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Integrality in the health care perspective: an experience of the Unified Health System in Brazil

La integralidad desde la perspectiva del cuidado en salud: una experiencia del Sistema Único de Salud en Brasil

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ABSTRACT Starting with a discussion of the biomedical model and its implications in the shaping of healthcare professionals and health practices, this article analyzes the concept of *integrality* as associated with the Unified Health System (SUS) [*Sistema Único de Salud*] in Brazil. Particular attention is paid to the disputes regarding the meaning of integrality and the ways of putting the concept into practice in everyday health care work. Based in a research study conducted at the national level, the authors suggest two aspects crucial to fostering *integrality*: an ethical-political project founded in the recognition that other people's lives are worthwhile and enriching; as well as the existence of additional spaces conducive to discovering diverse ways of producing life, in which *integrality* in health care is also possible and powerful. The authors affirm the relevance of this process as a contribution to the continual construction of the SUS in Brazil.

KEY WORDS Integrality in Health; Health Systems; Health Services; Humanization of Assistance; Brazil.

RESUMEN A partir de un debate en torno al modelo biomédico y sus desdoblamientos en la formación del profesional de la salud y en las prácticas de salud, se retoma el concepto de *integralidad* vinculado al Sistema Único de Salud (SUS) de Brasil, en particular, a las disputas sobre sus significados y a su puesta en práctica en el trabajo cotidiano en salud. A partir de una investigación realizada en el ámbito nacional, los autores señalan que para gestar la *integralidad* resulta necesario tanto un proyecto ético-político sustentado en el reconocimiento de que la vida del otro vale la pena y nos enriquece, como otros espacios favorables para el descubrimiento de diferentes producciones de vida, en los que también es posible y potente la *integralidad* del cuidado en salud. Los autores concluyen que este proceso es pertinente para avanzar en la constante construcción del SUS en Brasil.

PALABRAS CLAVES Integralidad en Salud; Sistemas de Salud; Servicios de Salud; Humanización de la Atención; Brasil.

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INTRODUCTION

> Life is the art of encounter, even though there is so much discord throughout life.
> Vinicius de Moraes

In this article[a] we invite the reader to reflect on the concepts of *integrality*, *healthcare work*, *care prevision encounters*, and *micropolitics,* among others. We have systematically analyzed these concepts in our research on the processes and practices of healthcare work in the context of Brazil's Unified Health System (SUS) [*Sistema Único de Saúde*]. In order to do so, we use our own lived experience as a starting point (as workers, managers, professors, and researchers in the healthcare sector), along with the preliminary results of a study titled "Shared Assessment Network – A 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." This 36-month study began in December of 2013, and is being conducted by members of our research team. Although this article is not meant to present the final results of this study, as it is still being conducted, we will explore some of its preliminary results in hopes of amplifying the debate which has arisen from the analysis of one of its lines of inquiry.

The purpose of this study is to analyze the production of care-related practices in healthcare networks in various municipal and regional contexts in Brazil. We start from the assumption that in addition to institutional norms and professional hierarchies, this production is rooted in the micropolitics of workers and their disputing visions. This intensive, dynamic, and ongoing process configures the day-to-day struggle of the SUS throughout Brazil [(1),(2)].

Integrality in care: a disputed notion

The creation of the SUS, conceived of and built from the ground up by a very large number of Brazilian healthcare workers, has had a positive impact on the health of Brazil's population, especially those who had little or no prior access to healthcare services. Nonetheless, numerous challenges to the consolidation of this system remain [(3),(4)], many of which arise from disputes between this new paradigm and the biomedical model, in which the organization and provision of healthcare services are firmly rooted.

The biomedical model – by far the predominant model – is founded on the basis of modern scientific medicine, which is in turn a result of the Cartesian paradigm's influence on medical thought. It is characterized by a strictly biological and mechanistic conception of the human body, which is understood as system of interconnected pieces that make up a complex machine, which must be broken down and analyzed piece by piece in order to understand the whole. According to this conception of the human body, where disease is primarily conceived of as a mechanical defect, heath is primarily understood as the absence of disease, leading to a technically oriented approach to health care. This approach prioritizes the incorporation of advanced technologies[(5)] and grants a disproportionately high value to obtaining advanced levels of specialization. In his work *The Normal and the Pathological* [(6)], Georges Canguilhem observes that this type of medical practice is rooted in organicism, reductionism, and contributes to fragmenting the conception of the individual.

Therefore, it should come as no surprise that in this approach to health care – or perhaps more precisely, to disease – the subjectivity associated with a body, complete with its knowledge, desires, and experiences, has little to no participation in the elaboration of therapeutic plans and prescriptions. For a model in which scientific knowledge is the only source of validity, it is in fact desirable that the user – or, more precisely, the "patient" – does not interfere with or question

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the professional's judgment regarding the presence of a bodily dysfunction upon the appearance of certain signs and symptoms. However, with regards to whether or not the patient will understand, accept, or desire the professional's prescription (presented as "care"), the predominant attitude is "I can't do anything about that," "that's not my responsibility," "I've done my part," or "it's all in [the patient's] hands now." These are some of the phrases frequently cited by healthcare workers to justify what they call "lack of adherence to treatment." Healthcare workers that operate within the biomedical model (that is, within the subjective framework we have just described), act as highly specialized and compartmentalized instruments that intervene with precision in an individual's body "with organs"[b], at no point taking on full responsibility for the overall care of said user.

As a consequence of this *modus operandi*, despite the technological advancements that have contributed to the overall improvement in medical assistance, there has been a deterioration in the relations between healthcare workers and users (including the doctor-patient relationship), with a low resolution capacity in response to healthcare needs and demands, and a generalization of prescriptive, authoritarian, and even fascist practices in the day-to-day work of healthcare service provision.

In another critique of the biomedical paradigm, Ayres reflects on how to transform a therapeutic encounter into a care-based relationship, noting "conceptual and practical challenges in humanizing healthcare practices"(7 p.18). He analyzes the necessity of broadening the normative horizons of the modern, technically-oriented biomedical sciences, of breaking with the limited concept of health promoted by the World Health Organization (WHO) since the 1970s, and of moving beyond technologies and practices that only address the functional morphology of the body. With these ends in mind, Ayres elaborates on a conception of human happiness employing Heidegger's ontological existentialism in order to explore the notion of care, focusing on the search for happiness in the doctor-patient relationship as a strategy to give new meaning to processes such as self-care.

Due to a general lack of contentment with established logics and prevailing ethics, a resistance movement arose in Brazil (or rather reappeared, was modified and strengthened), which took shape and gained momentum with the Healthcare Reform Movement of the 1970s. This movement became consolidated in the late 1980s alongside the creation of the SUS. The guiding principles of this new, free public health system were based on a broadened conception of health, which considered health-disease processes to be complex and multi-faceted, attending to all the different dimensions involved. This movement entered into conflict with the biomedical model, as it promoted practices aimed at guaranteeing integrality in care through a number of mechanisms, including: work in multi-disciplinary teams; personal bonds and a sense of shared responsibility in individuals' health; encouraging the growth of spaces where care provision practices could emerge; assigning value to diverse modes of knowledge production in the creation of individualized care plans (analyzing empirical experiences, modes of subjectivity, symbolic disputes, the desires of users and of workers, and differences in lifestyle). Furthermore, this movement proposed an integral approach to health technologies (hard, soft-hard, or soft technologies) in accordance with the particular necessities of the care provided, which positioned soft technologies as indispensible components that would orient actions in the health sector(5),(8) and prioritize above all the care of the user, rather than the procedures.

METHODOLOGICAL FRAMEWORK

In recent years, our research team has carried out a number of efforts to implement more sensible and appropriate research methodologies. In the "Shared Assessment

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Network" [*Rede de avaliação compartilhada*] study, we were able to capitalize and expand on that experience by including the participation of 52 researchers based at a number of Brazilian institutions of higher learning – predominantly in the public sector – as well as a number of other worker-researchers, user-researchers, manager-researchers, and students, among others, located in 17 municipalities throughout the country's Southeastern, Northeastern, Northern, and Southern regions.

This article deals with experiences in the production of care analyzed in monthly encounters held by a group of researchers based in a municipality in Southern Brazil. Given that the majority of the researchers were "external" and did not reside in the municipality, the encounters generally had a duration of 2 to 3 days per month, which were dedicated exclusively to conducting field work.

Our goal was to implement a research methodology that could capture the creative potential of this process of construction through "attentive and sensitive observation," a process we call *interference research*. This method was employed in order to witness the production of care in action, with workers and users forming part of the research process, such that we could gain access to their knowledge and witness their daily practices, as well as the innovations that resulted from the research process.[1],[2] This experience led to certain modifications in the daily actions of healthcare workers and users, which were not necessarily planned *a priori* but resulted from the interferences of the research process, stemming from the encounters and interactions of all actors involved [1],[2].

In the encounters held by the team of researchers, some had no part in provision or reception of healthcare services, while others, in addition to their role as researchers, were also protagonists in the process of production of care (users, workers, and managers). It was decided that the viewpoints of users and those regarding them would be given priority and "guide" the research process, as they clearly demonstrated the nuances of the care process to all those involved in the research, either through the therapeutic plans or through the users' interpretations of them. These narratives regarding the production of care were considered foundational to our discussion, whether they belonged to "users-guides," "workers-guides, or "managers-guides" involved in formal or informal healthcare provision networks.

This study was conducted in compliance with the ethical principals of the World Medical Association's Declaration of Helsinki and Resolution 466/2012 of Brazil's National Council of Health regarding informed consent of research participants. Confidentiality in data collection was guaranteed to all research participants. This study was submitted by the Universidade Federal do Rio de Janeiro (Macaé Campus) and approved by the National Committee for Research Ethics, in accordance with Decision No. 560.597/2014.

INTEGRALITY AS A MEANS FOR INTERROGATING THE ROUTINE

It should be clarified that the word-concept "integrality" – which stems from an "intention to pave the way for radical changes in healthcare actions," as if the word itself could guarantee the "protagonism of novel healthcare practices" – has become "pregnant," to borrow a term from Mehry[9 p.196], in multiple ways, given the different logics or action projects in dispute. Much has been said about the concept of integrality without contributing much to the discussion on the production of care. Indeed, the term has even been used to cloak longstanding authoritarian practices, camouflaging under its aegis the most traditional forms of healthcare work.

It is possible to identify and even experience such practices in a number of routine situations related to healthcare work. It is a common conception that integrality in healthcare means to immediately resolve any problem that presents itself, either through

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referrals or prescriptions, even when the patient leaves the encounter with the feeling that their problem was not addressed and returns to seek services a number of times without specific grievances. Is this situation external to the realm of healthcare work? If such occurrences are as frequent as we suggest, should healthcare workers resign themselves to this type of situation?

A situation witnessed by one member of our research team may help illustrate the ideas presented above. Joint pediatric consultations, conducted simultaneously by both a pediatrician and a nurse, were promoted as an innovative and "integral" healthcare practice at a clinic in a Brazilian municipality. The practice would proceed in the following manner: the child would enter the doctor's office with his or her mother, the nurse would take down the child's height and weight and perform auscultation, while the pediatrician would take notes and issue a prescription without as much as speaking to the child or mother – no dialogue or exchange whatsoever.

We do not mean to ignore the good intentions that may be behind such practices, and acknowledge that they often fall under the category of "technical" procedures. Nevertheless, we must pose the question as to whether or not collective, ongoing learning takes place as part of a care process, and how users participate in this learning process. We also recognize that the so-called "voids of assistentialism," such as problems with access to specialized care[4],[10], compromise the availability of hard and soft-hard technologies in the SUS, which are also important in assuring integrality. But how can the concept of "integrality" be given more meaning and significance in the process of producing more health, more life? What is this meaning and its significance? And from there, how can we enhance the production of care through our practices?

In order for these new processes to take place, it is undoubtedly necessary that we permanently question the established methods for the production of health. For Merhy and Feuerweker [9],[11], a prime opportunity to break with the dominant logic in health care is through its deconstruction in the realm of micropolitics, in the act of organization of living labor and its practices, in which professional protocol and standard procedure do not produce care *per se*. In this sense, although it can become generalized at times, we consider that the concept of integrality can be given new meaning through alternative ethical-political projects that would prioritize care in the production of healthcare practices and in the healthcare needs and demands of individuals and groups. From this perspective, it is also possible to give new meaning to the clinic through the use of soft technologies. This would not be possible without an understanding of the spaces of care production (the clinic included) as a *locus* of exchange, of listening, of dialogue, of mediation – that is to say, a place of encounters.

The potential of the encounter in the production of integrality

In order for an encounter to be a "good encounter" in Spinoza's sense of the term – that is, one that augments our potential for action[12] – whether it be an encounter with a healthcare user or a romantic encounter, it should be one that is full of possibilities. In a good encounter, that provides feelings of happiness and fulfillment, it is necessary that one feels cared for and heard. And setting up an appointment or encounter often leads to "butterflies in the stomach," fears, and anxieties. It is impossible to rehearse exactly what will be said and done beforehand! Herein lies the dose of uncertainty in any given encounter, which has little to do with being unprepared or unknowledgeable, but rather has to do with being open to what will happen, and to constructing the encounter and allowing it to be constructed in the act. This has to do with the ability to assume responsibility for accepting another person's knowledge while attempting to "see things through their eyes," recognizing otherness and producing alongside others[13].

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In a "good" encounter, soft technologies are put to use at any given moment and orient the use of other technologies. On the contrary, if we orient our practice based on routines and protocols we run the risk of solidifying, hardening, and formatting our practice, thereby eliminating opportunities for spontaneity and creativity, limiting ourselves to a type of dead labor[7]. Therefore, we run the risk of nullifying the potential of living labor that is produced in the act, which is precisely what makes for a good care provision encounter.

In such an encounter, there is mutual interference and joint construction from the moment that I recognize the "Other" as a valid interlocutor with whom it is worthwhile to negotiate[9],[11],[14]. That "Other" has needs, desires, expectations, and above all possesses a knowledge that most of the time differs from mine, and that enriches my practice.

Caponi, taking the contributions of Canguilhem regarding the notions of "normal" and "pathological" as a starting point, discusses health in terms of openness to risk. She identifies the impossibility of speaking about health without mentioning pain or pleasure – that is to say, it is "suffering, and not normative measurements or standard deviation, that establishes a state of disease"[15 p.60]. Calling attention to the singularity of these issues, the author emphasizes that it is important that healthcare professionals speak in the first person, rather than constantly resorting to the impersonal use of the third person, thereby making an encounter possible through the sharing of lived experience. She recognizes that scientific knowledge concerning the body is allied with and supports medical knowledge in such a manner that the former can contribute to the process of giving meaning to that which the healthcare user is unable to identify on his or her own.

The position we put forward is that if we operate with a model of care, health, happiness, and life that is *for* others, and we attempt to impose this model, we will be condemned to failure. Our "prescriptions" will not always be followed, or even worse they may be imposed as an act of violence. This may seem obvious at first, but by simply observing the naturalization of the "good habits" that we exalt as though they were doctrine ("you shall not smoke," "you shall exercise regularly," "you shall reduce your salt and sugar intake," and so on), disguised under the aegis of healthcare promotion, we can comprehend the discriminatory practices, impositions, and micro-aggressions that we commit by attempting to standardize others' behaviors in an authoritarian manner. Let us turn to two examples in order to illustrate these points.

Take the case of a nutritionist who attempted to formulate a diet plan for a 96-year-old man who had been bed-ridden for some time and lived with a number of chronic comorbidities. She made an effort to reconcile all of the different dietary restrictions that this man had – each of which had been proposed by different specialists – in order to devise a balanced dietary plan for him. But the number of restrictions was quite elevated – he could not eat red meat due to his dyslipidemia, carbohydrates and sugars were prohibited due to his diabetes, and he even had to abstain from consuming certain fruits and vegetables due to high levels of potassium. With all of these restrictions it had become almost impossible for this man to eat, much less be able to enjoy food. At 96 years old, were all of these measures really going to lead to significantly more longevity?

The other case was a 38-year-old healthcare user in a very precarious socioeconomic situation, and who had a background of severe alcohol and drug use. After a long period of being bed-ridden he developed muscular atrophy, and it was therefore crucial that he attend physical therapy in order to regain his ability to walk. He was unable to make it to his appointments on his own to continue care and had little support from his family. However, the healthcare team did not offer him an alternative transport solution nor did they offer to provide his physical therapy sessions at his home. The team of healthcare workers rather accused the user and his family of being "difficult," categorizing the alcohol and drug use as simply "social problems." Therefore, he

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was forced to remain bed-ridden and depend on a live-in care worker, even though he was able to walk. The alternative offered by the healthcare team basically consisted in institutionalizing the user as a solution for him and his family.

As professionals, must we be so restrictive, so punitive, not reflecting on the impact that our opinions may have on the context and on the quality of life of the person that we mean to provide care for? Furthermore, what proportion of what we prescribe is effectively implemented? And if it is, how much suffering do we cause? Is this the only conception of integrality possible?

When we fail to recognize others as beings with desires to live out their lives in diverse ways, that have their own plans and projections that may differ from those we lay out for them (which may or may not be in line with our "best practices"), we as professionals may at times design inefficient care plans, we may set out prescriptions that will not be followed, and we hamper the desires of others. In this sense, our actions may very well fail to reverberate, and our words may very well fall on deaf ears. In the absence of dialogue, we no longer learn, we no longer progress, and end up doing a repetitive, boring, and halfhearted job, towards which we may even grow cold and distant. This type of repetitive job does not provide anyone with satisfaction – neither us, nor our users. We stop seeing anything but problems that have to be eradicated, rather than seeing potential and power in others. In short, our work ceases to produce encounters, or worse yet, may even produce bad encounters.

Therein lies our principal challenge: to always remember that other people's lives are worth investing ourselves in, and that another person's life can enrich our own, as Mehry has observed[16]. Of course there are numerous situations in which we do just that, in which we unleash our potential for action and produce empathy, interpersonal ties, and a sense of shared responsibility with respect to the problems that may confront us. We must escape the routines and rigid protocols of healthcare services and knock on whatever doors are necessary, make phone calls, mobilize our team, study the case in whatever free time we can, and articulate our work with that of other care providers, whether they form part of our team or not. In this way, we can create good encounters and a path to care.

In our experience in the context of Brazil, as part of the "Shared Assessment Network" study, we have seen the great possibilities to produce such "good encounters" outside of the traditional sites of care provision, where integrality can be translated into action. This obliges us to reflect on the inefficiency of long-established spaces for care prevision. In Brazil, we have had positive experiences in other realms of practice that have demonstrated how the topic of care production has been affected by this debate.

Integrality in the production of care: alternative spaces

With regards to primary care, for example, depending on the institutional configuration adopted by different municipalities, members of the Family Health Program's teams enjoy high levels of autonomy and freedom of action. This has allowed for multiple innovations in their work, particularly outside the confines of healthcare service units and in the realm of day-to-day life. Encounters can thus occur under any circumstances, and when they do take place, they compel healthcare workers to dialogue, exchange, adapt, and reinvent their work.

Nonetheless, it is possible to "hide" from an encounter, for instance, behind the array of products and services offered as habitual solutions: consultations regarding early childhood care, prenatal care, gynecology, hypertension, diabetes, and so on. This has produced a great deal of inattention when it comes to individuals that do not fit into these "molds." It is almost as if receiving a service exempts them from receiving complete care. When healthcare workers hide behind these programs and protocols, the care process is paralyzed and may reduce the potential of the encounter.

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Home-based care is another example of an area that is rich with possibilities for the construction of integral practices, perhaps it is even the most promising given the reality check that many healthcare workers face in the homes of users. There, the environment stimulates a different mindset, one that encourages us to adapt our practices to the lifestyle of that person and their family, to rid ourselves of any preconceived notions we may have. Within the four walls of a person's home, the encounter is produced in a more balanced way; the power held by the healthcare professional encounters a limit, and challenges to it may become more visible[17]. In this space, knowledge is shared with many other subjects that are not socially recognized as bearers of valid forms of knowledge, despite the fact that in reality they are just that: the wife who has been at her husband's side for 40 years, the driver of the automobile, the lady next door, and so on.

In order to illustrate these points, we will now turn to a very interesting story shared with us by a nurse in a recent conversation with one of the members of our research team. This nurse had gone to a house call in a precarious settlement in Mato Grosso do Sul near the Brazilian-Paraguayan border, where there was supposedly a high prevalence of leprosy. She arrived to the house of a man who lived with his elderly father, whom he had been caring for quite some time; both had leprosy. In this encounter, the nurse found that the son had self-diagnosed his leprosy, even before the "official" diagnosis. And how could this be possible? One day the man noticed a sore on his body that gave off the same smell that he sensed every time he would tend to his father's sores. Without hesitating, he sought help. Upon returning to her home, the nurse searched through the scientific literature for some mention of particular smells related to leprosy sores, but was able to find no such information.

There are other spaces conducive to discovering the different possible ways that life is produced in the case of each individual healthcare user. At a therapeutic inpatient mental health facility in a Southern Brazilian municipality (which we visited as part of our work on the "Shared Assessment Network" project) we met ten residents, one of whom was a 60-year-old woman with an unspecified chronic mental condition, whom we will refer to as "Keiko." She had lived at a psychiatric hospital for a number of years, and after the de-institutionalization process she took up painting. And paint she did! Gorgeous landscapes, with a unique delicateness and precise detail. After a short period of living at the facility, Keiko had the opportunity to cultivate her talent through weekly painting classes. Undoubtedly she would not have been able to harness this potential, this amazing uniqueness that was Keiko, if she had remained institutionalized. Her life would have been reduced to the label of a "mental patient" or a "person with a mental disorder." She would have been condemned to a life of incapacity and limited in her freedom, especially with respect to the mode in which she desired to live her life. And, in our opinion, those in charge of her case would not have acted in good faith.

The home-based care strategy of the Family Health program, mental health care services, and other possible spaces for care prevision have allowed for this method of putting integrality into practice. But we must be cautious that the prescriptive model does not harness this potential, as it tends to establish the worker strictly as a healthcare professional. As Favoreto observed:

> ...In Brazil, based on the viewpoint that the assistentialist model and its practices must be overhauled in order to produce care alongside other actors, there has been much investment in alternative spaces and actors. Nonetheless, the incorporation of these subjects [the users] has been removed from their contexts and done in a haphazard manner, with a limited understanding of their healthcare needs.[18 p.209]

Therefore, integrality in the practices that produce care are linked with the recognition

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of difference and singularity of the "Other" and their way of life, their way of thinking, existing, and desiring, as a producer of their own life and of alternative forms of knowledge. This implies allowing oneself to be affected by the encounter in order to jointly construct care strategies that, in accordance with this perspective, can be considered integral. It also implies focusing the attention of care practices on the demands and needs of the individuals and collectives in order to re-signify institutionalized methods such as the clinical approach. With respect to this final point, we assume that we all employ the clinical approach,[c] which is after all not limited to diagnosing, treating, and preventing, but is also a shared space for exchanges related to different necessities and different action techniques[19].

As we have seen, these and other everyday examples of healthcare services force us to reflect on the word-concept of *integrality*.

FINAL CONSIDERATIONS

Could there be some formula to attain integrality? How can we apply it to our daily lives in the workplace? Although there is no formula, as we have attempted to make clear in this article, the possibilities are endless. Perhaps the first step is to critically reflect on the ethical-political project that informs and circumscribes our practice as healthcare workers, which at the same time forms the basis for our work process. How do I see others, whether they are a user, a co-worker, a service provider, or a manager? What is my contribution? A radical defense of the lives of others, the guiding ethical principal of our work – whether we are workers, managers, professors, or researchers – is an extremely significant element in the production of integrality in care. And this does not cease to apply outside of the traditional spheres of assistentialism, but quite the contrary.

Nevertheless, we must also remember that the world of work is also a school,[9] where valuable lessons are constantly being learned, and in the encounters we have with others (users, workers, managers) and in the exchanges and conversations we share with them, we are frequently made able to recognize the positive and negative aspects of our practice that we may not have perceived earlier.

In Brazil, Permanent Health Education is a strategic plan that encompasses approximately 5000 workers throughout the country. It is an invitation for SUS workers to reinvent their learning processes and practices of care by relying on the potential of living labor as it is put into practice.[16] From this point of view it is necessary that the day-to-day work of health care (which actively involves all those present) take on a porous character and prioritize actions that create alterations in the way in which healthcare workers analyze themselves as a group. This is done by affirming that for me to be able to perceive and analyze what I do, I necessarily rely on others, since it is by listening to them I am able to see myself through their eyes.[17]

This study shared a common aspect with the Permanent Health Education plan, namely a commitment to thoroughly focusing on the practices and day-to-day work of health care. We believe that this has empowered workers, managers, and users, but we also believe that the concepts of encounter and otherness have been indispensible elements in enriching the production of care from the distinct perspective of integrality. In this sense, we recognize that in the history of the Brazilian healthcare sector, the present moment can be understood as a privileged time for change, deconstruction, and permanent reconstruction with a drastically amplified horizon full of possibilities for stimulating integrality in the field of collective health.

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ENDNOTES

a. This article originated in a presentation entitled "Integrality in clinical practice, different dimensions of care," given in November 2014 at the 4th Healthcare Conference of the Province of Santa Fe, which took place in the city of Santa Fe, Argentina. The presentation centered on the topic of integrality and its relations with care, consistent with the findings of the study entitled "Micropolitics of work and care in the health sector," coordinated by Professor Emerson Elias Merhy.

b. Deleuze and Guattari develop the concept of "body without organs" in their work Anti-Oedipus.

c. According to Mehry (16), taking this vision of health technologies as a starting point, we can affirm that in one way or another all healthcare workers carry out clinical practice, which is the primary field in which soft technologies operate articulating other technological configurations. This is a valid argument even in the case of people that are not traditionally considered part of the field of health care – for example the doorman at a healthcare establishment. First of all, this affirmation is related to fact that in their encounters with healthcare workers, especially in healthcare centers, users seek out spaces for acceptance, responsibility, and connection. Secondly, understanding that clinical practice is not merely knowing how to diagnose, foresee, and treat health problems as "biological dysfunctions," but also as a process and a space for the co-production of relations and interventions, in which there is an interaction between necessities and technological methods of action. Thirdly, because there can be no production of spaces of dialogue, of collaboration and responsibility, of connections and acceptance without clinically oriented work. Nonetheless, the author contends that there are distinct loci of action among professionals, despite the fact that they do not all carry out clinical practice, that leave impressions in the distinct configurations of healthcare technologies, and at the same time they shape their capabilities to respond to the specific problems they are faced with.

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REFERENCIAS BIBLIOGRÁFICAS

1. Merhy EE, Feuerwerker LCM, Silva E. Contribuciones metodológicas para estudiar la producción del cuidado en salud: aprendizajes a partir de una investigación sobre barreras y acceso en salud mental. Salud Colectiva. 2012;8(1);25-34.

2. Gomes MPC, Merhy EE, (orgs). Pesquisadores In-Mundo: um estudo da produção do acesso e barreira em saúde mental. Porto Alegre: Rede UNIDA; 2014.

3. Ministério da Saúde. Índice de desempenho do Sistema Único de Saúde [Internet]. Brasília: Ministério da Saúde [cited 17 Feb 2015]. Available from: http://idsus.saude.gov.br

4. Oliveira PTR, Sellera PEG, Reis AT. O monitoramento e a avaliação na gestão do Ministério da Saúde. Revista Brasileira de Monitoramento e Avaliação. 2013;5(1):114-129.

5. Merhy EE. Saúde: a cartografia do trabalho vivo. São Paulo: Hucitec; 2002.

6. Canguilhem G. O normal e o patológico. Rio de Janeiro: Forense Universitária; 2009.

7. Ayres JRCM. Cuidado: trabalho e interação nas práticas de saúde. Rio de Janeiro: CEPESC, IMS-UERJ, ABRASCO; 2009.

8. Merhy EE, Feuerwerker LCM. Novo olhar sobre as tecnologias de saúde: uma necessidade contemporânea. In: Mandarino ACS, Gomberg E. Leituras de Novas Tecnologias e Saúde. São Cristóvão: Editora UFS; 2009.

9. Merhy EE. Engravidando palavras: o caso da integralidade. In: Pinheiro R, Mattos RA. Construção social da demanda. Rio de Janeiro: IMS-UERJ, CEPESC, ABRASCO; 2005.

10. Cecílio LCO. As necessidades de saúde como conceito estruturante na luta pela integralidade e equidade em saúde. In: Pinheiro R, Mattos RA. Os sentidos da integralidade na atenção e no cuidado à saúde. Rio de Janeiro: IMS-UERJ, ABRASCO; 2001.

11. Feuerwerker LMC. Micropolítica e saúde: produção do cuidado, gestão e formação. Porto Alegre: Rede Unida; 2014.

12. Deleuze G. Spinoza-Cours Vincennes 24/01/1978 [Internet]. 2010 [cited 16 Jun 2015]. Available from: http://goo.gl/mWVaXQ.

13. EPS em Movimento. O aprender e o engendramento de um novo campo de possibilidades: outrar-se [Internet]. 2014 [cited 2 Mar 2015]. Available from: http://goo.gl/KlgVb5.

14. Slomp Junior H, Feuerwerker LCM, Land MGP. Educação em saúde ou projeto terapêutico compartilhado?: O cuidado extravasa a dimensão pedagógica. Ciência & Saúde Coletiva. 2015;20(2):537-546.

15. Caponi S. A saúde como abertura ao risco. En: Czeresnia D, Freitas CM, (orgs). Promoção da saúde: conceitos, reflexões, tendências. Rio de Janeiro: Editora Fiocruz; 2003.

16. Merhy EE. A educação permanente em saúde em movimento [Video en Internet]. 2014 [cited 17 Feb 2015]. Available from: https://goo.gl/2zTnHL.

17. Carvalho LC, Feuerwerker LCM, Merhy EE. Disputas en torno a los planes de cuidado en la internación domiciliaria: una reflexion necesaria. Salud Colectiva. 2007;3(1):259-269.

SALUD COLECTIVA. 2016;12(1):113-123. DOI: 10.18294/sc.2016.874

18. Favoreto CAO. A velha e a renovada clínica dirigida à produção de um cuidado integral em saúde. In: Cuidado: as fronteiras da integralidade. Rio de Janeiro: CEPESC, UERJ, ABRASCO; 2008.

19. Merhy EE. A perda da dimensão cuidadora na produção da saúde: uma discussão do modelo assistencial e de intervenção no seu modo de trabalhar a assistência. In: Campos CR, Malta DC, Reis AT, Santos AF, Merhy EE, (orgs). O Sistema Único de Saúde em Belo Horizonte: reescrevendo o público. Belo Horizonte: Xamã; 1998.

20. Merhy EE, Feuerwerker LCM. Educação Permanente em Saúde: educação, saúde, gestão e produção do cuidado. In: Mandarino ACS, Gallo E, Gomberg E, (orgs). Informar e Educar em Saúde: análises e experiências. Salvador: Edufba; 2014.

21. Franco TB. As redes na micropolítica do processo de trabalho em saúde. In: Pinheiro R, Mattos RA, (orgs). Gestão em Redes: práticas de avaliação, formação e participação na saúde. Rio de Janeiro: CEPESC, IMS-UERJ, ABRASCO; 2006.

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