

Towards an education that moves like the tide and floods the everyday routines of healthcare services*

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The text proposes to reflect on practices of health care and management, understanding them as well dated social practices. Situated at the intersection between the areas of education and health, and, within them, in the area of body research, our study approaches health care practices as cultural pedagogies from which certain

meanings and behaviors are prescribed, but also through which new meanings and practices are constructed – and these new meanings and practices shift, bifurcate, and question those prescriptions. In other words, we understand the field of health as a territory of teaching (pedagogical–corporal formatting), but also of learning (experimentation of singular ways of doing and saying in health), and health care and management are understood here as a conflicting (corporal) assembly between subjection forms and experimentation forces, based on which health care practices are woven.

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The hugeness of the sea of health care practices

Diego had never seen the sea. His father, Santiago Kovadloff, took him in a journey to discover the sea. They travelled south. The sea was behind the high dunes, waiting. When the boy and his father finally reached those sandy heights, after walking for a long time, the sea was before their eyes. And the sea was so huge, and the sea was so bright, that the boy became speechless with all that beauty. And when he finally could speak, trembling, stuttering, he asked his father: “Help me look at it!” (Galeano, 2006, p.15)¹.

Among many other possibilities, Galeano’s text allows us to think about the processes of educating our capacity to look. And looking, in the context of this text, will be viewed as a capacity that extrapolates the biological dimension of the act of seeing and includes the movements of looking, apprehending and signifying what is seen, with the multiple meanings that different cultural groups produce in order to

¹ All the quotations have been translated into English for the purposes of this paper.

code, name and describe, in an active fashion, the world – people, objects, contexts and relationships – in which they live.

In this perspective, we can say that not only our vision, but also our bodies are educated through a set of processes that transform us into subjects of a culture; for example, subjects of a health culture and, even more specifically, of a professional health culture, which is exercised within the scope of the health care system in Brazil. Becoming a subject of this culture involves a complex of teaching and learning processes that permeate many levels and dimensions of our lives and include what other approaches separate as education and socialization. Therefore, the act of educating presupposes processes of teaching and processes of learning: who teaches us, what and how we are taught, and who learns and what and how is learned. *Learning*, according to Marlucy Paraíso (2011, p.147),

[...] means opening ourselves and rebuilding bodies, searching for creative acts, rebuilding life, finding the difference of each individual and following a path that has never been followed before. Learning means opening ourselves to the experience with “another one”, with “others”, with anything that arouses desire. Due to this, in order to learn, it is necessary, “first, to learn how to unlearn” (Caeiro, 1986). To learn how to unlearn the constituted senses, the produced meanings and the constructed thoughts, so that we can open in ourselves the differences.²

² The author explains that the notion of learning that she developed was inspired by Deleuze and Fernando Pessoa. The need to learn how to “unlearn”, mentioned by the author, is based on Alberto Caeiro (1986), who, in his instigative poem entitled *Deste modo ou daquele modo*, published in the book *O guardador de rebanhos*, says that we need to strip ourselves of what has been learned in order to produce new meanings, to be affected and build new routes to what is usually called ‘self’. In this same direction, Foucault (2010) talks about unlearning as a movement of testing life, disposing of corporal pedagogies that had been previously instilled and experimenting with learning processes that are less accustomed to the government of human conducts and to subjective formatting, and more interested in the incarnation of other forms of life, right there where, as Paraíso (2011) argues, the body opens itself to the miscegenation of the encounter with other bodies.

Teaching, to the same author, includes transmitting, informing, offering, presenting, expounding, explaining. To some extent, it is a process that aims to govern conducts, to produce certain practices, to include and exclude, to hierarchize, normalize and divide subjects: those who know and those who do not know, those who have good health and those who are ill, those who follow and those who do not follow the rules. In this sense, “teaching, therefore, is very different from learning” (Paraíso, 2011, p.147), as teaching presupposes homogenizing and learning presupposes the creation of possibilities of singularization (Guattari, Rolnik, 2000). Singularization is understood as the difference that results in us and which dissolves us, as we are opened to other ways of being and of being in the world, bifurcating the search for homogeneity that guides teaching. Both processes – teaching and learning – compose our education as subjects of a culture, our apprehension and our handling of language and of the codes that constitute it.

Thus, Diego’s request, expressed in the phrase “Help me look at it”, presupposes the assumption that the *sea* (the hugeness of the *sea* of health, the *sea* of education and professional practice in health, the *sea* of the health care system) does not exist in itself. In order to be seen, apprehended and signified as such, it needs to enter into a certain domain of signification, and this presupposes teaching how to see and also (re/un)learning how to see, with and based on certain systems of signification, and testing these same systems – denaturalizing them, understanding them as constellations of meanings produced in a certain time and in a certain space. In this direction, it is possible to say that nothing is ‘natural’³, nothing is given beforehand and that all that we teach, learn, apprehend and do, within these contexts, is anchored on partial and provisional knowledge and practices, which result from disputes fought in diverse social and cultural scopes. Precisely due to this, such practices can be seen, revised, questioned and modified. Admitting this is not a simple matter, as it brings the need to change the logic of our thought concerning several aspects of what we learn when we are talking about educating in the broad field of health.

³ It is important to highlight that we agree with Guacira Louro (2003) when she argues that what we usually configure as natural is also culturally produced.

The aim of this text is to suggest possibilities of ‘helping us look’ in order to reflect on care and management practices in health, including ourselves in them in other ways, viewing such practices as pedagogical processes that teach, on a daily basis (in different ways, under different perspectives and points of view), all the individuals who are involved in health production.

To guide this specific form of looking (seeing, apprehending and signifying) and to structure the argumentative axis that we outlined so as to materialize it into a text, we describe, in the next section, scenes of the daily routine of Brazilian health care services that we have experienced. We believe that these scenes are familiar to a large part of the potential readers of this text.

“Help me look at it” – *tides* that invade the daily routines of health care services

Scene 1: The playroom that does not have toys – In one capital city of the Northeastern region of Brazil, during a technical visit to a health care service for children, we were invited to see the physical space before participating in a playful activity with the children and their families. It was a hot morning and, in that space with few openings and little external light, the heat seemed to be even more intense. The children, spread across the many rooms of the service, were sweating, and so were we. On the corner, a door with colorful letters indicated the entrance to the ‘Playroom’. When we entered it, we saw children seated at tables, drawing, painting and writing. There were no toys in that room with empty shelves. We talked to the children and to the psychologist who was with them. Then we entered the coordination room and we were surprised to find that it had air conditioning. At the same time that we relieved ourselves of the heat, we were visibly bothered by the situation to which the children, their families and many workers were submitted in the other rooms of the service. Our attention was caught by shelves full of toys in this room. When the coordinator noticed that we were staring at the shelves, she said: “We keep the toys here because if they remain in the playroom, the children break them all”.

Scene 2: The aquarium – It is a health care service that looks more like a shed, divided into few rooms by partitions. Height from floor to ceiling is very large, the walls are dirty with dust and mould, the room smells of ‘poor cleaning’. About this space, one worker says: “When I arrived here, I was very upset about the ambience, the dirt, these walls – I found everything disgusting”. Tiles amplify the northeastern heat. The most ventilated area of the space remains closed and users are not allowed to circulate inside it, unless they have some activity monitored by a professional. After the activities are concluded, the ventilated space, without tiles, with some vegetation (the rest of the space is made of concrete) and breeze is closed. The rooms that have air conditioning are those that users attend according to schedule: coordination, assistance rooms, meeting rooms, conviviality rooms, technicians’ rooms. The latter is called “aquarium” by the users, because there is a rectangular, transparent glass composing the wall, through which, according to the users, the workers watch them “without having to mingle with us and without having to feel the heat”. During most of the time, users stay beneath the tiles and with no air conditioning or fan. One user states: “There was no workshop today. We spent the whole day just feeling the heat. From 8 to 11, everybody here doing nothing and they [referring to workers] remained inside that room”.

Scene 3: What is the use of involving users in management? – One of us attended a meeting of the technicians and managers of a municipal health department in a metropolitan region. The agenda was: discussing the strengthening of user participation in the spaces of collective management of the services. After some time, one of the technicians questions the group: “I don’t understand the purpose of this discussion about involving users. What we have to do is being well prepared to assist them when they come to our service...”. The meeting continued with other matters being discussed, and one of the decisions was to continue discussing the theme in another meeting. At a health care service, users are waiting for the arrival of professionals so that the meeting can begin. No technician arrives and they decide to start. After some more time, when the meeting was already under way, one worker

arrives and, irritated, questions the users' decision of starting the meeting by themselves.

Scene 4: Ministerial prescriptions - In a training space of the Ministry of Health, whose objective is to reflect on working processes in order to qualify them, promoted for professionals from all regions of Brazil who work in a specific type of health care service, one of the facilitators, in the morning, starts the activity, inviting the workers to share their practices, so that contextualized methodological clues could be constructed, based on the professionals' knowledge and experiences. In the afternoon, another facilitator, without taking into account what the group had produced in the morning (even though he had participated in the planning of the activity), and based on ministerial prescriptions, divides the group into three. At the end of the activity, the moment when there should be a plenary assembly in which the three groups would present the summary of the discussions, the facilitator speaks on behalf of the smallest group, to which he belonged, discusses the issues and leaves (late to take his flight), without opening the space for listening to and discussing the issues of the other two groups. The process was considered finalized, without any questioning on the part of the participants.

What do these *scenes/tides* enable us to see and question?

As educators who are also involved in policy planning and health care service management, perhaps we can start by saying that educating professionals in a continuous way to meet, in an agile and proactive way, demands and challenges that the daily routine of the work imposes on them is a central issue to the field of health. Everyday, new policies and programs that include educational processes are created, planned and executed in Brazil. Everyday, educational processes are reproduced, repeated, 'multiplied'. There are those that occur in the relationships among professionals, managers and users; in the relationships among the people who live, interact and circulate in the spaces of health care and management; there is also what is learned and taught in silence and/or without intention, through the organization of

the physical space or through the ways in which people behave inside it. Physical space and behaviors that are inscribed in a pedagogy of conducts and bodies that is fundamental in a biopolitical economy that disciplines the individual body and administers the body with multiple heads – the population (Foucault, 2008, 2002).

In this direction, and in consonance with the notion of education that introduces this text, it is possible to say that some of the forms through which health care processes teach involve silencing and not asking questions. With this, they produce the sensation that receiving care is a passive attitude, similarly to what school education teaches to the seated bodies, which are preferably in silence: bodies that are receptacles of information.

In other words, we understand that daily moments and spaces of health care (and also of health management) are scenes of teaching and learning in which therapeutic, organizational and corporal pedagogies act. That is, working processes in the field of health tend to foster the development of pedagogical projects articulated with the objective of incorporating habits and values that can support the broader society, understood as social body; and that can prepare men and women morally and physically, based on an education of their bodies, an education that is efficient in body production.

By indicating the field of health as an educational locus in which investments are made, above all, in the production of certain bodies – individual and collective –, we believe that it is important to indicate what we understand here as body. To Dagmar Meyer, the body is what is produced in the articulation between our “genetic inheritance” and “what we learn when we become subjects of a culture” (2009, p.218). The body is produced in signification processes and, for this reason, it is unstable, changeable, shifting. Denise Sant’Anna (2005, p.11) adds that it is necessary “to show the provisional character of the visibility regimes that define the truth of the body, of health and of disease in each period of time”, in each culture, in each historical moment. Guacira Louro complements by arguing that “named and classified within a culture, bodies become historical and situated. Bodies are ‘dated’; they earn a value that is always transitory and circumstantial” (2004, p.89). Within a culture, inside a

specific historical–political context, bodies are produced by countless markings: gender, sexuality, social class, race/skin color, religion, age group, region, etc. Therefore, they are produced and organized by such power marks. Based on them, bodies are classified, hierarchized, organized, ‘indexed’; they are worth more or less in a given context (Louro, 2004). Marlucy Paraíso (2011), in turn, states that the body is a space of tension, a conflict zone between forms of subjection and forms of experimentation, that is, bodies always open themselves to processes of unlearning that bring with them the power of denaturalizing cultural prescriptions; thus, they make culture itself change.

Broadly speaking, in this text we work with the idea that bodies tend to head towards singularization, that is, they are constructed in the interior of specific cultures, submitted to certain corporal pedagogies. However, to Dagoberto Machado, Michele Vasconcelos and Aldo Melo (2012), in addition to cultural constructs, bodies are political–ethical constructions. In other words, more than being woven by obeying certain cultural pedagogies, which organize them, teach them, prescribe ‘good’ conducts to them and evaluate their value, bodies have a tendency to singularization (Guattari, Rolnik, 2000), abandon the adherence to the subjective molds prescribed by such pedagogies, refuse what they are and grope the invention of other forms of subjectivity.

Our look over the processes of health care and management, in this text, views the body as a cultural–political–ethical construct and health practice as a pedagogical level through which marks are imprinted on bodies, but also as a pedagogical level through which the bodies of professionals, users and the very body of care can open themselves to new types of learning. It is in the convergence of these presuppositions that the questioning of the processes that form bodies (of workers, managers and users) can make sense. Therefore, we would like to reflect on the following questions: in what ways can health care be pedagogical to the person who receives care and also to the person who provides care? In what way can health management processes be spaces/strategies for the education of workers, managers and users? Prescriptive educational practices or educational practices that enable multiple forms of action,

incarnated in contextualized and collective needs? In the daily routine of health care practices, how can other pedagogical practices be woven, practices that are not limited to organizing the bodies of users, so as to silence them and make them be passive? What is taught-learned when the bodies of managers are organized as 'thinking heads' and the bodies of workers are organized as technicians who execute prescriptions proposed by others? In the daily routine of health care work, what can pedagogical practices produce?

With these questions, we return to the scenes described above. We believe that, together, they are powerful to 'help us look', based on the following, more specific, questions: What does a health care service, located in a very hot environment, teach with an air conditioner that works only in the coordination room? What does it teach when refrigerated places are restricted to professionals who spend a large part of the day seated at tables, looking, through a glass, at users, who spend the major part of the time in the hot shed "without doing anything"? What do dirt and stink teach to the professionals and users who inhabit the place? What management strategies could be employed in scenarios such as these to provide better working conditions for the professionals who develop their labor activities there, as well as better conditions for the users of these services and their families? What does a service teach when it maintains toys on shelves in the coordination room, while in the playroom there are no toys for the children? What does a medical consultation in which the user is not heard teach to those who participate in it (physician and user)? What possibilities could be used here to generate a powerful encounter from the pedagogical point of view? Why does the inclusion/presence/active participation of users in management spaces bothers some health care workers? What pedagogical strategies can be used in moments such as the meeting we described? What pedagogical strategies can help to shift the 'blind task-fulfillment' (which results in blaming individuals, individualizing answers and problems, and producing specificity and discontinuity of care, as well as lack of problem-solving) that tends to sustain the actions in the area of health? What does an educational space teach when, right after the space is opened for the exchange of experiences and knowledge, these are neglected in favor of the objective

of 'accomplishing the task', focusing on prescribing 'right' ways of doing? What tactics can be employed to undo pedagogical actions like these which, in the name of the circle, update traditional educational practices that merely transmit information?

Obviously, we do not pretend to answer such questions. Nor do we intend to list guilty individuals or blame people individually for such situations, mainly because we understand that those scenes are effects of the absence of spaces of reflection and collective constructions/answers for common problems. Our approach aims to promote reflections on how the working processes and the educational processes for working in the area of health can be reviewed. In addition, our intention is to suggest some possibilities to propose pedagogical processes that can be powerful in this direction.

In this sense and under this point of view, what do these scenes have in common? What *link* could we establish among them? What do we have to unlearn, to teach, and to (re)learn in situations like the ones depicted above, which are so recurrent and naturalized in the daily routines of our health care services? Briefly, we could say that the four scenes point to pedagogical dimensions that are important to be thought of and problematized by those who work in the field of health. We could say that such scenes are inscribed in the interior of traditional health care practices, in which power-knowledge relations are established and defined: vertical management, centrality of the medical discourse, asymmetry between professionals and users, lack of consideration for users' feelings, desires, concerns and questionings, education understood as mere transmission of information, prescription of 'a right way of doing' for 'unqualified' people, so that they acquire such capacities (Meyer, Félix, 2012a, 2012b; Pasche, Passos, 2010). In the scope of our interest here, it is necessary to ask: what pedagogical possibilities could be used in order to contribute to modify situations such as those? This is the question-axis that guides the argumentation that will be presented in the section below.

Working processes in the area of health transmuted into pedagogical practices

In conversations with some colleagues, when we shared the scenes described in this text, we were surprised to verify that situations like these are common. In many health care services for children, the toys remain stored and cannot be handled by them. In other services, users are maintained outside the 'aquariums'. And in many health care services that allegedly work with shared management, the active participation of users in management, even of their own care, tends to bother and be 'controlled' by professionals.

However, and we agree with Veyne (2008, p.264), "we should not falsify the appreciation of what is possible by arguing that 'things are what they are', [that 'this is the reality'], as, in fact, there are no things: only practices. And this is the keyword". Other practices are always possible, which means that things do not necessarily need to continue being what they are and that we can interfere. In this sense, it seems to be necessary to problematize naturalized processes of inhabiting the daily routine of the health care services, intervening in working processes in order to transform the ways of producing health that are accustomed to the typified organization of bodies. Therefore, it is necessary to invent and experiment with other forms of intervention in health care practices.

To achieve this, one possibility, among others, would be to invest in the implementation of continuing health education as a pedagogical-political way of placing 'real' working processes in the educational scene. Continuing education, according to Ricardo Ceccim, is an

[...] educational process that puts the daily routine of the work - or of education - in the area of health under analysis, a process which is permeated by the concrete relations that operate realities, and which enables to construct collective spaces to reflect and evaluate the meaning of the acts produced in daily life. (Ceccim, 2005, p.161)

Continuing health education regards the “construction of relations and processes” that involve teams, organizational practices and interinstitutional and/or intersector practices, articulating the teams’ agents, the health sector and the “policies in which health acts are inscribed” (Ceccim, 2005). It encompasses educational processes that involve all the subjects engaged in health production in a given context (a health care service, for example).

In the scope of these perspectives of education and continuing education, the question is: With which conception of management are we proposing to operate, based on the methodological path that has been outlined so far? In short, it is possible to say that we understand the working space as a space of collective production that belongs to all the subjects involved in the process of health production: managers, workers and users. We know, however, that these subjects do not occupy the same positions and that some of them exercise powers that were instituted because of several reasons: their professional education, the rules that govern their exercise in the area of health, the job they have, the political and/or academic authority that they have constructed or that has been attributed to them, the activities under their responsibility, etc. We also know that, in traditional health care practices, users would have a differentiated place, which is usually a ‘passive’ place, as, when we talk about participation, the usual connotation is collaboration so that what has been previously decided in other levels functions well.

Thus, we are proposing here that the frontiers of the instituted places are blurred for the production of new and possible encounters that involve managers and workers, in a joint reflection on their working and education processes, with the participation of users in the working processes in the area of health, when these subjects engage, together with the team that provides care for them and their families, in the construction of their therapeutic project; that is, when they participate in the management of care, or in the organizational decisions in meetings with users of the healthcare system, for example.

In the perspective of continuing health education, the subjects involved in the service – coordinators, professionals, patients’ relatives and also the children – would

propose to reflect on these situations. Each one, from his/her place and with his/her perceptions, adds elements “to the circle” for collective reflections and for the search of joint answers. Both situations – care management and organizational decision-making – can be used as a motto to think about the health care service (context, problems, possible solutions) in a broad way; they could enable bringing to the conversation other elements and situations that bother managers, workers, users, as well as some possibilities to solve clashes and difficulties.

It is obvious that this is not a simple process; moreover, there are neither ready answers nor models to be followed. On the contrary, each context, situation and group of people can think of and experiment with different answers. Without losing the condition of apprentices and understanding education as a construction of forms of action, users and professionals can not only invent answers, but also bring new problems to health work and education. In this sense, we view continuing education as an interesting political and methodological strategy.

It seems to us that it is important to consider that, in the health care services, and also in the health management spheres, beyond subjects of automation and of the present rationalizing routines, there are pulsating lives that request that space is opened to new possibilities; there are productions of self (Foucault, 2010) on the part of workers, managers and users. Thus, betting on a micropolitics of the daily routine and maintaining ourselves open to events, encounters, relations, affections and problems that occur right there, we aim to test and invent new health care practices, including educational practices, in the institutionalized spaces, understanding this movement of creation as something that is immanent in the daily routine of the services, of the working processes, of the practices of health care and management.

Therefore, the invitation is to participate in the construction of an ethics that enables us to transpose the limit of what is conditioned by the society of which we are part and venture, within the gaps of the health care practices, on the experimentation of “a production that has, in its emergence, the strength of a conspiracy and of the invention of possibilities in a world in which individuals try to regulate/manage life in the form of a deadly order. [...] Implicated, implicating”, we try to put lines of escape

on what is instituted in the trajectories of the bodies subject to health care practices” (Rodrigues, 2009, p.205). In concrete terms, this means going beyond what the protocols and modes of organization instituted in health production spaces allow: to (re)think and modify working processes; to utilize cultural artifacts as mechanisms to change situations/problems that eventually affect the work, life and health of workers; to construct and implement educational processes that escape from the common place of traditional qualifications and trainings, from an education that is understood as “transmission of contents, mostly marked by rationalization, awareness-raising, technicism” (Barros, 2005, p.135), towards the invention of education practices that produce twists in these hegemonic ways of operating in the scope of health education. There are neither rules nor models; there are possibilities that can be modified and reinvented collectively, on a daily basis (Meyer, Félix, 2012a, 2012b).

In this direction, the reinvention of the working processes and of the pedagogies that are put into operation within them should have the involvement of all the actors engaged in the process of health production (Ceccim, Feuerwerker, 2004). What is usually seen, however, are educational processes that propose to change the daily routine of the health care work by involving health professionals or managers separately. It is in this sense, too, that users are those at whom the actions are targeted, and they are hardly involved in such activities. Evidently, we are not talking about something new here, nor of something that is easy to perform. We are talking about changes in the culture of health care institutions and, consequently, in the modes of working and managing in the area of health, and also in the modes of being assisted by the health care services. Above all, we are talking about the necessary change in the management processes of work and assistance in the area of health. The invitation mentioned above unfolds into a bet: reviewing and changing pedagogical health practices. Many of them seem to need being reviewed and/or abolished, while others seem to need being incorporated into the daily routine of the services, either as attitudes (as they inform a new ethics in care and management), or as practices that are updated to incarnate new working processes. We would like to emphasize that the aim of this bet is the creation of collective and permanent spaces of discussions about

working processes in the area of health, with the engagement of all the actors involved, composing processes that manage the care and the work. Ultimately, the invitation–bet is, by shattering the “forms of action”⁴, testing:

An education that is configured in multiple forms of action, such as the production of knowledge and social practices that institute action subjects, permanent learning, and not modeling practices [...], escaping from the production of professionals as goods that are amorphous, powerless, silent and serialized [...] who value only “technical competence” and who insist in distinguishing what is “specifically providing care” from what is “specifically political”. [...] Our practices can be an important support to the changes we want. (Barros, 2005, p.137)

Thus, a joint reflection on the working processes means encompassing aspects that affect, bother, mobilize and move managers and workers, in their daily labor practices, and also users, in the utilization of the services occupied by these professionals. In this sense, we present here the management of working processes as a collective challenge, by means of a joint reflection on these processes and on the collective weaving of health actions. In our opinion, such reflections can produce, beyond other new ways of managing working processes, new encounters and meanings.

Let us revisit, for example, the scene of the air conditioner only in the coordination room and of the playroom without toys. When we suggest, through a reflection on working processes, to change practices of production of health and of the self, by means of interferences in everyday scenes like that one, we intend to run contrary to positionings that are in favor of the existence of an origin, a primary identity to the things that compose ‘reality’ – in the case described here, the reality of the health care services, of the bodies and pedagogies that circulate there, as if they were homogeneous and equal. Reality is thought here as a historical production, “it

⁴ Expression used by Elizabeth Barros, coined by Ana Heckert.

does not exist in itself and by itself; it is always constructed by social practices” (Coimbra, 2001, p.38). Such practices “gradually engender in the world objects, subjects, knowledge and truths that are always diverse, always different” (Coimbra, 2001, p.38). From these multiple practices, multiple faces are gradually constituted throughout history, as well as multiple objectifications (Veyne, 2008).

Courses, workshops, formal educational processes and many other institutionalized pedagogical processes can be employed to discuss the issues we have presented here. Although we understand the importance of such processes for worker education and we recognize their effects in the field of health, we bet on educational spaces that are produced inside the services, engaging all the subjects involved (Ceccim, 2005); spaces that are continuous and that are included in the processes of work and management of that service/unit/department. We believe in the power of these non-formal educational encounters as spaces/moments of promotion of local changes. From our standpoint, working processes engage the entire team in thinking about common problems and searching for collective answers; at the same time, they constitute powerful pedagogical processes that have concrete effects on improving the working processes in which the team is involved.

Relearning and re-apprehending how to look at and dimension the sea and its tides

Heading towards a conclusion, we could ask once again: what would children and adults, users of a health care service, have to say about the processes of management and education of the professionals who assist them and who organize the services that they use? Well, what is the sense of the health care services if they are not inhabited by users? In this direction, users, as much as managers and workers, should participate in decision-making processes and could contribute to the continuing education of professionals and managers. In addition, it would be necessary to consider the knowledge and experiences brought by those who live in/occupies the service and produce health in the intertwining of this knowledge and these experiences.

The knowledge and actions of a child who might question the fact that the playroom does not have toys and that these are kept in the refrigerated room of the coordination would challenge the 'certainties' that produced this *status quo*. If we are sensitive to such questionings and if we use them to trigger a collective reflection in that context, perhaps we realize that it makes no sense to have boxed toys and children without toys in the same health production space, mainly in one that is called 'playroom'. Perhaps it is also possible to realize that the coordinator wanted to 'protect' the toys, to maintain them intact, and that, as absurd as it may seem, 'protecting the toys from the children who may violate their integrity' may reveal the good intention of the manager who coordinates the service, who desires to preserve the materials. In other words, by discussing challenges and problems collectively, we have the possibility of observing diverse ways of dealing with a question and diverse reasons that led some people to make some decisions; thus, it is possible to answer the questions collectively, to meet collectively the demands of the daily routine of the health work, and to invent new problems and practices. Precisely because these new problems and practices are produced collectively, based on the needs of each context, each moment and each subject, they can solve more problems. And this, from our standpoint, is part of the processes of education and management of all the individuals involved in the health care service.

How can we deal with the tides that invade us in order to recompose daily routines?

Based on the understanding of working processes as pedagogical practices, we would like to conclude the text by outlining some possibilities that may contribute to qualify educational health processes. These possibilities emerged when we listened to workers, managers and users in the field of health and from some texts (Pasche, Passos, 2010; Barros, 2005; Ceccim, 2005) that were also produced by means of experimentations and through listening to these actors. They were the ones who helped us "look" (Galeano, 2006). It is important to highlight that these possibilities

can be useful provided that we do not view them as prescriptions, but as ideas to be tested and reinvented in each context:

1) Traditional pedagogical practices tend to be targeted at changing individual behaviors. Through the transmission of information, they aim to prescribe the 'right way of doing' in the area of health, by means of offering specific moments of qualifications and trainings. Such practices have encumbered the public finances and, even considering that they may produce positive effects, generally speaking, they have not produced 'great' effects, except for maintaining workers in a condition of automatism and involved in a tiresome accomplishment of tasks. Prescriptions tend to be little incorporated and conducts are not corrected as desired. Bodies resist!

2) Instead of aiming at the correction of individual behaviors, educational actions that tend to be powerful, in the sense of producing changes in health care practices, take as their object the working processes in health (which tend to reflect incipient modes of work organization and to express precarious conditions of work and assistance). Thus, spaces are opened for daily and collective learning, with the purpose of changing practices of care and management, qualifying them, and engaging workers, managers and users in the process of work implementation.

3) It should be taken into account that, if there is no such thing as a correct way of doing in the area of health, these modes should be constructed from the specificities of each context, service, health care team, and assisted users.

4) Understanding working processes as pedagogical practices, such practices are, therefore, "pertinent to the theme of management and of concrete working conditions" (Pasche, Passos, 2010, p.8).

5) Pedagogical actions that take place in the daily spaces of the services tend to be more powerful (Ceccim, 2005).

6) Pedagogical processes that are likely to make sense for workers are those that are based on problems they face daily in their work and which take into account knowledge and experiences that were built right there: in the everyday routine of the work (and not only, nor primarily, the knowledge that comes from laboratories, libraries, and the academia).

7) During the planning of educational actions, it is important to start by surveying the needs of the people involved, including users' demands.

8) The professionals involved in health care practices should be included in all the stages of the educational process: planning, formulation of proposals, facilitation and evaluation. Being even bolder, different subjects, as well as their knowledge and experiences, should be included, even users.

9) It could be important to produce methodologies for educational processes that enable to experiment with a collective action: workshops, conversation circles, discussion of movies, reflections based on discourses and scenes experienced at the service, songs, poems, literature and other cultural artifacts.

10) It could be important to produce a connection between technical-scientific education and management in the constructed educational processes, so as to understand that the qualification of health care practices is related to changing and qualifying management processes.

Similarly to what happened to Galeano's (2006) character Diego, the hugeness of the sea, which here represents health, health work, and health education, many times makes us speechless. What authorizes us to speak – even though trembling, stuttering and leaving the habitual linguistic and political maps that usually conduct our bodies to 'good' health care practices – is the encounter with the subjects (in their subjections and insurrections) that are produced in the midst of these practices: workers, managers and users. Together, we speak, we dare to have other discourses and actions. Together, we can resist the biopolitical technologies of body conduction, experimenting with “an intense micropolitical and pedagogical action” (Ceccim, Merhy, 2009), through which the outline of pedagogical practices of resistance is unfolded, practices that are not merely reactive in relation to a certain exercise of power, but affirmative of other modes of education, other forms of life, (re)existences. Together, we can, therefore, produce other health care practices and other practices of the self.

Collaborators

The authors worked together in all the stages of the production of the manuscript.

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