COLLABORATIVE GROUP PRACTICES: EXERCIZING DIALOGUE IN A HEALTHCARE SETTING

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The healthcare system in Brazil has undergone extensive reform over the last two decades. In an attempt to realize the national healthcare goals, emphasis has been placed on the primary healthcare. For that, a strategy called Family Health Program was created in order to strengthen the primary care delivery and help connect all points of care, thereby creating a unified and coherent system (WHO, 2003).

In an attempt to be more collaborative, there has been an emphasis on community based healthcare and its form of care delivery. Collaborative here refers to the attention given to developing forms of health-related intervention with the involvement of the entire community that are, consequently, coherent with local values, beliefs, and practices. Through this process, more quality interaction between health professionals and community is encouraged (Camargo-Borges & Cardoso, 2005).

In order to realize the goals of a more collective and collaborative approach in the Family Health Program, there are some mandatory activities that each team should develop within its working community. One is the development of group activities. Usually, the aim of these

groups is to help participants (i.e., community members) develop more knowledge about the disease or topic, providing information and access to the health system (Brasil, 1997). However, traditionally the most common tool for helping people with health problems is the health professionals' medical expertise. Therefore, the ultimate goal of collaboration among professionals and community members does not automatically contribute to a dialogic, relationally sensitive opportunity for equal participation in healthcare issues (Camargo-Borges & Japur, 2005). There is a gap between traditional training in techniques and skills, such as diagnosis and treatment, and training in understanding the complexity of human communication processes (Camargo-Borges & Cardoso, 2005).

How can healthcare professionals learn to move beyond their analytical and practical skills (content) and develop sensitivity to more collaborative and relational modes of practice (process)? This question points to the need of developing a dialogic approach to healthcare, which centers on a relational meaning making, that can improve and transform the process of healthcare delivery by transforming the professional/patient relationship. In an attempt to contribute to this effort, the objective of this chapter is to explore the very practical ways in which participants of a group in the healthcare context work together to create the opportunity for dialogue.

For that, a theoretical understanding of dialogue will be offered followed by a brief case study of a group intervention that will illustrate dialogic practices in action by showing some interaction between health professionals and participants. The chapter ends discussing the implication of dialogue in practice, showing the potential to create engagement and co-responsibility. Furthermore, it reflects about the ways in which dialogue might be useful to help transforming healthcare practices by transforming relationships.

Exercizing dialogue

The term dialogue is used in many disciplines having different understandings. According to Gergen, Gergen and Barrett (2004), there is no such thing as consensus among scholars about the function of dialogue and its applications. Additionally, the commonsense definition of dialogue is too vague, indicating that dialogue is simply conversation among people. For that reason, the authors emphasize the importance of showing explicitly the approach one is taking when talking about dialogue.

The theoretical approach of this work is dialogue as understood by authors such as Bakhtin (1981), Buber (1970), Gergen (1994), Penman (2000) and Sampson (1993). These authors share in common the understanding of dialogue as a coordination of discourse, a concept and a praxis in which meaning and knowledge are constructed by people coordinating their activities and not by isolated individuals exchanging their unique subjectivity.

According to Bakhtin (1981), dialogue is a responsive activity, in which communication is a fluctuating, unpredictable and multivocal process. The interlocutors are immersed in a process that shapes and forms them even as they shape and form it and one another in ways that are not entirely predictable or finalizable. To Bakhtin, as well as to Buber (1970), dialogue occurs when conditions of curiosity are fostered, despite differences in values and beliefs. Participants in dialogue engage with one another with respect and curiosity. According to Gergen

(1994), dialogue is about interrelatedness. When people engage in a dialogue, they become inextricably interrelated in their talk, therefore enlarging the possibilities of interrelated future actions.

Two core concepts are important for us to consider in order to better understand dialogue and communication: monologism and dialogism. Monologism, according to Sampson (1993), is characterized by a focus called the self-contained individual. In monologic relations, an individual only need focus on him/herself – his or her motives, beliefs, intentions, and cognitive abilities – to understand. In short, monologism prioritizes the individual and his or her reasoning abilities with little to no consideration for the other as a reasoning being.

Dialogism, on the other hand, offers a very different understanding of human interaction. As Sampson (1993) explains, in dialogism "*the most important thing about people is not what is contained within them, but what transpires between them*" (p. 20, italics original). Dialogism is informed by the idea of a relational and engaged process of communication among people with endless re-descriptions of the world. The dialogic understanding of meaning that Bakhtin (1981), Sampson (1993) and a host of others propose, cannot be mistaken as a "feel good" process but is concerned first and foremost with appreciating the complex process by which our worlds are made. Taking dialogue as a continuous process of meaning making requires a focus that is less centered on any specific content and more attentive to the relational aspects that enhance and invite participants to respectfully engage in the construction of new social realities (Penman, 2000).

Social constructionism and dialogue are two interrelated theories as both embrace a relational view of a person, focusing on the ongoing relational processes happening in a conversation. Furthermore, both also give attention to the potential of multiple local realities

amplifying the voices of the participants and enriching the conversation (Gergen, McNamee & Barrett, 2001).

The Hypertension Group: dialogic practices in action

The particular group presented here had been identified by health professionals as an extremely successful group. The group had been meeting consistently for three years, while other similarly organized groups (e.g., a diabetes group, a diet group, a women's group) disbanded as soon as the coordinator in charge had provided all of her/his professional knowledge about the group's health concerns.

The hypertension group was initially created to help people suffering from the chronic disease of hypertension. Interestingly, it quickly transformed into a group focused more on general, daily issues. For example, it was not at all unusual for this group to organize parties and meals for the community as a whole, to practice and perform dance, or to plan a cooking class where participants could learn how to prepare a nuturious and tasty meal for under one Brazilian Real. In fact, this group began inviting the community of the local health center to participate despite their lack of affiliation with the formal purpose of the group (i.e., hypertension).

The group was coordinated by a nurse and her assistant. In addition, there was always a student participating (e.g., medical student, nursing student, pharmacology student, etc,). It was also not unusual to have experts from other fields present, depending on what the group wanted to discuss. The group members could be hypertension patients or not, as indicated above. Often, participants brought friends. As we can see, one feature that permeated this group was a flexibility concerning membership.

The group established a pattern of open conversation, letting the group members – in concert with the health professionals – co-create the topic for discussion at each meeting. The group maintained their identity as "the hypertension group" by taking blood pressure readings collectively at the end of each meeting and by following the treatment needs of each member. Regardless of one's health record, the reading was taken, with everyone – professionals and participants together – using the appropriate measurements.

Not surprisingly, this group was recognized as a group where any new information within the community (as well as within the health center) could be discussed. Advice about setting up new activities were frequently sought from this group, as well as ideas or questions that might potentially effect the entire community.

This present study wanted to explore the features that function to make this group a success. In so doing, the interactional practices of this group were viewed as dialogic. The question was: What are the particular interactive features demonstrated in this group that enable dialogue? The objective was to explore the very practical ways in which participants work together to create the opportunity for dialogue (Camargo-Borges, 2007). The investigation of this group's conversational practices can assist future design and facilitation of dialogic groups in a wide range of contexts. Also the understanding of how this group succeeds in creating a dialogic process offers important information concerning (1) the role of professionals and, in the present case, (2) the promotion of health.

The specific case focuses on the responsivity of group members (professionals and participants) to each other. For example, the striking difference in this group's interaction is the way in which the professional (a pharmacist in this case) positions herself in relation to the group members. She is both expert and learner. To that end, one might say that dialogue is about

significant social reform – in the present case, reform of the professional's "all knowing" position as well as reform of the patient's lack of knowledge and expertise. This kind of social transformation can be achieved through participants' mutual responsivity.

What can be learned from this one group that has succeeded in operating in a manner that can be clearly distinguished from a traditional, hierarchical model of professional-client communication? Examining this group in detail offers some interesting ideas about healthcare in any context.

The Responsivity of Dialogue in the Group

For the purpose of creating reflection about dialogic practices in the field of health care, an illustration, in the context of the Family Health Program will be given. The excerpt offered is of a brief interaction within this hypertension group that was considered to be a fresh form of dialogue and can help in illustrating the features of dialogue in practice. This excerpt is from a meeting attended by ten participants/patients and four health professionals. One of the health professionals is a pharmacist, invited by the group, to talk about medications. Prior to this meeting, the group had been discussing the varied problems they each experienced with their medications and how they each coped with their difficulties initiated by different medications and various combinations of prescriptive drugs. These discussions prompted them to invite the pharmacist to offer her expertise on these issues. At a certain point in the meeting, the topic of home remedies emerged.

Cissa (PARTICIPANT) – I went back to the old days, you know? The story is about a doctor who told me to use an anti-inflamatory cream to treat an irritation, right?

Laila (PHARMACIST) – Yes.

Cissa (PARTICIPANT) – It was really painful. A very sharp pain. The cream burned my whole heel! The skin was coming off! You should have seen it! Well, then I stopped using that cream. And do you know what I did? My mother used to use this remedy. She made an alcohol solution out of grain… no… it was grain alcohol with "cloves" and pepper. The one … the whole clove, you know?

Donna (PARTICIPANT) – And how about your skin? Didn't this mixture irritate it?

Cissa (PARTICIPANT) – No. Not this remedy.

The pharmacist, who was facilitating the meeting, adopted a non-judgmental stance within the group, letting the patient talk about how she managed the situation. With just one word, "Yes," she was responsive to Cissa's story and encouraged her to continue with her description of her mother's commonsense treatment. The pharmacist's listening position seemed to give room for other stories to emerge. Group members started to offer their own stories about home-made remedies. They felt free to talk about healthcare treatments that are very much part of their local culture yet are alien to the culture of modern medicine.

Cissa (PARTICIPANT)- Listen, after that, my knee started to hurt.

Donna (PARTICIPANT) – What? (expression of astonishment)

Cissa (PARTICIPANT) - I took a book that I have at home. Avocado with grain alcohol. I put the prescription the doctor had given me aside and then started to

use this home remedy on my knee. It got better! Now, I can't take the medicine. I can't take the anti-inflamatory medications. I can't put any of this on my knee.

Jane (PARTICIPANT)– Is it the one with avocado?

Laila (PHARMACIST) – The alcohol... the alcohol. It is... in fact.... it is going to help in the healing process.

Jane (PARTICIPANT)– The avocado that you cut, was it ripe? I have done this as well.

Cissa (PARTICIPANT)– No. You have to put the avocado in the sun and take the brown skin off. Then you cut it all and put it inside a glass.

Laila (PHARMACIST) – Some people use the avocado's seed. They put it in alcohol and leave it there until it softens. Then they use the solution – the alcohol with residue from the avocado seed – on the problem area.

Group member – Really?

Cissa (PARTICIPANT)– Wow!! It really gets better…

Jane (PARTICIPANT) – We have to cut it when it is green like that, when you just pick it from the tree.

Laila (PHARMACIST) – Will you remember to do some research about the avocado seed to find out how it can be used to treat rheumatosis? (Asking the student of pharmacology who was attending the group that day)

Here, we see the pharmacist adopting an open stance. She opens the conversation to all participants, allowing more interaction among the group and allowing them to bring and share stories about how they have treated their own health problems. They feel free, even in the presence of a pharmacist, to exchange stories of their own home remedies and the success they

have had using them. By allowing the group to share their knowledge, the pharmacist does not need to abandon her own scientific knowledge. As a form of collaboration, she explains the healing process of alcohol to the group and asks her student assistant to conduct further research into the healing powers of the avocado seed.

> Laila (PHARMACIST) – Listen, the next time I come here, do you know what we can discuss? Let's talk about home-made medicine. I think that would be interesting.
>
> Cissa (PARTICIPANT) – Nice!
>
> RESEARCHER – So, is it a deal?
>
> Laila (PHARMACIST) – Home-made medicine!!!

In this short excerpt, the pharmacist, in her invitation to extend the group's conversation in another meeting, was being responsive to the contributions of the participants. She was illustrating her curiosity for the members' ways of making sense of their own healthcare. As the expert or scientist, the pharmacist was open to the comments of the participants. By making space and legitimating the discussion of the participants' non-traditional health treatments, the possibility for future collaborations was crafted. Participants became curious about each other's remedies and apparantely were more comfortable to share both their knowledge and practices with professionals

The argument here is not that healthcare professionals should give up the medical or scientific discourse that allows them to diagnose and treat illness. In this illustration, the pharmacist is seen as "holding her own" (i.e., she is the professional) while being open to the understandings and local practices of the other. This is an illustration of the tensionality of dialogue (Stewart & Zediker, 2002). Neither the professional nor the patient has the "truth."

Rather, they all have coherent stories and the challenge is to coordinate those stories so that health is promoted.

Implications of Dialogic Collaboration

Is it possible to value community members' home remedies along with scientific medical treatments? This kind of dialogic tension can be useful when talking about a health team working within a specific community. By locating a health center within the community, a culture shock of sorts is created by virtue of connecting extremely diverse backgrounds – specifically, medical/technical expertise vs. folk wisdom, local knowledge, and home remedies. The distinction can be seen as a clash between science and commonsense. The challenge becomes one of approaching each side of this culture divide with respect and curiosity for each community's coherence.

This excerpt of the group is identified as an example of dialogic process based on the collaborative way in which they have and continue to create a strong sense of relational connection, participation and belonging among themselves as well as to the broader community (McNamee & Shotter, 2004). They have found a way to maintain an open door policy that invites others from the community to join their activities thereby keeping alive a fluid and constant relationship between the community and health professionals.

One central feature of dialogue that happens in this group and seems to be one of the reasons for its success is the focus on the process of their conversation and their relational connection, rather than on the purported content (i.e., hypertension). We see this group coordinating multiple beliefs and values. There is no attempt to determine whether the expert's

information or the community members' remedies are the best answer. The group manages to let these multiple realities co-mingle with no attempt to come to consensus or a decision of one method over another. It seems that they have, over time, successfully created a context where the same old topic (in the present case, healthcare treatments) can be discussed in a way that differs dramatically from the typical medical encounter.

Clearly, other medical contexts demand very different forms of practice. There are times when a healthcare professional does not want to consider the folk wisdom of the patient because doing so would endanger his or her life. However, the dialogic group process being described here is still significant. A patient who has been able to tell his/her story, to share his/her beliefs and fears with a health professional and experiences that professional's responsivity to his/her stories, is more likely to be responsive him or herself when the professional offers an alternative understanding of the situation. The group in this illustration does not exclude the voices of any group participants, professional and community alike. Nor does this group seek to find one answer to a medical ailment. They work instead to respectfully learn about the various ways in which their ailments can be relieved, constructing a new sense of care and shared responsibility (McNamee & Gergen, 1999).

This group, by some standards, could be seen as a dysfunctional group because their conversations are not focused on hypertension and behavioral change. However, from a dialogic perspective, this group can be seen as creating an important conversational space where diverse understandings of health and treatment are equally respected. Through this group process, the expertise of the professionals is respected as is the local expertise of the community members. In this way, they create an environment where they can continue in dialogue with each other,

finding alternatives to deal with their health and creating common modes of treatment, even when professionals and patients differ in their opinions.

Here there is a suggestion that the dialogic process developed within the hypertension group could work to inform a new mode of healthcare delivery. This group offers useful ideas for developing health practices based on responsivity, dialogue and relationally sensitive process of communication and negotiation between health professionals and patients. Dialogue among the hypertension group created a different relational context, which subsequently transformed the relationships among all participants. They successfully achieved the construction of a context where all participants felt connected to the health center, motivated and willing to come back to the group and also were able to gain whatever support they needed as they negotiated the complex process of health/illness.

While this case illustration may seem small, those in the community as well as those working at the health center have recognized this group as successful. Their success is visible in two ways. First, it is the only group that is enduring and well attended. Second, the success of this group helps to strengthen the relationship between the health center and the community. Thus, in a small but significant manner, the dialogic mode of operating within the hypertension group offers generative ideas for addressing group practices.

This kind of intervention is not about therapeutic process in the sense of working to change the way patients think or feel, nor is about changing their undesirable behaviors. It is about the possibility of creating a coordinated pattern where people can go on together, negotiating their needs and creating actions that are meaningful for both patients and professionals. This example shows us that dialogue is not just about finding the “right” method

to “cure” an individual’s problem. Rather, dialogue is about transforming healthcare practices, as well as energizing new ways of building community/professional relationships.

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