

## Health education or a shared therapeutic project? Health care goes beyond the pedagogical dimension

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**Abstract** *The general objective of this research was to assess the possible contribution of homeopathy to the development of caregiving therapeutic projects in multidisciplinary workshops of permanent education in health, in the context of primary health care. The chosen points of analysis were the series of inconveniences expressed by health workers with respect to their work processes and it was the emergence of the theme of health education in the first meetings with the teams that led to the production of this article. This study discusses the existential territory of “being a health professional” as understood from a concept of education as a significant benchmark, and of a certain interventionist mission as a transcendent value. A progressive waning of the importance of health education was observed during the workshops, sometimes even disappearing from the discussions, as the caregiving therapeutic projects took shape. The conclusion reached is that this waning involved a process of moving towards a pact with the health system user, eventually considered to be a valid interlocutor; and that health care transcends any strictly pedagogical dimension.*

**Key words** *Permanent health education, Health education, Therapeutic project*

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## Introduction

This article problematizes the production of field research that, while it studies the possible contributions of homeopathic rationality to the development of caregivers' therapeutic projects, has also produced results that do not require ideas or perspectives arising from this rationality, and which are reported and discussed here. The central concepts of the framework adopted will be presented next, and the operating concepts used can be found in the "methods" section.

The idea of a *therapeutic project* comes from a well-known source in the field of health services: the trend towards the deinstitutionalization of mental asylums in Italy during the 1960s and 1970s; at that time, faced by the challenge of finding new proposals for the care of mental suffering, it was considered necessary to create new devices<sup>1</sup>. It was seen necessary to take a look in a way which was concerned not only with recognizing health service problems, but also with producing relations and building a chain of caring<sup>2</sup>. This proposal created echoes, including in Brazil, starting with Santos's work in mental health in the first half of the 1990s<sup>1</sup>, which contributed to new formulations in the Brazilian context of health and psychiatric reforms, such as the *In Defense of Life* current of the health movement, in the late 1980s and throughout the 1990s. At the time Merhy<sup>3</sup>, for example, pointed to the therapeutic project as a strategic device in the process of working in health services; in the 2000s the same author, among others, returned to the topic when concerned about the change of the medical school<sup>4</sup>. In parallel the production of another line of research was developing, committed to developing and operationalizing a therapeutic project approach called "singular", and considered as a method, among others, to be employed in the context of the so-called extended clinical practices<sup>5,6</sup>, and proposed especially for the area of basic health services<sup>7</sup>.

Another important reference for this research was *institutional analysis (IA)*, where the initial research can be attributed to the authors, René Lourau and Georges Lapassade. This present study was guided by a later Brazilian study<sup>8</sup>, as well as its relation to the field of so-called micro-politics, in particular the work of Felix Guattari<sup>9</sup>. From this field we will initially use the meaning of *institutions*, considered here not in the sense of organizations or establishments, but of the relations that people establish between each other and with the world around them, con-

structs of living and thinking that are constituted socially. Sometimes such relations naturalize discourses and certain equilibria: the so-called *instituted*<sup>8</sup>. However for Michel Foucault<sup>10</sup> an institution is *everything in a society that functions as a coercive system, without being enunciated, that is, all non-discursive social practices*. On the other hand there are the *instituting movements* that give rise to an invention designed with the purpose of weakening the instituted reality. So IA could be defined as a clearly political intervention (in its macro and micro dimensions) in the sense of making visible the institutions that actually permeate every reality, put them under analysis, in order to produce new subjectivities: "intervene to investigate" and "transform to know" are well-known maxims of institutionalists<sup>8</sup>.

Another concept of the approach used here is that of *analyzers*, which are seen as everything that, by generating new questions, places the institutional reality under analysis. Among them are some that arise internally in the group under review<sup>8</sup>, for example: the fragmentation or lack of internal communication within the team, the difficulty of coping with a personal incompatibility with the user, or the belief in a definitive solution originated from outside the group in question, just to give a few examples that are consistent with the work described herein.

One can also make use of the so-called *devices*, that is, any analyzers constructed by a mediator (in this case the researcher-facilitator) with regard to a collective under analysis<sup>8</sup>. For Foucault<sup>10</sup>, a device is a network established between heterogeneous elements (discourses, regulatory decisions, administrative measures, scientific enunciations, philosophical and moral propositions), it is the same kind of relation that can exist between these elements (changes in position and function), being both discursive and non-discursive practices. Considering that in this research we use this concept as a tool in person, we should add that for Foucault a device is a rational and organized intervention in the power relations at play in a particular social setting, having therefore a strategic function when one intends to operate such forces, stabilizing or developing them in a certain direction<sup>10</sup>.

The last concept of IA used in the research is that of *implication*, which is the set of emotional, historical and professional ties between individuals and groups, of the organization or even, in the end, of the whole institutional system<sup>8</sup>. Merhy<sup>11</sup> understands that the epistemic subject, desired by hegemonic science for being ideally impartial in

the field of knowledge production, is that which is, by means of certain methods and theories, focuses on the objects of science; however the author warns that the same does not precede the other subjects (technical, political, pedagogical and affections) possibly involved in this process, especially that which the author calls the *implicated subject*: that seeks to build a militant form of knowledge which is available for self-analysis, for the re-framing of his/her own intentions.

The reference case for *permanent health education* (PHE) can be summarized from the reviews of Merhy et al.<sup>12</sup> and Merhy & Feuerwerker<sup>13</sup>. Constructed from various theoretical frameworks - including that of the Brazilian Paulo Freire - and initially targeting the reform of adult learning, PHE begins with the uncomfortable situations experienced with the reality lived in person, and counts on the prior knowledge of each subject, and becomes possible and necessary for *learning* to be considered *significant*. The addition of so-called Participatory Strategic Planning transmutes health problems from the causes of distress and discomfort to substrates of the pedagogical process in day-to-day health services work, making it possible to obtain from them all of the transforming power that the reality in health services offers<sup>12,13</sup>.

A Brazilian version of PHE was adopted as public policy in the mid-2000s, by the Ministry of Health, with the incorporation of the IA perspective and, principally, the radicalization of the dialogue on permanent education, originally raised by the Pan American Health Organization, with the referenced theoretical-practical production based on the field of *micro-politics in work and care in health service*<sup>4,12,13</sup>. This new branch of PHE is founded on the view that, if the health service is produced in person, such health service actions are carried out by workers when they are in possession of the three types of health service technologies: *hard* (instruments, medicines, equipment, everything that results from dead labor); *hard-soft* (structured technical knowledge) and *soft* or relational, those that give "life" itself to this so special work, that it is alive and happens through actions, by a provider (or preventer) of caring<sup>4,14</sup>. Of these, PHE will position soft technologies as a guide to the other forms, understanding them as the set of *relations* experienced in the act of the encounter between health service worker-user (listening, interest, ties, trust, ethics), enabling the apprehension of singularities: the context, the cultural universe, the specific ways of feeling and living, the affective and

power relations. Through them the user is more likely to negotiate, interact and even contest the meanings and significances of the care encounter that is (or is not) being built. Soft technologies, which are an essential base for the development of therapeutic projects, and even support models that consider the whole of one's life to be worthwhile, constitute a powerful *toolbox* to build a *dimension* which is effectively *caring*, whether in the area of health management or assistance<sup>3,14</sup>. In the present study the Brazilian approach to PHE was used as a basis to enable the methodological operation.

This research had the overall objective of understanding the possible contributions of homeopathic concepts in the collective construction of caregivers' therapeutic projects in multidisciplinary workshops for permanent health education, in the context of basic health services.

## Methods

This was an exploratory study of the type *research-intervention* in health services. According to Rocha and Aguiar<sup>15</sup> in this type of research *the intervention interacts with the research to produce another relation between the teaching institution-application of knowledge, theory-practice, subject-object*, such that, at the same time, the researcher abandons his/her neutrality and objectivity regarding the apprehension of reality and knowledge production. Considering the implicated subject, that according to Merhy<sup>11</sup> is one that does not separate the production of knowledge from the meaning for his own action, in this study we took pains to identify in the action those subjects involved in its various existential manifestations considering the implications and tensions that territorial disputes engender.

Accompanied by three students studying medicine at the Federal University of Paraná, the researcher conducted and coordinated 34 PHE workshops. They were held weekly, with one to two hours duration, during the regular opening hours of the basic health service units in the city of Colombo-PR. They were attended by five family health teams from three basic health service units. Each team consisted of eight professionals: a doctor, a nurse, a nursing technician and five community health workers and, in one case, a professional from the unit's reception area also participated. The principal researcher, who was also the coordinator of the workshops, had already worked as a doctor in the city, at other basic

health service units, but during the period of the study he was working in the central healthcare management team.

As a methodological strategy, the workshops with each team were kicked-off with the problematization of the following questions: *What does this team consider to be a difficult case?* and *Why this case and not any other one.* Following this the team initiated the collective preparation of a therapeutic project for the case. The workshop discussions were recorded, and simultaneously the researcher recorded his observations in a *field journal*. At the end of the fieldwork period, the subjects were requested to draft a *narrative* relating how it had been, for each one of them, to participate in the research experience. Altogether, nine subjects agreed to this request, and the impressions and considerations contained in their narratives were incorporated as empirical material to be processed. We applied the therapeutic project approach assuming that the transforming power of this resource depends heavily on the condition in which it is used: not only as a method, tool or resource, but also as a device for the production of the meeting and of the caring.

Besides the reference cited in the previous section, the analysis of the material obtained drew upon other operating concepts within the micro-politics field. The use of the word *enunciation* is intended to mean “acts of speech”, considering that what language transmits in fact are “slogans”, formed from a *collective agency of enunciation*, this being understood as a combination of expression and content to emerge from both the significance of communication (assuming the interpretation) and the subjectivation processes (assuming the action)<sup>16</sup>. In the words of Deleuze & Guattari<sup>16</sup>: *For us slogans are not a particular category of explicit enunciations (for example, in the imperative), but the relation of any word or any enunciation with implicit assumptions, that is, acts of speaking that are realized in the enunciation, and which can only be realized in it. Slogans do not refer, then, only to commands, but to all acts that are attached to enunciations by a social obligation.* In the same text the authors describe the limits of the perspective used in this research<sup>16</sup>: *It is not sufficient to consider the meaning, or even the reference, since the notions of meaning and reference still relate to an expression structure that is assumed to be autonomous and constant. [...] The content is not meaning nor is the expression significant, but both are variables of agency.*

A consequence of the idea of the collective agency of enunciation is the concept of *existen-*

*tial territory or territory related-to-identity*, such as defined by Felix Guattari<sup>9</sup>: the traditional conception of the subject, rationalist-structuralist, presupposes individuation as a unifier of states of consciousness (in the order of I) and a focus of expressiveness. Therefore, one can apply discursive sets, among which: the *significant references* which make up the so-called semiotic expressions (family, education, environment, religion, art, sport, the media industry); and the *transcendent values*, including, for example, the true, the good and the beautiful. By the intensive repetition of these discursive sets and transcendent values one is affirming a certain standardization of existential processes, or a self-referenced *existential territory*. The analyzers that emerged during the study were chosen based on this perspective.

This study was approved by the Committee for Ethics in Research of the Clementino Fraga Filho University Hospital (UFRJ). After the approval of the project from an ethical perspective, each participating subject read and signed a form consenting freely and with understanding to his/her participation.

## Results

We believe that the main or central analyzer, which was present in all of the groups, was *the set of discomforts* that the workers expressed with regard to their work process. This was broken down into two operating analyzers, each one composed of several enunciations. Such division was solely for pragmatic purposes, and was developed only for the purpose of analysis, and does not constitute a categorization process. The “first” and “second” analyzers are as follows.

The *first analyzer* is the set of frequent comments whenever collective discussion opportunities were provided for the health service teams, or when using support or supervision devices with them. In this block we also grouped the enunciations which were organized to define a certain territory related-to-identity that we would call *being a health service professional*, that is, the significant reference or set of assumptions and beliefs that describe everything that would identify this worker as an actor in the field of health services. The first of them is the set of feelings of helplessness, weakness, anxiety or sadness that are manifested by the staff in response to suffering in general. Also, there were impasses in worker-user relations, such as prejudices, feelings of “disgust”, impulses “to give up” on

the case. Highly significant was the dilemma of therapeutic intervention: if drugs are used the intervention is said to be mainly medical, but if it is not medical who does it and how is it done? Sometimes the question arose as to whose case was it? If we bring in the social service worker are we “passing” the case to them? After this, is it no longer “ours”? In some cases there were users that could be described as “invisible” to the teams, because they were not in the focus of the teams’ immediate interests. In some workshops, there were debates about the health service professional and the myth of a necessary interventionism, both immediate and radical, regarding health issues. A further frequent idea was that a solution from outside the team should always be provided as an aid to solving everyday challenges. Also not forgotten were the multiple dimension of the family approach and the difficulty of its apprehension-operation. The operation of the therapeutic project in the context of PHE sometimes appeared as an intensification of the case, generating more discomfort instead of meeting the initial expectations of contributions. Finally, the gaps in programs and support, fragmenting the attention paid to health services, did not fail to leave their mark as concrete challenges to providing caring in basic health services.

In some cases, during the study period, no change was achieved other than causing discomfort, however even in these cases there appeared to be self-analysis. Moreover the majority of the teams also reported significant experiences in relation to the strengthening the relations with the users, as well as to teamwork and the building of networks of caring.

In the empirical context in which the study was organized, in general at the beginning of the work of each team, the theme of healthcare education (HE) arose on a number of occasions and in a number of teams, especially as regards to addressing chronic diseases and at the beginning of the discussions. On the other hand, during the discussions and in the development of new initiatives, the changes in perspective obtained from the case discussions coincided with a progressive reduction of such concerns in the comments, and the demand for EIS gradually lost its central position as a technical intentionality, followed by the highlighting of other actions in caring in the sphere of soft technologies, leading to the delineation of a specific analyzer, which will be developed below.

The *second analyzer* grouped together enunciations that expressed tensions in trying to establish a territory related-to-identity that we call

here *be a professional-educator in health services*, a dimension that certainly is integrated within the territory related-to-identity mentioned earlier, however artificially highlighted in this study because of the relevance that the teams gave it in the early stages of the fieldwork research. This relevance was expressed in enunciations such as: team’s feeling of frustration due to the failure of the “educational” actions with users, the multiplicity of users and the different possibilities of reaction-opposition to conventional educational offerings in health services, the implications of the assumptions or beliefs *a priori* of part of the workers; and difficulties in dealing with the multiple disputes for caring.

## Discussion

Considering that health service work always happens in person, and based on a significant degree of autonomy of the worker who executes it<sup>4</sup> as a powerful encounter, able to produce (or not) the caring and a configurator even of the real situations of disputes over health service and projects of caring, we understand that it is precisely from the changes in the process of health service work that it will be possible to fix significant transformations in terms of strengthening caring<sup>2,14</sup>. But to achieve this one must count on supporters or facilitators operating in specially created collective spaces and which are politically guaranteed for such end, as well as operating tools or devices that bring, in their interior, the ability to affect and be affected, in every situation of day-to-day health service work<sup>2</sup>. To affect, in time, based on a clear *ethical-political project*, a non-negotiable implication: the production of caring aimed at the defense of all and any life, seeing the user as a valid interlocutor with whom one has to establish agreements<sup>2,11</sup>. In these spaces, and mediated by facilitators or helpers, PHE exposes the discomforts present in the daily work, placing them under analysis, thus generating self-analysis and self-management<sup>17</sup>. Thus, in this approach one does not operate in support of the externality of who brings the health teams solutions or methods to be applied, as some workers demanded at first, during the first workshops, but as support for affections, a form of mediation-facilitation in which one celebrates the multiplicity of existence, rather than discriminating them or trying to correct them by replacing representations of risk by representations more appropriate to a preventive order.

Indeed, the analyzers in this study were derived from the discomfort that the use of these devices and technologies generated: an intensification of the relations in the daily life of the teams. The meetings held during this study were conducted during the work routine of the teams in the basic health service units, in the middle of a wide variety of impacts on this routine caused by the establishment of the research project, which at the same time also imposed on it, all of which strongly affected the discussions and the production obtained: the one analyzing is also under analysis.

The following enunciation related to the first analyzer and is worthy of note: *the operation of the therapeutic project in the PHE approach as an intensification of the case, generating discomfort instead of meeting the initial expectations*. It can be seen that we are not dealing with exactly the same discomfort that was present in the study's central analyzer, or we are, but pushed to the limit, because the process required a lot of each participant, making it part of the construction of productive paths in the sense of the transformation of their daily routines. Also with this analyzer a number of enunciations emerged that pervaded several aspects of the teamwork in basic health services, and had been discussed in the workshops: from the limits of the scope of the workspace of each professional in the team (the various assignments in the context of therapeutic intervention, and the professional boundaries in terms of responsibility for the case), through to the relations with the user, which is sometimes difficult to link, and even in the absence of them when certain users were not even perceived as such by the team. Also there were enunciations that pointed to the delicate aspects of the necessary family approach, which however brings with it an unquestionable power for the construction of caring. The discomforts covered here culminated with the intensity of the feelings of helplessness, weakness, anxiety or sadness in response to suffering in general. One cannot forget, of course, the commonplace structural gaps in our health services system. We must admit also that external contributions to the team are sometimes necessary, especially with regard to the lack of people and resources, and also in relation to soft-hard and hard technologies; however even the obvious weaknesses in the chain of caring available can be addressed, in part at least, from a collective construction of new flows and, principally, from the establishment of an effective team.

One statement that led to quite productive discussions was the *idea of immediate and rad-*

*ical intervention in health service problems*, that almost all the subjects verbalized at some point. It is interesting to observe what is enunciated when a question is made, for example: What does "solve" a problem effectively mean? What is to "act" to solve a problem? Would such effective and "objective" action only contemplate hard and soft-hard technologies? The theme of *institutionalization*, for example, which arose in cases related to mental health and home care, prompted a repositioning of what it is to take action in health services, especially when it comes to caring, since it led to a reflection on an ethical-political project that goes beyond the act of trying, simply, to "eradicate" a problem quickly. Obviously here one is not weighing the relative value of the interventions required in urgencies-emergencies, for example, however the question remains: to provide caring or to obey a slogan? Only another collective agency enables self-analysis and a repositioning of the implications, which can be confirmed in the PHE approach<sup>13,17</sup>.

However the main point of this article was precisely the fact that a certain theme emerged with intensity in the initial process of the research, that of HE, which led to the choice of whether to define a second block of enunciations (or a second analyzer) and a new question: what had led the teams to value, to such an extent, the supposed need for effective HE techniques when building a therapeutic project?

Let's examine this. HE, also known as "sanitary education", is considered to be a branch or method of preventive medicine<sup>18</sup> and can be understood as the *educational process for knowledge building in health services that aims to ensure that the population takes ownership of the theme*<sup>19</sup>; or a *way to make the individuals of a people change their habits to assimilate hygiene practices and medical recommendations that would prevent the development of a set of diseases*<sup>20</sup>, for example, presentations to the community, as *transfer of norms and guidelines of hygiene and good conduct*<sup>20</sup>. Regarding this issue much has been discussed and experienced over the past few decades in the Western world, ever since the need for prevention and for addressing a certain "risk" appeared in relation to health sector workers<sup>21</sup>.

Several streams of thought sought to formulate increasingly less vertical HE approaches, seeking to go beyond the simple efficient persuasion of the user to induce behavioral change<sup>20,22</sup>. In the opinion of Pereira et al., when studying the negative representations regarding the H1N1 vaccination during the prenatal period, *it is essen-*

tial to develop communication strategies between the health services professional and the pregnant woman in order to establish a relation of trust<sup>23</sup>. A micro-politics interpretation would say that relations of caring precede representations, and that one has not entered the caring dimension if there has been no effect on the production of caring; on the other hand, if there is an effect, it is essential to monitor in which direction the change happened, supporting, facilitating the process towards the production of caring.

That is, the agency that leads us, health service professionals who are properly conformed in our territory, to intervene, as we have seen, includes educational activities, and exposes an implicit assumption: it is not a question of whether or not and when one should educate the user regarding the most appropriate way of living, since there is a risk to face, but the most efficient form of expression that one must resort to for this to be achieved. We believe that the certain initial discomfort with the proposal of *harm reduction*, perceived in certain workshops in which they discussed this concept, confirms the creation of that territory related-to-identity, since the acceptance of harm reduction, rather than inducing the abstinence of something, mitigates any interventionism. In the research such identity of the health services professional appeared to have undergone a deterritorialization, of an interventional nature, of its pedagogical mission, a process that ultimately produced some changes in the teams and even in the lives of the users involved, a finding based on the fact that in the present study the demand of for HE was increasingly losing its central position in every team debate: in some cases because the user effectively adopted another way of life, in others because it happened even before some of the supposed needs that had been brought to light in the discussions had been entirely resolved, and in others because other or new needs had now become more important for all involved.

Therefore, another line of questioning came to us in the course of the meetings with the teams: Why was HE presented as a big source of tensions and weaknesses by the teams, and then faded out in the debates, to the point where sometimes it was not even mentioned? This raised the questions: Was such behavioral change no longer necessary? Or it would have happened in another way? The answers, mostly positive, indicated a change, recent and even more important for the employees, now not only related to the user but to the team itself.

We understand that another form of agency was mobilized by the research, which shifted the terminology of an established territory. The device of a therapeutic project built based on soft technologies was maintained throughout the discussions, leading invariably to the subjects involved prioritizing other weaknesses in their work process, and not necessarily the lack of appropriate techniques to induce behavioral changes among users. New devices then began to be used in the process of facilitating the work. What effectively changed? Did the approach change and it was no longer necessary to “teach” someone to do this or that? Or was it perceived that there is a whole life that requires caring, and that we need to know more about it before giving any behavioral prescription? The present analysis tends to the second option: the theme of HE, which emerged and then disappeared, was shown to be a rather weak implicit assumption when the existential territory in which it had been based was put under review.

We understand that in this case it was likely that there was a disestablishment of the health services professional’s self-referential territory, denominated by authors such as Deleuze & Guattari<sup>9,16</sup> as *deterritorialization*. The assumption used here is that we (health service professionals) are shaped in the context of a territory of beliefs that normalize behavior with the objective of legitimizing prescriptions; this is “our” territory.

It is important to note that the process of deterritorialization, which is often likely to happen in collective situations in which the logic of affection prevails, has a great power to stimulate the emergence of another ethical-political engagement based on a project to defend all and any life<sup>4,11</sup>, that we consider essential in the context of live work in person: to give existence to caring in the health service, having as an implicit assumption a user-centered project. Only in this way do we understand it to be possible to enter into another semiotic system that engenders enunciation agencies capable of opening up possibilities for effective changes in reality, even when simultaneously leading to new reterritorializations.

It is worth noting, in this regard, that any deterritorialization needs to be conducted carefully, in a meticulous manner, since it transposes thresholds, and can even lead to considerable losses<sup>24</sup>. Indeed, the work of facilitating collective situations in the PHE field is an operation that is intensive in soft technologies, and as such, can both produce tools for the enhancement of caring in the teams’ daily lives, and undo work

that currently guarantees some level of results in assistance, without offering other possibilities for strengthening caring. In this sense, the above-mentioned ethical-political framework becomes crucial.

Obviously no one would defend the concealment of information about health-disease, currently accessible by the health services sector via a number of internal or external information channels, however this study leads us to propose, at least when it comes to enhancing caring and, especially in collective situations producing self-analysis, an increased level of encouragement for the shared operation of the device of a caregiver's therapeutic project.

If we take as an assumption that all pedagogic action starts with an intention, that of teaching, and so in this case is linked to the territory related-to-identity outlined here, it is not difficult to infer that the movements of self-analysis engendered by PHE pass both "inside" and "outside" this pedagogic dimension: inside, in the form of a *pedagogy of implication*, since it must place, at the center of the pedagogic process, the ethical-aesthetic-political implication of the worker in his action<sup>11,25</sup>; and outside, if we admit that not every change resulting from experiments in person is consistent with a prior intention, or even restricted to the field of learning. Thus, with regard to the debate raging around the so-called HE, this study indicates that the construction of an effective caring dimension goes beyond - well beyond - any strictly pedagogic dimension.

Further studies could provide more depth to this investigation, however we tend to conclude that it is not a question of insisting purely on expanding the pedagogical dimension of HE, but also transposing it, to go beyond the mission of teaching someone to live, and the way towards this could be indicated, in the case of the family

health teams, by the way one takes advantage of devices like the therapeutic project. It is essential to provoke a situation of deterritorialization with prudence and being under the guidance of an ethical-aesthetic-political project that does not negotiate the defense of all and any life. However whenever it is necessary to engender it, yes, to go beyond the established subject based on a certain conception of education as a significant reference, and on a certain interventionist mission as a transcendent value, aiming at effective changes in the sense of strengthening caring.

### Final considerations

The authors conclude that, by ensuring collective spaces for the development of therapeutic projects, based on a user-centered ethical-political engagement, the discomforts present in daily work routines are exposed and placed under analysis. One of the main discomforts identified by this study was the demand for HE, which however lost its central position during the course of the workshops. This change, which was not limited to a strictly pedagogical dimension, and which had been triggered by the shared operation of the therapeutic project as a device, was understood as a process of the deterritorialization of a certain conception of education linked to an interventionist mission, considered as established by health service professionals in general. As a result, the teams began to consider the user as a valid interlocutor with whom one has to establish agreements, even before positioning such user as the object of an educational process. The conclusions of this study are limited to the scope of its own realization, and to the conditions in which it was conducted, and further studies could provide depth to the analysis developed here.



## Collaborations

H. Slomp Junior participated in the conception of the project, conducted the fieldwork for the research and analysis, and drafted the final version of the article. LCM Feuerwerker participated in the conception of the project, gave guidance on the research and analysis, reviewed and gave guidance on the final draft of the article. MGP Land revised and gave guidance on the final draft of the article.

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