/desires; (ii) the accumulation of capital rather than work; and (iii) the social vulnerabilities that are still very strongly present in the Brazilian reality. Clinical excellence, rather than representing a technical quality resulting from training and intellectual qualification, should meet the social demand, eliminating the discriminatory practices of the human being in the health system.

“... the professional is not listening to the patient, is not paying attention, I think that he feels badly paid – and as a result certain things are not right, they throw the patient from one side to another, not trying to resolve a problem that often would be simple: in the public sector of

healthcare this happens a lot, and it makes me sad. I think that there are professionals who don't know what poverty is and do not respect unsophisticated people who come here". (P 6)

A healthcare with a listening function that does not hear, attention that does not involve, and, normally, does not resolve, suggests that the ideal of professional success as historically reinforced in the liberalizing-private-sector worldview still interferes in work relationships in the public sector of healthcare as a hegemonic practice that does not work in favor of a change of paradigms. Where the rational liberal-economic view is kept as the only possibility, this excludes principles of alliance and commitment as mutual recognition of other beings in the becoming aware of their own identity: There is a need for a faculty of dialog that recognizes the 'you' before the 'I'.

According to Cortina⁸, it is not enough to employ a conception based on the 'I' as a rational individual that would freely choose his/her form of life, without taking into account his/her identity as forged in non-chosen communities; or on a conception based on formal universalism, without perceiving it as an interpreter of meanings that are already shared in communities; or on prioritization of the individual and his/her rights as an extremely valuable capacity of citizenship, without demanding responsibility for this community as an action; nor on the voice of conscience as sufficient for a morality that does not seek to renew social bonds and reform public life in the subject-community relationship.

Thus, the bioethical configuration of a new and necessary relationship between subjects with reciprocal collective/individual rights and duties must go beyond the political-liberal discourse of rights, duties, contracts and interest groups, in the cause of a collective clinical excellence which:

1. Seeks a relational construction prior to the merely contractual relationship: An alliance between equal subjects in the SUS-dependent context; a benefactor commitment to the 'other' who is different and/or has been made vulnerable; and a solidarity engaged in the construction of a new attitude of dialog in the horizon of collective health.

2. Denounces the inadequacy of the market-inspired linking of the 'liberal-economic contract' with the 'how it should be' paradigm of the free public service; rebuilds a horizontalized knowledge-power, with a new integrative meaning, that is interdisciplinary and beneficent; and fosters social ties under a solidarity that is formed in collective action.

3. Indicates the need for solidarity, alliance and commitment as a possibility, which should become real.

"... some patients that come to the primary healthcare unit [*Unidade Básica de Saúde, or UBS*] are not only people with low levels of schooling and purchasing power – there are people of the middle classes who are coming, with a higher degree of knowledge, because this access exists; today there is more care taken than one used to hear about when we were at university, stories of a dismissive attitude to the patient, of the difference of treatment between the private and the public systems. I think that this has a lot of influence, because there are professionals who give

their orientation, and then the next patient is waiting, and they don't concern themselves as to whether the patient understood the orientation or not. But, with this change of public, when the patient does question things – asks for more explanation, asks for more time – the professional is concerned as to whether the patient understood, and this creates a different type of link. The training/qualification has probably changed a lot as well". (P21)

The perception of a greater effect from the 'middle classes' in the improvement of the quality of care in the public health system, as one more demand, seems to be associated with (i) widening of the population's access to health services – to a new access to goods and services for the broad poorer classes in Brazilian society, in recent decades – so that they assume a new stance of being demanding; and (ii) the transitions to the context and understanding of work in post-industrial society. The latter would represent a new organization of production with a new level of communication, information and education as part of the process of restructuring, resulting in new processes of subjectivization, not only for the specialized worker, but generalized to workers in the industrial and service sectors.

Mehry and Franco⁹ point to the possibility of transition to a new paradigm of production in healthcare. This would be made possible by wider self-management of the work in healthcare, associated with the life-work relationship as an act, and with the need for reduction of consumption and costs, a technological inversion centered on healthcare, would superimpose needs/interests of the patient over the inputs and the machinery. The market's investment in managed healthcare has so far tended to draw public attention to professional-centered action. Meanwhile managed healthcare discloses the relationship not in the interests of the professional or the patient, but in the interest of the financial capital as the new controller of the relationship space, creating the figure of an entity that takes care of the interests of the capital, more than of the user.

A relationship change in the meaning of healthcare can already be perceived by the professional in the public healthcare sector, who can relate it, also, to changes in training and qualification. The incorporation of new competencies in the new Education Bases Directives Law (Lei de Diretrizes e Bases da Educação, or LDB), and in the National Curriculum Guidelines (Diretrizes Curriculares Nacionais, DCN), highlights the importance of the student 'cultivating a new relationship with community, based on attention, confidence, respect and on the healthcare itself'^{10:524}. A process that shows the inductive role of the State and of other external factors in strengthening people's autonomy: laws and public policies; the functioning of the economy; culture and values; access to information; and critical capacity¹¹.

In spite of this, the hegemony of instrumental rationality, and some damaging positionings on the part of professionals and teachers, tend to cause the concept of a transformative manner of teaching, that obliges one to think of the need for new spaces of bioethics debate, prior and permanently, in healthcare service, still to appear as some kind of utopia.

“... we sometimes see (the professional) treat patients as if they were garbage – they are in the public health system because they don’t have the money to pay a private healthcare agent” . (P2)

“... the great problem in the public system is that there are some colleagues who make this distinction from the private system ... in the private system a lawsuit has a greater financial repercussion than in the public system” . (P15)

The ideological law of value, strengthened by the emergence of the double tyranny of money and of (dis)information in the restructuring, is gaining space in healthcare and has an indelible effect on the relational singularities, making the excellence of productivity and quality in the free public system somewhat nebulous. The Family Health Strategy, cooperative technologies, and management models of co-management and social participation, assume an anti-hegemonic meaning as humanizing measures, factors inducing in favor of civic values and solidarity that suppose a democratic framework of greater commitment and professional satisfaction¹².

However, great challenges are created in the allocation of responsibility to the professional and his/her involvement with communities and subjects, since the creative potential of collectives comes up against the contemporary means of subjectivation and sociability, which negate the ‘other-ness’ due to individual narcissism and solidarity due to self-sufficiency: the process of work continues to be one of procedure and instruments, and the culture of non-participation persists: professionals do not behave as users-subjects of the process¹³.

According to Adela Cortina², the stimulus that is socially constructed from an individualism in which ‘each one is an end in itself and the others are nothing for him’, normally comes associated with a claimed solidarity and justice. On the one hand, an atomized individual takes care of his/her own health/beauty/perfection in an obsessive way, under contractual relationships in a social environment which in practice separates lives and classes by purchasing power and access to material and cultural goods – including the access to health. On the other hand, there is transmitted an abstract feeling of solidarity, constructor of a perverse cosmopolitanism of ‘internal hypocrisy’ and of ‘uprooting of roots’, which calls upon bioethics to re-think the sense of solidarity.

The reorganization of life and of work on a higher level of civility, through knowledge as a strategy in the configuration of new occupational paths in the postindustrial society, where the social and democratic dialog would be something inclusive, and transformative, coexists with major retrogressions in the combination of the new with the old in employment relations in capitalist societies that are not developed, such as Brazil, where sub-contracting of manpower and functional illiteracy keep a major part of the population excluded from the process of production. This would be a civilizing level, that feeds new forms of immaterial riches such as leisure, creativity, community, etc., but at the same time, inversely, deepens social exclusion and separation¹⁴.

The hyper-preventive and hyper-individualist biopolitical strategy of a self-imposed allocation of blame associated with individual or collective risk, puts pressure upon a good part of the population, making their situation banal, and excluding them, keeping in conditions of subhuman inferiority, and even making their exclusion from the political world of rights and beauties appear natural, as if they were in some way a population-body of a different species¹⁵. This amounts to an invisible and totalizing action that assumes eugenic and racist characteristics, which directly reflect on separatist relationships in health: communication on the basis of dialog appears as a consumer good, or a comfort acquired by some. The individual artificially distanced from the whole, as opposites, is demonstrated, as a reality, in the replacement of social ties by money value.

In the opinion of Sá and Azevedo¹⁶, in the point of view of the salvationist strategies of consumption, of the Brazilian elites, the poor and oppressed are increasingly seen not as real people, having rights and existence, but more as a sort of social residue that has not been absorbed, with which we have to learn to live. Guideline ideas such as solidarity and equity go contrary to the dominant social values and practices, creating a context that is adverse for management in the public health organizations under shared and collective projects. Belonging as they do to different symbolic universes, distinct worlds between professional and patient, they corroborate daily humiliations and symbolic violences to the population is submitted in the public health services.

According to Zizek¹⁷, the biopolicy keeps fractions of the working class in dissociated spheres, apparently made autonomous in developed societies under three components of production: Intellectual planning and marketing; material production; and supply of resources. These would be the fractions of workers that are seeking their identities, each one with their lifestyle and ideology: The informed hedonism and multiculturalism of the intellectual grouping; the regressive populist fundamentalism of the old working class; and more extreme and singular forms of the fraction that comprises the excluded: a process that results in the absence of a universal public space, in which the three fractions can meet.

New professional identities are sought, but this intellectualized fraction of workers shows a greater affinity with capital than with labor. Older relationships of power still strengthen the insertion of the technical-hierarchical role into the professional, who is not perceived as a worker and an equal – although intellectually differentiated – giving an appearance of naturalness to a view of the world that separates people by purchasing power and knowledge, corroborating an instrumental contractual relationship, that is even more distorted in the public healthcare sector, where the segregation by class grouping appears as evident.

Amplified invisible walls between manual and intellectual work, associated with the centrality of specialized knowledge over traditional values, have their effect on relationships in health and make intercommunication more difficult: for the professional who does not have time or desire to build a way of listening that takes the individual into account in the context of his life and

his singularities, and for the patient/user who has a simplified understanding of something prescribed for him in a technical language. At this crossroads, Latin American bioethics is seeking paths that are in opposition to hedonism, amplifying the possibility of a renewed activity of dialog in the dream of the autonomy of the individual, as 'being' and in the sense of 'being more' ... human.

"... it's always a concern that you are treating the patient without thinking about profit – so I think that we are always thinking whether we can do better for the patient of the public health system". (P13)

To cultivate humanizing values in work in the public system as part of a set of universalizable social norms constitutes a sensation of identity for society: Alliance and commitment as an engaged social act. Not only in the interlocution of autonomous subjects, but also people co-participating in established conditions, social realities and vulnerabilities, which implies a social and political responsibility for the professional, in a 'critical understanding of his/her rights and duties as a citizen'^{18:117} acting together with a scientific training and education.

The inter-subjectivity in terms of dialog, under this new perspective, admits the possibility of mutual recognition of beings that have the competence of communication, much more so than the formal purchasing power or knowledge, because it fosters the idea of what is in common, as the motive force of action. Due to its inter-subjective character and, at the same time, its character of cooperative intercession through cognition, communication in language assumes a conceptual-strategic role. However, the decision in favor of construction of a truly significant dialog, assumed as a new professional stance, requires awareness – action and reflection, of a differentiated way of operating, a qualified version of the utopia of social justice, and something contrary to the fatalistic view of reality as unchangeable. On this basis, one cannot maintain the 'other' as a 'thing': On the contrary, one must seek to establish a relationship of permanent dialog for the purpose of re-creating knowledge/awareness, and hence the need for commitment and engagement¹⁹.

A praxis of solidarity on a critical and non-alienated plane, guided by self-government of the professional in his process of live, intellectual and artisanal work, while being inter-subjective-relational and collective, repositions him as an agent of change in his relationships with the world: not a human that is abstract and disconnected from the world, nor a world as absent reality. Based on new loyalties to the subjects of the dialog, reinforced by bonds between humans and persons in a collective and a community, a world of social atoms separated from each other, with links that are merely instrumental and an individual-hedonistic ethical nucleus⁸, is refuted.

According to Barros and Gomes²⁰, happiness takes place in the collective plane, in the co-organization of individuals and of worlds, of ways of working, of managing work and making it subjective. Care taken of one's self as care of the soul, space for thinking, reflection, dialog and meeting with one's fellow human beings, means a constant evaluation of the relationship with

others and with the world, where taking care transforms an act into an attitude: occupation, concern, taking of responsibility and involvement of the affections.

The relational and inter-subjective dimension of work builds unconscious processes and formations with effects on the quality of care, requiring that the professionals have awareness of their own subjectivity, and also actions for change in people. A social capital that is structured as a lasting network of knowledge and mutual recognition, and as ethical values and attitudes centered on confidence, generating reciprocity and cooperation, would seem to resist hyper-individualism²¹, facilitating joint projects, civic virtues and interest in public affairs.

However, it is not just any technique or association that is capable of creating this type of human resources.

“... because it’s very bureaucratic, very separated into compartments – you don’t manage to accompany the patient fully. If the patient has a problem that means you need to send him/her to some specialized sector, you don’t get an answer of what happened with him, because they are patients with vague knowledge, low level of schooling, they don’t manage to pass on to you what happened in that specific sector, and this causes difficulty”. (P21)

There would be a need to cut across the paralysis of bureaucracy and the clientelism, with a positive structuring of the system, with the creation of jobs and salaries that favor working together as a complete group, identity, and the allocation of value; and to assume co-responsibility at a new level, under an alliance that extrapolates from any one person’s single interest in the direction of universal conditions of identity and reciprocity, and also a beneficial and protective commitment – if these things were done, it would result in a new excellence in public clinical healthcare.

Even with structural and organizational deficiencies, it seems necessary to mobilize a collective reflection-action on the experiences of operating as a group, strengthened by the subjects and by the managers themselves, that would cultivate new feelings and repertoires of ideas in terms of teams/the collective, both formal and non-formal. Networks of cooperation and interaction that expand the sense of the ‘I’ within the ‘we’ or which create sensitivity for collective values and benefits, in horizontal relationships, without hierarchy and dependence, stimulate the creative capacity, solidarity and capacity for dialog of the subjects.

“... in the public system the people are more simple, and find things more difficult to understand – everything you explain you have to explain two or three times until the person understands, contributing to the treatment not working. In the private system, the understanding is much better, people have more knowledge and schooling, they understand things more easily”. (P 5)

“... the lower the social-economic level, the greater the difficulty for understanding of the treatment”. (P16)

It does not seem to be enough anymore just to blame the patient or the status quo as a barrier to a communication based on dialog. Dialog as an act of joint creation, without the domination-dominated relationship, cannot be reduced to ideas to be consumed, nor to a warlike dispute by someone trying to impose their truth; on the contrary, its conception depends on the right to speak and to be heard, and is far from mere prescription in the direction of liberation, through a basic connection: professional-patient / user-professional.

Adding together the thinking of Paulo Freire¹⁹ and consideration of work and training, in healthcare, it can be said that it is not enough for the professional to adopt a stance of knowledge as a donation from those who judge themselves wise, to the non-wise, making an absolute judgment that ignorance is something that has always been found only in the ‘other’ – in this model the professional teaches, knows, thinks, opts and prescribes his option, identifies the knowledge with his functional authority and is the subject of the relationship, while the patient is a mere spectator who does not know, does not think, does not opt and must adapt him/herself to the thought, and the experience, that are narrated.

The whole instrumental-strategic communication that centers on the consequences of acting, within the reach of objectives through the manipulatory influences on the decision ‘through arms or goods, threats or seductions’²² (p. 165), needs to be superseded by action that is discursive, considered as the ideal form of communication and cooperative search for the truth: a way of acting that is seated in a knowledge that is proportional and shared inter-subjectively, in a normative agreement and in a reciprocal confidence with grounding in one’s own judgments – autonomous, inter- and intra-subjective – since no collective authority limits the margin of individual judgment. Dialog as an activity with the precise meaning of mutual understanding, in which the subjects seek internally to harmonize their plans of action, pursuing aims in the direction of a common agreement/consensus²³.

The following then are necessary as the guidelines for dialog: (1) recognition of equal right to justification of the thought and to participation in the discussion; (2) equal right for one’s interests to be considered; and (3) commitment of co-responsibility, exercise of concern jointly with the others, so that the pragmatic rights of the possible interlocutors are respected; and the human or moral rights are respected, without which it is impossible to exercise pragmatic rights; and to find more appropriate solutions, promoting institutions that best guarantee these rights².

“... on some things, they don’t understand very well how we would like it to be, they are not very preventive – they are more curative – they only want to resolve the immediate problem”. (P10)

“... there is always a difference in terms of the aspect of education, what the public understands; the time to care for health, to carry out physical activity, to have good diet, finishes up being more expensive”. (P11)

Healthcare centered on the curative-immediate is part of a category of moral conflicts lived through by the health professional that bioethics has the task of thinking through as conflicts that intersperse the quality of life of individuals and populations, which for social-historical reasons do not fully live their citizenship, that is to say, they continue to be socially vulnerable. A line of discourse that would seek to reach a serious agreement cannot leave out of account the interdependence between the right to health and other individual and social rights, with a material and cultural standard of living that makes dialog on the basis of equality possible: *human rights that are legalized and historically made concrete*².

Considering de-humanization as a result of an unjust order that generates violence and results in people ‘being less’, and humanization by de-alienation as an affirmation of ‘being for one’s self’, the act of having solidarity with the ‘other’ is not to discover one’s self in the position of oppressor and suffer for this; it is not only to provide assistance that keeps people tied down to the same position of dependence; it is not to rationalize the blame in a paternal fashion, but to assume the situation of the person with whom one is assuming solidarity, and try to change it. Bioethics, then, should have regard to the ‘process of being’ as a protection of rights and construction of knowledge that do not come into existence fully-formed, but which happen in a new practice of dialog and solidarity: Without isolation of individualism, overcoming the *intellectualism that alienates, the authoritarianism of banks and the false consciousness of the world*⁹.

Following a line of criticism based on the philosophy of liberation, that works with the legitimacy of the ethical-political dream of overcoming the unjust reality, the outlook of liberation of the world from need as the most basic human requirement appears to create grounds for a bridge between the philosophical reflection as abstract universalism and a concrete moral community, since human liberty is not ‘*ab-solute*’ – *separated* and disconnected from everything, but *ob-liged* (Latin *ligare* = to connect), connected to the people and to the things that are part of me, that are valuable in themselves and for this reason are beyond any price, beyond any calculation² (p. 184).

Thus, the idea of health as a quality of life expanded in the direction of the social context as a legitimate field of bioethical studies and intervention²⁴ compels clinical bioethics to incorporate alliance and commitment as values that foster social bonds of solidarity between subjects, committed to transform the quality of healthcare in the public system – still contractual of the rationalist, abstract and impersonal type – into clinical relationships of collective excellence. A change towards acceptance and practice of this new dialog-based clinical practice, guided by a new, different way of listening and looking, with rational argumentation grounded on the consequences of the actions and on the insertion of the professional into a community of concrete

work and life – in which individuals learn to give value to each other, socialize with each other and recognize each other as people – calls for a 'cultural change'²⁵.

Collective processes for taking of decision – in which risks and benefits, strategies and theories are weighted – and as a practical tool for teaching the construction of autonomy²⁶, expand the sense of protecting and intervening as an action of that protection, to achieve autonomy in a positive orientation of social action, that surpasses frontiers: in the relationship between equals, the relationship between professional and management, professional and patient, professional and community, and between individual and society as a whole.

For this purpose, the construction of collective bioethical spaces that take decisions, are democratic, operate between and across disciplines, that apply to clinical practice as a factor really making public ethical problems in the professional-patient relationship – until then a private act – and, also, as a space for permanent education/qualification, appears to strengthen values such as alliance, commitment and solidarity in new dialog-based paradigms in the practices of the SUS. The bioethics of protection, then, transforms itself into intervention, when its critical involvement in a reality results in emerging action, since 'reflection, if it really is reflection, leads to action in practice'¹⁹ (p. 73).

Conclusion

Public policies and the logic of social need interact with complex and contradictory realities that point to the challenge of restoration of social bonds to a place beyond the desires of consumption constructed by the market and by the contractual-biomedical knowledge-power relationship, building a new dialog-based relationship between professional and patient as a new standard of clinical excellence in the practices of the SUS. Bioethics, as a discipline that brings together theoretical knowledge of applied ethics in a context of taking of decisions, emerges as a necessary area of debate.

In a movement that is contrary to the hegemony of individualizing injunctions of the contemporary model of atomized society, expanding spaces for bioethical debate would strengthen the dialog-based quality of interaction between the patient, community, the professional and the service, and to stimulate changes in values, with incorporation of alliance, commitment, and solidarity – especially in a region like the metropolitan region that was studied, which has a strong interlocking of interests and a substantial relational disconnect between the public and private systems.

Collaborators

Doris Gomes worked on the conception and drafting of the article; Flávia Ramos worked on the critical revision of the article.

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