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COLONIALISM IN THE RELATIONSHIP BETWEEN WORKERS AND SERVICE USERS DURING CARE PRACTICES: IMPLICATIONS FOR COMPREHENSIVE CARE

Colonialismo nas relações entre trabalhadores e usuários durante as práticas de cuidado: implicações para a integralidade da atenção

Colonialismo en las relaciones entre trabajadores y usuarios durante las prácticas de atención: implicaciones para la integralidad de la atención

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ABSTRACT

Objective: To report on the relationships between the workers and service users and the implications of these for continuity of care. **Methods:** Qualitative research, undertaken based on a case study, between February and July 2012. The subjects were health workers and the users of a Family Health Unit(FHU). Participant observation, interviews and document and record searches were made. **Results:** Instances were evidenced in which the team generalizes the service users, which disregards their uniqueness; this dismisses the service user, revealing the fragility of the comprehensiveness of the care. **Conclusion:** There are implications of colonialist relationships which consider the service users as objects, affecting the continuity of the care. The nurses' participation in the processwas revealed, emphasizing the need to deepen reflection in regard to professional practice.

Keywords: Patient Participation; Continuity of Patient Care; Unified Health System; Nursing; Comprehensive Health Care.

RESUMO

Este estudo objetivou relatar as relações entre trabalhadores e usuários e suas implicações para a continuidade do cuidado. **Métodos:** Trata-se de uma pesquisa qualitativa, desenvolvida a partir de um estudo de caso, de fevereiro a julho de 2012. Os sujeitos foram trabalhadores de saúde e usuários de uma Unidade de Saúde da Família. Realizaram-se observação participante, entrevistas e buscas em documentos e registros. **Resultados:** Evidenciaram-se momentos em que os usuários são generalizados pela equipe, que desconsidera sua singularidade; isso desqualifica o usuário, revelando a fragilidade da integralidade da atenção. **Conclusão:** Há implicações das relações colonialistas que consideram usuários como objetos, afetando a continuidade do cuidado. Descortinou-se a participação de enfermeiros neste processo, reforçando a necessidade de se aprofundar a reflexão acerca da prática profissional.

Palavras-chave: Participação do Paciente; Continuidade da Assistência ao Paciente; Sistema Único de Saúde; Enfermagem; Assistência Integral à Saúde.

RESUMEN

Objetivo: Relatar las relaciones entre trabajadores y usuarios y sus implicaciones para la continuidad de la atención. **Métodos:** Es una investigación cualitativa, desarrollada a partir de un estudio de caso, de Febrero a Julio de 2012. Los sujetos fueron trabajadores de salud y usuarios de una Unidad Salud de la Familia. Se realizó la observación participante, entrevistas y búsquedas en documentos y registros. **Resultados:** Fueron evidenciados momentos donde los usuarios son generalizados por el equipo, que desconsidera su singularidad; descalifica el usuario, revelando fragilidad de la atención integral. **Conclusión:** Hay implicaciones de las relaciones coloniales que consideran usuarios como objetos, afectando la continuidad de la atención. Fue revelado la participación de enfermeros en este proceso, reforzando la necesidad de mayor reflexión sobre la práctica profesional.

Palavras-clave: Participación del Paciente; Continuidad de la Atención al Paciente; Sistema Único de Salud; Enfermería; Atención Integral de Salud.

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INTRODUCTION

Comprehensiveness is a structuring conceptof the care in the Unified Health System (SUS), although its polysemic character involves non-fragmented care practices as much as continuity in the various services which became necessary. The service user's participation in the construction of his or her therapeutic project is a condition for individualization in the health services and actions. The workers' and managers' conception of the service users, however, is of their being an object, a generic being, without peculiar characteristics. This is observed judging by how they organize the services or carry out the health actions, without incorporating human or social aspects allied to the health-illness process. The Brazilian citizen, with a Federal Constitution which presupposes universal, comprehensive and equal access, does not find services which cover this right.

The issue which needs to be faced is the failure to recognize the service user as a citizen and participant in the process, which can be called colonialism, revealed in "the ignorance of the reciprocity and in the inability to conceive of the other except as an object"[1:81]. The health workers impose their knowledge and their perspective on the service users and do not recognize them as subjects, thus perpetuating a relationship of submission.

Studies which address the relationships between health workers and service users indicate that this is a field which remains open to reveal the implications in the continuity of the care[2,3]. The participation of the service user in her care has occurred without some essential elements, among which is the explicit encouragement on the part of the health professional for the patient's participation, and the valorization of the service user's right to perform an active role in the decision-making[4]. This practice could strengthen the service users' autonomy and co-responsibilization in the therapeutic approach chosen.

The experience with teaching, research and extension activities in the Family Health Strategy (FHS) Units in Santa Maria, Rio Grande do Sul, Brazil, allowed the authors to observe that the service user's need is often translated by a referral to another service of the Health Care Network (HCN) without the service user's participation. By HCN is meant the integrated coordination of health actions and services of differing technological densities, which seek to ensure the comprehensiveness of the care[5].

The comprehensiveness is permeated by the relationships, in which the appropriate attention to the service users' needs is given, promoting ways of acting in health which are radically dedicated to the "production of life"[6:100]. This article is based on a doctorate study, which focused on the following question: "how can the aspects related to the negotiating and the shared decision-making between health workers and service users during care practices in a Family Health Unit (FHU) put into effect the continuity of care in the HCN of the municipality of Santa Maria?".

This article's objective is to report the relationships between health workers and service users, and the implications of these for the continuity of the care.

LITERATURE REVIEW

Co-responsibilization between health workers and service users in the care practices.

Among the characteristics of the care practices for achieving comprehensiveness is that of their being undertaken as teamwork, with complementarity and interdependence of the actions so as to provide comprehensive and resolutive care[7]. The comprehensiveness also presupposes co-responsibilization between health workers and service users and thatthe local management should take place in a cooperative manner between the territory's multiple social actors[8]. The responsibilization evokes the issue of the relationships between the health workers and the service users, a space in which the promotion of citizenship can occur.

Citizens' participation is inherent to public policies in societies which valuedemocracy highly. The historical Brazilian process of recognizing rights is permeated by gaps of access and participation, not limited to health. Emphasis is placed on the service user's participation, through the consequences of the demographic and epidemiological transition which increased the incidence of chronic health problems. The service user's participation in the decisions regarding her health is urgent, as it is a condition for the co-responsibilization and construction of individualized therapeutic projects (ITP)[9].

The continuation of colonialist relationships in the health services, denyingthe proposal of the subjects' emancipation, impedes co-responsibilization, as in order to include the service users in the decisions, it is necessary to de-colonize minds and to share knowledges[1,10]. Decolonialization occurs when the health worker perceives the service user as a subject, rather than just as a body. The construction of the continuity of the care in a responsibly-shared way will leave Utopia when there is an understanding that the service users and "the social groups have the right to be equal when the difference makes them inferior, and the right to be different when equality de-characterizes them"[11:12]. The recognition of the service user as having the right to be different must be a guiding principle of the care practices, above all given the magnitude of the chronic conditions.

Shared decision-making is also fundamental to adherence with and continuity of the treatment. The shared decision is related to the dimensions of the patient-centered care, among which are: the biopsychosocial perspective of the service user; the understanding of the user as a person with rights (citizen); responsibility and power shared between the health worker and the service user; construction of the therapeutic alliance and understanding the health worker as a person, rather than merely as a qualified technician[12].

Interlinking the principles of Primary Care (PC) and of the FHS with responsibilization, negotiation and shared decision-making becomes necessary to take forward equal access to the SUS and to truly make it a right of citizenship. The history of health reform in Brazil originated articulated with the democratic movement in the mid-80's and culminated in the proposal of democratic instruments as the social control in the management of public policies.

METHOD

This is qualitative research, undertaken based on a case study. A case study "investigates a contemporary phenomenon in depth and in its real-life context, specifically when the limits between the phenomenon and the context are not clearly evident"[13:39]. The five essential components of the case study were covered: the study's questions; proposals; the unit of analysis; the coherence which unites the data to the proposals, and criteria for interpretation of the data.

The unit of analysis, or "case", was a FHU in Santa Maria, which is located in the center of the state of Rio Grande do Sul and has a population of around 261 thousand inhabitants. In the FHUs, there are 16 FHS teams, each team being composed of doctors, nurses, nursing technicians and Community Health Workers (CHW). In five units there are oral health teams - a dentist and Dentistry Assistant (DA). One team works in two rural FHUs.

The unit of analysis studied is a FHU with two basic teams and an oral health team, establishing the case's spacial limit[13]. The nurses, nursing technicians, dentist and DA joined the FHS by passing the public examination held in 2011. The doctor worked on a temporary contract of provision of services, as through the public examination it was not possible to fill all the vacancies for FHS doctors in the municipality. The CHWs had joined through the public examination held in 2008, although the majority had already been working as contracted CHWs prior to this. In addition to the health professionals who work in this FHU, there are also: one receptionist, who started working in the unit as a cleaner and, over time, took on the role of receptionist; one staff member who did the unit's cleaning, and on the afternoon shift also took over reception duties; and the unit's coordinator, a position bestowed by the municipal government.

It is stressed that case studies "are generalizable to the theoretical propositions and not to the populations"; therefore, the FHU is not being considered as a sample for the other FHS in Santa Maria[13:36]. The objective is to expand and analytically generalize the results.

The data collection met the three essential principles, which are: the use of multiple sources of evidence; the creation of a data-base, and the maintenance of a connection between these evidences[13]. The following were undertaken: observation, interviews with the workers and service users, and searches in documents and records held in the information systems.

The observation carried out was of the participant type, unstructured and direct, undertaken during periods in which the FHU was running, principally during care practices. Care practices were considered to be all the actions which involved the meeting of health workers and service users. Team meetings were also observed, as were meetings with the community and meetings between team members which occur informally during the work shifts.

It is worth highlighting that in order to describe the observations, efforts were made to be thorough, detailed and dense, attempting to capture everything that was happening during the periods observed. With the field diary constructed in this way, the analysis was facilitated, minimizing conventional thinking[14]. In order to increase the reliability of the data observed and to avoid partiality, the researcher was always accompanied by auxiliary observers who had received training beforehand. The field diaries were prepared by the researcher and the auxiliary, being later compared and discussed so as to ensure more faithful representativeness of what was observed. The periods observed made up a total of 76 hand 25 minutes. The time limit for data collection, therefore, was from February to July 2012.

The interviews were held with the two nurses, two nursingtechnicians, one doctor, one dentist, one CHW, with the DA, with the general services assistant, with the FHU's coordinator, and with four CHWs. Also interviewed were six service users who, during the data collection period, were referred to another point of the HCN in Santa Maria, making a total of 19 interviews.

The documentation analyzed consisted of the team's record books, team reports, management reports from the Municipal Health Department, appointments of the referrals and letters received. The documentation was used with care, not being taken as literal records of what had happened, it being remembered that the documents had not been re-typed for the research but rather for another, specific, purpose[13].

The study analysis was conducted so as to seek aresponse to the research question and to the objectives established, along with the theoretical approaches, which are constantly updated. Additionally the data collection, mediated by theoretical guidance,with established assumptions, guided the analysis[13]. The analytical strategy was the elaboration of the research's corpus. The research's data was revisited various times, allowing the identification of important landmarks for guiding the analysis and avoiding *a priori* interpretations.

In order to ensure and value ethical conduct during the research process, the advice and provisions of Resolution nº 196/96, of the Ministry of Health, were taken into account. The project was submitted to UNIFESP's Research Ethics Committee and was approved, under protocol nº 1939/11. Participation in the research occurred based on the subjects'

acceptance and was confirmed through the participants signing the Terms of Free and Informed Consent. The team decided in a meeting that codenames should be first names. The service users also chose this option. This article uses the initials of the codenames.

RESULTS

The thematic axis presented in this article reports times at which the service users were generalized by the team, which disregards their uniqueness. In these situations, it may be perceived that the health professional does not commit herself to the overcoming of the difficulties which the patients present, indicating sometimes the perspective of equal treatment, and sometimes the common knowledge, judgmental view in relation to the population's needs.

> *[...] one Wednesday morning, Nurse F attends a woman in the reception area who wants to change the form of the antibiotic (ATB). Her 24-year-old daughter had had an appointment that morning and had been prescribed tablets of ATB, and the mothersays that it needs to be in the form of a solution, as her daughter cannot manage to swallow the tablet. First, the nurse says that it cannot be changed because she doesn't know the equivalent dosage of the solution. This question dealt with, she says that it is necessary to collect a new prescription. The mother says: Can't you give me just a single bottle, tomorrow I'll come and get a new numberand change the prescription. Nurse F: I cannot provide ATB without a prescription, tomorrow (as on Wednesday afternoons there is no attendance and it's now 11 o' clock and there isn't a doctor present any more in the FHU) come back and get the medication. She asks what the daughter has. Thelady answers that she has a discharge from her ear. The researcher (speaking only to the nurse): you can leave her another 24 hours without ATB, I have a child, I know what it this is like. Nurse F agrees to provide it, and asks the lady to return the next day to collect the prescription, as she will be owing for it.After the lady goes, Nurse F says: I can't accept that a person 24 years old can't swallow a tablet! (Field diary, 05/16/12)*

> *(Team meeting) CHW J talks about a separate case of abused children and that the Council of Guardianship left them with a sick person who is unable to look after the children. Some CHWs say that contraceptive injections should be given to all these women. Researcher: it's not okay to generalize. CHWS agrees. ACS D says: if I were the President, I would decree this. (Field diary, 05/30/12)*

Some of the team's verbalizations suggest the degree of disqualification to which the service user is subject, referring to the service users as "loonies" (Field diary, 03/12/12), and "hypochondriac" (Field diary, 03/23/12). One CHW provides an example, highlighting that the team lacks a singularized view.

> *Look, I'll tell you, there's a lady in my area who's invented every type of illness there is, she's gone to them all - angiologist, cardiologist, neurologist, now she wants to see an otolaryngologist [...]. This is what I see that the clinic lacks, it's that they don't offer anything, the FHS doesn't offer anything, it doesn't offer a group, it doesn't offer recreation, it doesn't offer anything for this type of person [...](Interview CHW J)*

The issue is to discuss the relationship which exists between the disqualification of the service user and the lack of individualization. When the problem, for the team, is that the service user is wrong, it does not mobilize to resolve the case. This reveals a limitation in the professional training and work, which works with a generic subject who should accept what is prescribed.

> *(Interval between doctor's consultations) Nurse T comes in and talks about a pregnant patient who was visited by CHW A, who is dizzy and uses captopril and hydrochlorothiazide and is obese. [...] Shall I refer her to the Obstetric Center? She's really high risk! She didn't come to the last check-up, she didn't do the ultrasound. Doctor: is she one of those? Nurse T: She is. I told her in the last check-up that she has too many children, not in those words, but I told her, and she said: I want more children! [...] Later, Nurse T returned to the doctor's office and said: I rang that pregnant woman, she said it (the dizziness) had passed. The researcher suggests a home visit. Nurse T says: but she has to come here too, she didn't come to the check-up. (Field diary, 03/15/12)*

During a doctor's appointment, with the aim of reinforcing the correct use of the medication prescribed by a cardiologist, the health professional uses a personal example, citing her own esthetic treatment.

> *(Doctor's appointment) Doctor: I also take coconut oil, linoleic oiland collagen, in the morning this too, at mid-day (cites them all again) and at night (cites them all again), and do you see me complaining? No, because it they're for my health, I have to take them. (Field diary, 03/01/12).*

The health professional did not use her knowledge to clarify the benefits brought by the medication prescribed

by the cardiologist -which could increase the degree of the service user's autonomy and help in her adherence to the treatment. On the contrary: she compared a post-infarct treatment to one for esthetic treatment, absolutizing the service user's ignorance.

At the end of the shift, the nurses commented on the case of a pregnant woman who mentioned during the nurse consultation observed that she was taking ferrous sulphate with milk. They say that she had been treated for verminosis and syphilis during the pregnancy, and that only now had she received a negative result for the test, and that that was the major concern. Nurse F says that since the first consultation they advised her that the ferrous sulphate is to be taken with juice and "she can't be bothered" with which the other nurse agrees (Field diary, 03/26/12). CHW J talks about the lack of knowledge of the context.

> *Researcher: our health professionals, here inside the FHS, what could they do differently to help in this regard? CHW J: (silence) Well, these things make me really confused, because first of all, you have to be familiar with the people's context, and knowledge of that, here in the clinic, is unusual. (Interview CHWJ)*

At some points, the service user is also subject to value judgments. It is considered that this impedes embracement by the team, as when the moral question is not involved, the team embraces the same person.

> *(In the reception area, 3 p.m) A mother arrives, whose child has had fever and vomiting since morning. Nurse F says that the doctor doesn't attend more than 15 patients and that there's no point in insisting. She also states that this is neglect on the mother's part, that she had all day to do something for the child to get better and it's only now, at three p.m, that she turns up in the FHU. (Field diary, 04/19/12)*

> *It was ten past four in the afternoon and the consultations with one of the clinical doctors still hadn't finished. A young man turns up and asks to be seen by a doctor. Nurse F: What happened to you? Young man: A nail went into my foot twenty days ago. Nurse F: Who is your community health worker? Young man: It's that I don't live here, I just work here, I took this medication (cephalexin) and the doctor there made an incision, but I think she didn't cut enough, now there's a lump and it really hurts. Nurse F: C (the technician) take him for the dressing, and I'll be right there. We arrive in the dressing room, Nursing technician C is examining his foot and says: there's a hard ball here, it seems like...how do you say? Nurse F: Is there pus coming out? Technician C presses a little and says: Yes, there is. [...] Nurse F: Come tomorrow morning and get an appointment with the doctor, you have to arrive at seven-thirty. It starts at eight, but there's always a line, but tomorrow there are two doctors, you'll manage. (Field diary, 03/29/12).*

In this case, the service user lived outside the unit's area of coverage, had arrived outside the FHU's opening hours, and even so the nurse and the technician assisted himand responded to the case.

> *(Consultation with Doctor [...] Female patient: But how can I feel weak, being this size? (overweight) Dr: Being fat is not healthy -on the contrary, it's an illness. What sort of things do you eat? Do you eat a lot of pasta, potato? You have to eat more fruit, greens, meat, milk. Patient: But that is what I eat, I don't eat much pasta. [...] Service users leave. The Doctor says: I can't believe that she eats what she says she eats, she's anemic and overweight, and doesn't like pasta? This is the result of empty calories. (Field diary, 03/15/12).*

The doctor does not believe the service user - once again, the patient's life history is disregarded, as other possibilities regarding eating habitswhich may be determining the overweight and anemia are not discussed.

DISCUSSION

The pattern of the team's relationship with the service users suggests that there is no space for the latters' participation in the decisions regarding their therapeutic proposals, crystalizing processes of submission, abandonment of treatment and fragmentation of care. It is necessary to discuss the interfaces which result from these relationships as well as the conception which the worker has of who the service user is. The problematization of this issue aims to shed light on possible ways for transforming this panorama. This being the case, it is necessary to treat this issue by includingthe whole of society, and not just the team studied, speaking of "us" and not "them".

The results indicate that there is a normalized view of the service users, in which all need to behave in the same way, a standard of behavior being required of them. This view strengthens the prescriptive pattern of attendance, in which the emphasis is onthe repetition of the indication and not on ascertaining the reason why there was no adherence. Emphasis is placed on the colonialism present in the relationships, which influences the health practices and the continuity of the care. "Recodifying as order", colonialism implies the conception of the "knowledge as a principle of order over things and over the others", making it difficult to recognize the other in the condition of subject[1:79].

Corroborating the above, it is necessary to be clear that each person is unique and must be recognized as such in the health actions, due to the fact that[15:67].

> *Although the world is a common land for all, those who are present occupy different places in it, and the place of one cannot coincide with that of another, in the same way that two objects cannot occupy the same place in space.*

Human plurality, defended by the author, bases the defense of the uniqueness on the difference. It follows from this that the health worker cannot occupy the service user's space in decisions regarding the latter's life, and that this does not authorize the formerto subjugate the latter. The subject has an explanation for her illness and for her life, and it falls to the health professional to know how to listen and take these elements into account in the construction of a ITP[9]. The construction of a project, whose objective is evendecided upon collectively, eliminates prescriptiveness from the health action, in the sense of an authoritarian act, "an imposition of the option of one consciousness upon another"[16:18]; in the case of health, the consciousness of the health professional upon that of the service user. Bear in mind that here the issue is not exclusively the prescription of medications, an act restricted to some professionals, but is rather all the recommendationsprescribed. Acting, in health, remains limited to a hygienic aspect, prescribing the service users' lives.

For the project to be decided with the service users' participation, it is necessary to exercise listening, as a mediator of dialog, which is only possible between equals. Listening is born from how the agent of care cares, is entailed in the things which she does, making it possible to identify innumerable ways of listening which characterize different care approaches. Sensitive listening, for example, does not measure, does not compare, and appreciates the differentiated placewhich each subject occupies in the social relationships[17]. When the worker considers herself the owner of the knowledge, she does not permit dialog to take place, and ends up oppressing. Placing obstacles in the path of dialog, transforming the subject into a thing, is the objective of the oppressor[16]. Thepossibility of revealing this relationship occurs due to the fact that it is "in the action and in the discourse" that the human being shows who he is, revealing "actively his personal and unique identities, and presenting them in the human world, while his physical identities are revealed". This revelation of "who" somebody is "is implicit in everything that is said and done"[15:192].

With this understanding, one should reflect that "only to the degree in which" the subject is aware that she is hosting the oppressor within herself can she "contribute to the delivery of liberating pedagogy".

> *The struggle for humanization, through free work, through de-alienation, through the affirmation of humans as people, as "beings for themselves", would not have meaning. This is only possible because dehumanization, even though a concrete fact in history, isnot a destiny bestowed, but is the result of the unjust "order" which creates the oppressors' violence, and this, being less[16:16].*

The humanization of health work needsto roll back the "lesser being" of service users who, in a FHU, have their lack of knowledge mocked and their life history disregarded. It is appropriate here, based on the author's proposal, to indicate some elements for overcoming the dehumanizing relationship in health. The first is that the oppressed person needs to recognize that he has a dialectic relationship with the oppressor, but the oppressor also needs to recognize himself as such. However, even suffering with this recognition, it is not enough to be in solidarity with the oppressed person; true solidarity is necessary, which only happens when "his gestures cease to be cheesy and sentimental, with an individual character, and become an act of love to the others"[16:20]. It is not in the abstraction that one develops solidarity, it is in the actual human being, in the service user who has not been embraced, in the link which has not been built, in the worker who does not self-govern. To act in a concrete situation avoids the summary affirmation that the human being is free, that she can make her choices, without doing anything to make this assertion an objective. Besides recognition, it is essential that the liberating praxis takes place. The subjectivity, therefore, cannot be disassociated from the objectivity, under the penalty of both losing the importance and falling into an ingenuous oversimplification.

The solidarity is the knowledge acquired "in the process, always unfinished, of making ourselves capable of reciprocity through the construction and recognition of the intersubjectivity". The prominence of the solidarity transforms the community "into the privileged field of emancipatory knowledge". The community "is a symbolic field in which are developed specific territorialities and temporalities which allow us to conceive of our neighbor in an intersubjective web of reciprocities"[1:81].

The objective reality is not the result of chance, but rather is the fruit of human action, and is also not transformed by chance, it is a historical and human task. The greatest challenge is to make the domesticated context emerge, which is only possible through authentic praxis, which operates in a dialectical relationship between action and reflection, acting on the world to transform it. For this, critical integration is necessary, which flees from the subjectivism and objectivism, avoiding immobilism[16].

The immobility occurs when the subjectivism creates an imaginary reality upon which it is impossible to act. The critical insertion, which is the action itself, cannot occur without the subjectivity-objectivity dialecticity. This dialectic unity creates "a correctacting and thinking in and about the reality to transform it". The more "the popular masses reveal the objective and challenging context upon which they must address their transformative action, the more they are "inserted" in it critically"[16:22].

In order to insert oneself critically, there are difficulties to do with the antidialogical matrix. In the obstacle to the dialog, every imposed word is a false word, of a dominating character. Also in this list of domination, there are prescription, labelling, the "deposit", leading, manipulation, which cannot be part of transformative praxis. The dialog with the oppressed masses is a condition for the authentic revolution, which is what differs from military coups. However[16:73],

> *Not all have the courage for this meeting, and we are enriched in the mismatch in which we transform the others into pure objects. And, as we proceed in this way, we become necrophiles instead of biophiles. We kill life, instead of nourishing life. Instead of seeking it, we run from it.*

It is contradictory to think that in the health practices which presuppose the care for the other, one can be "killing life", in obstructing the dialog and the service user's participation. Dialectically, however, the health worker can constitute a "lucid leadership" which is capable of transforming the reality. This leadership does not nominate itself, it "authenticates itself in its praxis[..], never in the mismatch or in the dirigisme"[16:73].

Behind lack of dialog, there may be the myth of the "absolutization of the ignorance", in which somebody decrees that the other is ignorant. With the decree done, there is distancing from the people considered things, dismissed. The health worker, considering the service user to be ignorant, "recognizes himself and the class to which he belongs as those who know or were born to know. His word becomes the "true" word, which imposes or seeks to impose on others. And these are always the oppressed, robbed of their word"[16:75].

The consequence of the estrangement is the disbelief, much emphasized in the research, in which the health workers do not believe the service users and these in their turn know thisand the CHWs, sometimes, set themselves as spokespeople, intermediating the dialog. The disbelief which the worker feels for the service user, in this case, can make dialog impossible[16]. Another antidialogical characteristic is the cultural invasion, in which knowledge is imposed on folk knowledge. Society -this including the family and school, added to a classist position, may be producing in the majority of professionals the adherence to an antidialogical action. Based in this conviction, they believe that they need to "transfer", "take" or "deliver" their knowledge to the service users, as promoters of health. They consider it absurd to need to consult them, much less to respect their view of the world, acting as dominators[16].

When the invaded express some attitude which can be interpreted as a refusal to be invaded, seen in the research as absences in the consultations, in the appointments, in those who do not comply with the advice given by the professionals, the latter see them as "lazy" and "ungrateful". It is necessary to problematize the relationship existing between the failure of the actions proposed by the professionals and the violent act of invasion, not in a simplified relationship of cause and consequence, but in a complex one.

The cultural action with a dominating character is not always exercised deliberately; the health workers too are equally dominated human beings, overdominated in their own status of the oppression. For the professionals to break with the pattern of domination is far from easy, as renouncing it means to die a little[16]. The previous author emphasizes that the revolutionary leadership needs to problematize this and other difficulties *with the* oppressed, so that we can advance in the collection of ideas of the social transformation, proposed by the promotion of health.

The idea of health promotion is related to the positive conception of health, related to the area of promotion of the life which needs State policies, but also the subjects' autonomy and uniqueness. Promotion involves that of strengthening the individual and collective capacity to deal with the multiplicity of conditioning factors of health, and goes beyond a technical and normative application. The construction of ability to choose is implicit in this concept, as well as the use of the knowledge to be alert to the happenings' differences and uniquenesses[18].

In addition to this, health promotion has the potential to overcome the banking education and the behaviorism, as these do not respond to the complex relationships of the health-illness process. Recognizing the importance of human agency, which is psychological empowerment, associated with social empowerment, which is concerned with confronting the social inequalities and making efforts such that the strategies and actions utilized may not be reductionist, leading "to the blaming of the victims of social ills in hyperdimensioning the individual responsibility regarding the health problems"[18:2032].

To finalize the discussion regarding the existence of colonialism in the relationships, one should emphasize the fact of this being a Brazilian context, revealed based on a case study in a FHS, but generalizable by exemplification[1], one can say that the point of view, or ideology, which molds the relationships revealed in the research goes beyond the subjects involved. It is necessary to construct knowledges which promote solidarity, as "the knowledge as solidarity aims to substitute the object-for-the-subject forthe reciprocity between subjects"[1:83].

FINAL CONSIDERATIONS

In the search for answers to the research question, a colonialist pattern of relationship was found, in which neither the worker nor the service user is recognized as a subject. The respect for human plurality is defended, which allows us to be unique in the difference and does not allow us to take another's place, that is, a health worker cannot speak or decide for the service user.

The listening becomes essential, with the service user's participation being deliberately encouraged, to promote the escape from oppression. There is a dialectical relationship

between the oppressed and the oppressor, which is compromising the humanization in health; the need to leave immobilism is defended, reflecting on this, but also acting. It means acting in the concrete reality so as to transform it, and betting on the health worker with an expectation of a leadership which defends life.

It is necessary to invert the order of cultural invasion for that of the promotion of health, that is, to leave the position of knowing what is best for the life of the other, and defending the conscious participation of the other in the paths of her health and the health of her community. For this, it is necessary to respect and encourage the subjects' ability to choose, without hyperdimensioning the individual component in the illness, and principally without blaming him.

The context studied reveals the fragility of the comprehensiveness of the care, compromised in the microspace of the meetings between worker and service user. There are implications of the colonialist relationships, which consider the service users as objects, affecting the continuity of the care. The whole team is involved in the process, including that of nursing, strengthening the need to deepen reflection regarding the professional practice.

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