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Life stories, homeopathy and permanent education: construction of shared healthcare

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Abstract *Taking its inspiration from the homeopathic method of collecting data, and acting in a context of permanent education in health, this study aimed to analyze the possibilities that can be offered for healthcare by construction of Life Histories, in organized encounters for collective elaboration of shared therapeutic projects. Some changes that arose from the use of this strategy are discussed: health workers and users changed their stances in relation to each other; teams looked at cases with a new approach; and both these developments appeared to have created stronger and more effective encounters to produce care. It is concluded that, in the ambit of this study, Life Histories, by intensifying the collective operation of soft technologies, in an invitation to the shared therapeutic project, increased the porosity of the teams, and the recognition of the user as a valid interlocutor. The conclusion favors reorientation of approach to the other technological levels in health work, and recognition of Life Histories as powerful elements for production of effective healthcare.*

Key words *Life histories, Therapeutic project, Permanent education in health, Homeopathy*

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Introduction

This article presents a view on results of a study also dealt with elsewhere[1], the main aim of which was 'to understand the extra-clinical possibilities of homeopathy in contributing to collective construction of healthcare projects, in multi-professional workshops for permanent education in health, in the context of basic healthcare'. The base reference point for the whole study was Permanent Education in Health (PEH), which can be summed up based on the reviews by Merhy et al.[2], and by Merhy and Feuerwerker[3]: based on the discomforts the subject has experienced in real life, and being aware of the prior knowledge of each subject, it is possible to mobilize the transformational power of the reality of healthcare. In this way of working, which interacts with output in the field of the *micro-politics in work and care in health services*, there is a series of concepts of the several spheres or levels of technology in health. These are: hard technology (instruments, medication, equipment, everything that is previously prepared and ready for the healthcare encounter); soft-hard technology (structured technical knowledge, which when applied may be influenced by that encounter); and soft technology – relational technologies, and those that give 'life' to healthcare work, which take place through personal action, and which will produce (or not) the care[4,5]. This present work seeks to explore the potential of Life Histories (LH) as a soft technology, which is applied at the time of the healthcare encounter.

From the above terms of reference one can extract a certain concept of a 'device', an analytical tool that can be built by a mediator working with a group of people in analysis[1,6]. In Foucault's view, a 'device' can be understood as a rational and organized intervention in the relations of force that are in play in any given social scenario, thus having a strategic function when one intends to operate those forces, stabilizing them or developing them in a given direction[7]. In this study a device was employed which we have called the Shared Therapeutic Project (STP)[1], with which it was sought to produce new relationships when articulating a 'chain of healthcare'[8]. This device was to be a product, constructed collectively, and be able to involve a multiprofessional healthcare team, users, involved family, health managers, as indeed the healthcare networks as a whole. This conception of a therapeutic project finds its original approach in the field of mental health, but with added contributions from the body of research work which has been given the name of *micro-politics in work and care in health services*[1,4,5].

LH are used in research activities in various areas of knowledge, and various different procedures are chosen for collection, processing and analysis of information. In the field of health there is, for example, recent work – the 'first-person experience'[9,10] – that applies the phenomenological method in the anthropological proposition of the experience of becoming ill, and is currently making its first empirical efforts based on this formulation. Developing that proposal is outside the scope of this present text, but we can state here that, in spite of approximations in relation to the importance of LH for understanding certain dimensions of reality, having in common, for example, appreciation of the importance of the effect of prior experience on the present illness, the option taken by this present study was the use of mediation through narrative, by the whole health team involved in the treatment.

Built on certain Hippocratic principles, the most important being similarity, and using dynamized medications, homoeopathy was institutionalized in Brazil as a medical specialty and subsequently as a specialty of other health professions. Founded at the end of the eighteenth century, it uses various techniques and procedures, including specific attention to the facts of the patient's life that might be useful for a homeopathic reading of his illness. In his most important work, The Organ on of the Healing Art, Samuel Hahnemann, the founder of homeopathy, set up a first systematization of how to approach a case in homeopathic clinical practice[11], in which what was given a position of high importance in the hierarchy of symptoms, whatever the disease, was referred to as 'the state of spirit or mental state'. He also proposed giving attention and value to 'external' influences in the present process of illness, coming from 'special circumstances of life' (way of life, occupation, diet, etc.), and also a certain susceptibility or predisposition to illness in the individual, which some authors subsequently related also to the individual's constitution and temperament[12,13]. Also, in the homeopathic theory there was the assumption that we are all subject to a progressive chronic illness, that is to say, significant events during life can set off the activity of a silent or latent illness, which as from those moments begins to set off a succession of changes/sufferings which are not always obviously related to each other[14], if we consider the present-day nosological parameters.

Paschero[15] emphasized that all those who seek out homeopathy have a story to be explored, which in general will provide information that is hierarchically important for choice of the medication to be prescribed. Eizayaga[13]describes the mapping of information that is important in the biographical history, and the history of illnesses – in the technical jargon, the biopathographic history, or biopathography – taking as a starting point a narrative that should go beyond the pathological or medical history, recommending special attention for the mode of response to the existential circumstances. Thus, though one cannot say there is a life history model that is specific for homeopathy, it is certainly true that there are epistemic and clinical reasons for homeopaths to frequently use that resource, even if, *a priori*, as a simple instrument for data collection.

It is supposed, though, that there are effects of such a use that could go beyond the comprehension of homeopaths themselves: users who go to homeopaths bring to them their sufferings, their complaints, and, more than their 'illnesses', also a history full of desires and values, 'the life that comes with each one'[8], and perhaps because of this, new relational possibilities are opened up, something which is prior to the effect of the homeopathic remedy. Might this not be the reason why this modality of doctor-patient relationship often takes on different outlines, in relation to what is established in the sphere of official medical-scientific rationality? This study is an attempt to see such a process in action.

The study assumed the hypothesis that operation of LH, inspired by the homeopathic conception, and used in healthcare encounters, might result in intensive operation of soft technologies, in which the whole approach to the healthcare technologies could be re-oriented (that is to say, allowing the meeting itself, and the porosity to the user's needs, to dominate the use of soft-hard and hard technologies).The study attempted to experience the same resource that is an instrument in homeopathy, but now with the objective of evaluating the possibilities of such an approach in another circumstance than the homeopathic medical consultation: specifically, in shared construction of therapeutic projects by family health teams, in a PEH matrix.

Ethical and methodological aspects

This is an exploratory study, approved by the Research Ethics Committee of the Clementino Fraga Filho University Hospital of the Federal University of Rio de Janeiro (UFRJ).After approval of the project by the Ethics Committee, subjects participated after reading and signing the Informed Consent Form. The real names of subjects were kept secret.

The principal investigator of the study carried out and coordinated 34 weekly PEH workshops, with five family health teams, established in three basic units of the municipality of Colombo in the Brazilian state of Paraná. Each team comprised eight professionals: One doctor, one nurse, one nursing technician and five community health agents; one of the teams also had a professional working of the reception of the unit; and in one other, an oral health technician participated. In the discussion that follows the workers participating in the project were named as wk1, wk2, wk3, etc., according to the chronological order of their first statements during the workshops.

The following sources of empirical material were used: Recorded audio of the meetings; notes by the investigator-facilitator in a field diary; and a voluntary narrative of each one about their experience of the survey, requested at the end of the period of field work (a total of nine subjects agreed to the request for this).

Each team was invited to select a case based on the following stimulatory questions: What is a 'difficult case' for this team? And then, 'why this case, and no other?' After the problems involved in these choices had been discussed, the next stage was collective preparation of a therapeutic project for each case selected. All the 21 cases on which works was done with the groups in the study presented, in clinical terms, indications of a significant illness that would be susceptible to a homeopathic reading; however, only for some of them was the composition of a LH justified for the purposes of this survey.

Whenever tensions emerged in the production of the care (examples: the sense of powerlessness in the face of the user's problems, due to the difficulties of understanding the inter-relation of problems in the case; difficulties of communication and/or relationship between the team and the user; sometime a sensation of 'incompatibility'; and supposed disinterest by the user – and/or the user's family members – in relation to healthcare), the investigator-facilitator brought conceptions from the field of homeopathy into the debate. Of these, the concept that most enriched the debates was the construction of the LH, which is the subject of this report. Based on the assumption that discomforts with various users' lives arose also from the invisibility of their lives, from the process of their production as protagonists, the construction of their LH was then proposed – now no longer in connection with its original roll in homeopathy, but with another purpose: that of a device facilitating the preparation of the Shared Therapeutic Project.

No unique model for the LH was decided in advance, as long as the information obtained was significant for the user and for the team: depending on the case, concentration was directed to a long period of the life in question, or to only a restricted group of facts. The way of building the report was also defined case-by-case. However, some procedures became useful for all the cases: the researcher proposed visits to the health user in question, with at least two people from the team, one of them to note the information; a period was established, usually two weeks, for discussing the first product in the group. Considering that there was already a certain link between the team and the user, what was announced to the user was only a different purpose for those meetings, which would be, for example, 'to get to know you better, to hear you, to find out a little about your life so as to be able to take care of your health problems better' (as wk1 reported). These meetings with the user took place only with the user's consent, and were not sound-recorded. Invariably, the initial receptivity was good, and other visits followed for the complementation of the LH.

Special attention was requested for exploration of certain significant clues already known about the life of the user in question, such as the main adverse health effects that the subject presented to the team, and certain points were then agreed to guide the quest for more information. The most important of these guidelines, also oriented by homeopathy, was greater attention to the *turning-point moments* in life: whenever there were facts that were considered to be important by the subject herself/himself, or events that had caused changes, they were to be more deeply explored.

The artist and sculptor Pilar Rocha, in an artistic exercise[16], laid bands of plaster on parts of the bodies of living people which, after they had dried and been taken off the model, resulted in suspended and fleeting images that did little more than to suggest a human figure: the artist gave this mode of expression the name of 'transitory profiles'. We took inspiration from this notion in that, for processing of a life history, it was understood that there was, a priori, a certain *transitory profile*, through which the team would define the user, before the workshop began, and to which the process of the study itself, inviting an opening-up to the multiplicity of the subject, would add new information, new perceptions and new understandings in relation to the relationships that were involved in the lives in question. The trigger question that was used to orient this recomposition/adaptation of the user's transitory profile was: "What changed about (name of user) for you?"

Due to the limited space available for this article, a single case was selected, as an example, based on three criteria: that it was possible to apply the approach to the problem as proposed, during the field work; that it was possible to make significant advances in construction, stage by stage, of the LH; and that it was also possible for the resulting effects to be processed by the group acting as a group.

The next section reports: the facts and subjects which the team considered to be most important in the chosen case; the motivation for taking the case; the changes that took place (or not) during and after the process, both in the team itself, and also in the user involved; and the influences that such changes may have had on the collective leadership in taking the case forward.

Results

The activity proposed was not routine for the health teams in general, and experiencing it caused some sensation of strangeness, for example, in relation to the need to collect facts and internal experiences lived through by the user in past years, if one was no longer able to change them in the present moment. What one worker said was significant: "It's impossible to solve what happened in the past, so why go into it? Wouldn't it be better to do what the family members are probably doing: just put a big lid on it?" (wk3). Going into these questions gave rise to new questions, which significantly mobilized the teams to reposition themselves in relation to the cases: "Do you think there will only be insoluble problems in the past, only pain? What about if there are also great joys that have been forgotten?" (Interventions by the investigator).

With each debate, and discussion of its problems, new visits were made and the workers showed themselves to be less 'armed' with a strictly biomedical and preventive mission, and more mobilized to hear the stories that the users wanted to share, and which previously were not regarded as fitting in with the dead work that rules many of our health service routines. With each new meeting, the teams not only gained additional information for the comprehension of the case itself, though this was significant, but showed new possibilities of relationships, action and leading of the cases. After some meetings, several workers and health users said that they were now no longer "the same anymore". What was happening now? In fact, the workers effectively "lowered their guard"– as wk3 referred to the new relationship that was established, both by the teams and by the user. We now report the case that was selected.

Case report. Ana Maura, aged 62, 16 years a widow (her husband died suddenly), with three sons and four grandchildren, was the first case to be investigated in detail in the study. For the team, the 'transitory profile' of the user was of a woman with a languid attitude, and who had inexplicable and frequent fainting fits whenever confronted with her 'responsibilities' as a user of the health service. There was some dispute about this characteristic of Ana, because she is also diabetic and the team wondered what the role of a possible hyperglycemia might be in these manifestations. In any event, these fainting fits had become the stigma of Ana within the team – which did not consider them to be 'real': "When you go to her house it's difficult to have a dialog, she almost doesn't converse, she speaks very softly, slowly (...) she speaks almost inaudibly. When we arrived she usually 'has a little faint'. She is always dying. Isn't that right?" (wk3). "Her daughter has already said: 'I've given up on my mother'" (wk2).

The motivation for the choice of this case had arisen from the incompatibility of the team in relation to the user, and the sensation of impotence of some workers for taking care of her: "We don't see many solutions, we're always trying to make efforts and it doesn't work, you know? A great deal of disappointment: we haven't succeeded in making any progress with her by the traditional methods, have we?" (wk2). "She doesn't want to do anything right, she wants to be the exception to the rule. She wants to do it her way" (wk3) "That's the way it is and she'll die with that still being the way it is."(wk2). "It's stress for us, it's wearing, one wants her to get into line, but she is the exception." (wk3).

The team previously compared this lady with other more friendly and disciplined users, who accepted the measures that were prescribed. When the daughter made the statement of having "given up on" her mother, this sentiment was shared by the team – and thus the choice of this case was a consensus.

During the course of its construction, the principal mark of the story of Ana Maura for the team was the report of her losses of family members, whom the team imagined to have been three, but it was found that there were eight, one year after another: Adopted mother, husband, son, son-in-law (the last two murdered), brother, sister, sister-in-law and grandson: "…as from the first loss, she just got worse and worse, not having the spirit to live. What the family most complains about is her general discouragement, her lack of any will to improve. The illness has just gone on, and continues to go on, killing her more and more, becoming more and more established in her. High blood pressure she already had, diabetes, but then depression emerged more. So, she treats with various specialties – and each specialty does one treatment, of course – isn't that right? She takes an average of 20 pills a day." (wk2)

There were two losses that had most upset her and which were taken, initially, by the team, as being *turning point moments*: The death of the son ("I had him just for me for eight years, and I lost him!", she had said, according to wk2), and the sister-in-law ("she was her true friend, they even exchanged clothes", according to wk4). According towk3 the son that was lost, who was murdered just over 30 years of age, seven years ago, "was always her companion, and when he reached adulthood it was always he who took care of her"; this son left a grandson who is now 17 years old, and always together with the grandmother.

It was revealed that she was born in the interior of Minas Gerais, that 40 years ago she moved to Paraná, got married and set up a home in the metropolitan region of Curitiba. She likes to go to church, and said she was concerned about the recent pregnancy of her daughter, who is now 40, and lives with her. This information contradicts the initial *transitory profile*, that she only lamented the loss of another son, but that she did not concern herself with the person who actually take care of her: this daughter, who had a risk pregnancy.

Another subject area considered to be important was the fact that she was adopted: She had 11 'foster brothers', and keeps contact with all of them (she says she has six 'brothers in blood', practically unknown). Her adoptive mother died of leukemia when she was 14, and it was subsequently discovered that she had been presenting her 'fainting fits' since then. Many changes took place in the construction of this LH. In some discussions different references to Ana began to emerge, such as when, for example, she had been seen talking 'normally' with a female neighbor; and another day that she was 'working with pans' when the team arrived (her previous transitory profile had been of an 'unproductive' person). The prejudices that until then had been part of the discourse of the workers began to cede to other points of view: Ana "was now another person, she even smiled sometimes" (wk3).

She also began to take a different attitude in the visits; previously she had not visited the health unit, and she began to do so. She had commented that she was always quiet, did not have the habit of conversation, and that previously she had never had the opportunity to talk about her life: "Life had always been a thing of much suffering, who would want to hear?" (wk4). As the conversations with the team progressed, she was asked about her marriage, whether it had been "for love": "It was to escape from my brother, who bullied us on our little piece of farmland," she reportedly answered towk3. A debate followed on the subject of marriage as an 'escape valve' for many women in that region. It did not stop there, and one day the team revealed that they had asked an even more intimate question: "I asked: 'Everyone has had one great passion: Have you had yours?'; she answered: 'Yes', and I then asked if it was before her present husband, and once again she said yes, and said, 'He promised to come back to get me one day…'" (wk4).

Now it seemed that there was no longer any 'aversion' to the user, or irritation with her rebelliousness or even with her previously 'irritating fainting fits'. The very enunciation of the burden of accumulated suffering in that life (at some point someone remembered Ana showing personal objects that made her remember the past, and crying…) began to become part of the same phenomenon as desires that were still present, the potential for life that there was in that existence (there was still a great deal of pain for the losses, but also great hope for the return of a beloved person in her personal history, whom she had not seen for a long time). Her loves (the son, the daughter-in-law and the beloved person from her past), and the corresponding reminiscences, began to inhabit the daily life of the user, and her conversations with the team.

As her LH was constructed, the team increasingly changed their stance in relation to the user, and there was no more talk of 'a lost case': "She was not brought up by her parents; she did not marry for love, she has always worked extremely hard, but that's not the life she would have liked to have had' (wk4)". "I felt a little guilty, because I previously couldn't stand that 'hopelessness' that she had; I think now one can go to her house with less of a sense of rejection" (wk2). "She smiled more than once, and her face was so pretty!" (wk4). "Her face completely changed" (wk3, complementing wk4). The report of one of the last visits during the study is representative of this observation. "She came to us looking different, it seemed that she'd got 10 years younger, she was going out more, yesterday she went to church, she started sewing again" (wk3). "The house is a bit more agitated, now" (wk4). "She is worrying about Aurelice's pregnancy, now she says she is afraid of losing her." (wk2).

There was discussion of the issue of whether the fainting fits were 'real', or not (subject of previous attributions by the group), and what importance this might have at this moment. Now a mutual opening between the user and the team was predominating, and people in the team even went to a birthday party in her house – something unprecedented. Then the construction of the therapeutic project in the workshops went deeper, discussing various subjects, such as the triangle between mother, favorite son dead, and daughter who currently lives with her. In this case it was concluded that the relationship with the daughter, who is pregnant and who is accompanied by a high risk prenatal service, in reality was burdened with much more intricate implications in terms of affection. It was also concluded that for us, this daughter herself was also an important candidate for a therapeutic project.

The visits to Ana that follows the phase of the conversations to build the LH, now once again took up the subject of her health, but trying primarily to understand her view in relation to this, the values that she attributed to the life ahead of her, and the place that care of her health occupy in this context. In one of these last visits we had a surprise: "She even asked me whether I had brought my blood pressure device, and asked me to take her blood pressure: It was 16/10" (wk3). The barrier had been overcome.

Discussion

The changes reported above, both for the health workers and for the health user, relate to a more developed encounters between the health workers, and also between the user and the team, provided by the experience of LH. They provided an opportunity for all to talk about their own experiences, for the first time in a long time, and in that context of health, which until then had seemed to all to be codified in some other way. The taking of a LH, the prolonging of the physical time of personal interaction between the team and users, appears to have made it possible to re-qualify the relationships by making them in themselves something singular, and also to produce other types of link. The cognitive record began to not be enough, on its own, for the recognition of all those intensities that escaped a simple 're-comprehension' of past events. More than that, this process seems to have put new – and also collective – affects into circulation, and as a result, certain plans for creation of a new existence, both for the workers and for the user, gained visibility.

Because they ceased to make sense, the transitory profiles, previously shared by users and teams, are then abandoned, revisited, reoriented. These profiles, with their scope limited by medical diagnoses, and by modes of relationship that were in general very restricted, hid the lives that were present there, and created a structure of professional interventions in accordance with protocols, which were not always efficient by themselves, and are sometimes even frustrating for both parts. The debates were now inhabited by lives that did not seem so distant from those of each member of the group, including that of the investigator. Lives which in themselves are multifaceted no longer fitted into transitory profiles – which had sometimes been taken as definitive. This change was not restricted to the way in which the user was seen by the team, but also the other way around: as a result of new outlooks in the encounter, her own power for life was amplified.

This study was not looking for strictly rational, social or psychodynamic interpretations, nor even any confrontation of possible 'causes' in the past for present problems. Rather, it sought to intensify the encounter, in the sense of causing other meanings for life to emerge, opening the way for new possibilities of organizing, building and managing care. A study on mental health carried out in the city of Campinas (São Paulo State), also from a micro-politics perspective, enabled a formulation of a manner for construction of cases similar to the one used in this study[17]. In the paragraphs below we outline the conceptual matrix relating to the LH delineated in that study, to facilitate understanding of meanings that were opened up for the case reported here, and beyond it.

In that study the LH were produced as a group of approximations of the lives in question, without any linearity or even hierarchy, each one of them being at the same time many and different stories – a multiplicity, one might say. For this reason, we have borrowed from that study a concept that we consider to be central for the purpose of the one reported here: the concept of *networks of existential connections*. This is an image to be extracted from the LH whenever all the meanings come back to a singular field of relationships and encounters between the user and people, services or even events[18].

These provide a cartography of the intertwined series of relations and connections that the healthcare user constructs with people, family members, events, places and services, and which are fundamentals for the way in which the person produces himself in the world.

Another aspect considered, this time more obvious, is the *history of the illnesses* of each subject, which habitually link the subject to a diagnosis, based on rules of enunciation that are specific to the health services. One of the important problems that the health teams face is frequently the restriction of exploration of the user's history only and precisely to the field related to the user's diseases, limiting the explanatory nexuses of the current suffering to the biological dimension. Ways of being in the world, the meanings attributed to different aspects of existence, etc., go unnoticed or are not even thought about as important in recognizing 'the life that comes with' the user – and these are part of the production and the possibilities for dealing with certain sufferings. It can be said at this point: the history of illness is coherent with the homeopathic biopathography, at least in its technical outline, while a collective reading 'of the life that comes with' the user brings other dimensions of the LH into the picture. On this aspect, the *history of family units* is also indispensable, since, according to the study cited above, they are the means by which paths are built inside the family nucleus in the networks of existential connections[17]. Intimately related to this dimension of the subject's history, there is also *the territory of everyday life*, a space that is replete with significant reports to be shared, especially when it is possible to experience, together with the care team, the interest in all the possibilities of connections that living with others, of varied and unpredictable types, can allow[17].

Finally, another construct that comprises the LH point of view that we have operated with here is that of *life trajectories*, understood in micro-politics terms as the multiple paths, each one with its line of significance, that the user sets off in the networks in which he inserts himself and of which he is a part, at certain moments of his existence[17].

The case reported above gives us an example of those dimensions. Its way of communicating and presenting itself to the health community and team – *a priori* a transitory profile, initially confined to the user's history of illnesses – when it emerged in the territory of everyday life, actually translated, in the directions taken by the subject's life, into profound changes in a singular network of existential connections, and indeed inside the subject's family unit. It was possible to carry out a similar existential mapping in other cases in the study, during the period of field work, and we have reasons to believe that it can be done in the majority of cases.

The losses that the user experienced in the case reported above are examples of what we previously named *turning-point moments*, which, upon analysis, appear to have become milestones mapped onto the various paths of life of each user, and the histories of the family units and of the user's illnesses, and which operated as inflection points in the existential connections that the user established at each moment, undoing some of them and connecting herself to others at each 'turning point'.

We restate this: It is not a case of taking the turning-point moments as causal benchmarks, but of recognizing that they can be useful in the analysis of an existential mapping.

Thus it is that we believe: this study achieved the emergence of maps of multiple paths and histories, which go beyond the existences in question, motivating the teams to place themselves under analysis; and on the other hand the users themselves, who, upon being recognized as valid interlocutors, begin to operate in a different way. In practical fact it changed the way in which the care team saw itself as being expected to connect – to activate what we would call *networks* or *chains of care in action*; and this movement also included not only the ways in which the user began to start to make movements in her/his own life, but also the constitutive tension between the micropolicy of action – due to the installation of a different relationship between the carer and the cared-for – and the lifeless work instituted by rules and regulations of the health organizations[8,17].

This seems to us to be a fundamental element of the experience that is analyzed here: from being a problematic body/no knowledge subject/object of intervention by the team – and thus not a qualified interlocutor – the healthcare user becomes a person who has a complex life, with its knowledge and desires, with whom it is necessary that the team should hold a dialog so as to produce, in a shared manner, new possibilities of handling the problems and sufferings. In this study the strategy of construction of the LH appears to have led to this repositioning, by creating a mechanism that empowers the encounter, which helped enrich other technological levels of care, such as the clinical care itself that is in play in each case – thus operating as a device for production of an encounter that provides care.

Final considerations

Further studies could clarify the importance of the inspiration having arisen from homeopathy in terms of obtaining the results that have been reported here. Anyway, over the course of this survey, the role of LH in the construction of therapeutic projects was experienced in workshops with teams of family health professionals. In these conditions, changes were seen, in the repositioning of both health workers and health users, and in their relationship to each other, and also in the way in which the cases were approached by the teams – who appear to have been influential in the building of the care-producing encounter.

It was concluded that, in the context of this study, Life Histories, by intensifying the collective operation of soft technologies in a healthcare encounter, provided by the invitation to take part in the shared therapeutic project, operated a reorientation of the other spheres of health technologies in the context of care, and acted as strong devices for the production of healthcare.

Collaborations

H Slomp Junior participated in the project design, carried out the field work and analysis and wrote up the final version of the article. LCM Feuerwerker participated in the project design, provided guidance on the research and its analysis, and supported in the revision and guidance for the final version of the article. EE Merhy participated in the project design, and revised and provided guidance for the final version of the article.

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