Professional-user of Family health relationship: perspective of contractualist bioethics

Cássio de Almeida Lima [1], Ana Paula Soares Oliveira [2], Beatriz Ferreira Macedo [3], Orlene Veloso Dias [4], Simone de Melo Costa [5]

Abstract

The relationship between health professionals and users is a challenging theme for the reorganization of public health services. The objective was to discuss the professional-user members on care and health education issues in the Family Health Strategy (FHS) context using the Contractualist Bioethics perspective. As for the method, a literature and critique review was done in the Virtual Library of Health Ethical journals. The ethics issues are part of the care and health education in the FHS. The contractualist model is the most desirable related to the professional and users of the health services, since it involves commitment of both parts. Unlikely, the priest, engineer and high school models should be avoided because they characterize domination, accommodation, negotiation and submission. The host was suggested as a tool for confronting the undesirable models. The care process and health education should be based on the Contractualist model between the professional and a user. The real interpersonal relationship impacts positively to workers and users, since it suggests empowerment of those involved in the family health work process.

Key words: Bioethics. Professional-patient relations. Professional-family relations. the Family Health Program. Primary health care.

Resumo

Relação profissional-usuário de saúde da família: perspectiva da bioética contratualista

A relação entre profissionais de saúde e usuários é tema desafiador para a reorganização dos serviços de saúde pública. Objetivou-se discutir a relação profissional-usuário nas questões do cuidar e da educação em saúde no contexto da Estratégia Saúde da Família (ESF), utilizando a perspectiva da bioética contratualista. Como método, realizou-se uma revisão narrativa e crítica em periódicos da Biblioteca Virtual de Saúde. O modelo contratualista é o mais desejável por envolver compromisso de ambas as partes. Diferentemente, os modelos sacerdotal, engenheiro e colegial devem ser evitados por caracterizar dominação, acomodação, negociação e submissão. O acolhimento foi sugerido como instrumento de enfrentamento aos modelos relacionais indesejáveis. Concluiu-se que o processo de cuidar e a educação em saúde devem se pautar no modelo contratualista entre profissional-usuário. A relação interpessoal verdadeira impacta positivamente para trabalhadores e usuários, pois sugere empoderamento dos envolvidos no processo de trabalho de saúde da família.

Palavras-chave: Bioética. Relações profissional-paciente. Relações profissional-família. Programa Saúde da Família. Atenção primária à saúde.

Resumen

Relación del profesional con el usuario de la salud de la familia: perspectiva de la bioética contractualista

La relación entre los profesionales sanitarios y los usuarios es un reto para la reorganización de los servicios de salud pública. El objetivo fue discutir la relación del profesional con el usuario, en los temas del cuidado y de la educación en salud en el contexto de la Estrategia y Salud de la Familia (ESF), haciendo uso de la perspectiva de la Bioética contractualista. Como método de llevar a cabo una revisión narrativay crítica en periódicos de la Biblioteca Virtual en Salud. El modelo contractualista es el más aconsejable en la relación del profesional con los usuarios de los servicios de salud, por tener un compromiso por parte de ambos. Diferentemente, los modelos sacerdotales, ingeniero y colegial debe evitarse pues caracterizan dominación, acomodación, negociación y sumisión. La recepción fue propuesta como herramienta para hacer frente a los modelos de relación indeseables. El proceso de cuidar y la educación en salud deben basarse en el modelo contractualista del profesional con el usuario. La relación interpersonal verdadera causa un efecto positivo para trabajadores y usuarios, pues sugiere la participación de los involucrados en el proceso de trabajo y salud de la familia.

Palabras-clave: Bioética. Relaciones del profesional con el enfermo. Relaciones del profesional con la familia. Programa Salud de la Familia. Atención primaria de salud.

1. Graduate cassio-enfermagem2011@hotmail.com **2.** Graduate anapaulas.o@hotmail.com **3.** Graduate bmacedo43@yahoo.com **4.** Master orlenedias@yahoo.com.br **5.** Doctor smelocosta@gmail.com – Universidade Estadual de Montes Claros, Montes Claros/MG, Brazil.

Correspondence
Cássio de Almeida Lima – Rua Rodrigues Alves, 243 Centro MG CEP 39400-062. Montes Claros/MG, Brazil.

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Research article

The Family Health Strategy (Estratégia Saúde da Família – ESF) and the implementation of the National Humanization Policy (PNH) triggered changes in the organization of services and the role of health professionals [1]. However, the change of the work process in health is only possible if there is an understanding for each worker on how to produce health and join the new way of acting in relation to the user [2].

The ESF has proposed to reorganize primary health care from the family and their physical and social environment, enabling greater understanding of the health-disease process, interventions beyond healing practices [3]. In the everyday context of health care the theme healthy environment and quality of life should be considered, because they influence the quality of service provided to and impact on health promotion. Still, with regard to the quality of service provided in public health, the Brazilian Constitution legitimizes the right of everyone, without any discrimination in health care. The Unified Health System (SUS), in all care levels, is guided by guidelines that value health practices focused on human rights [4].

The relations established between users and health professionals are among the challenging issues for the reorganization of health services, and, thus, this is essential for the full implementation of the SUS. As the system is anchored in laws with the status of State policies, their implementation also depends on the relations between workers and users [1]. The organization of the work process in the ESF team, relationships with service users and the challenge of working by seeking a balance between autonomy and accountability are not being guided by managers and health professionals [5].

The ethical aspects of daily care in the ESF are often not noticed, resulting in damage to the attention, especially with regard to the connection and co-responsibility for health. To work in family health, the professionals, besides redirecting their clinical practice, need to resize their sensitivity to notice, understand and ponder on ethically significant or problematic situations [6]. Accordingly, the construction of SUS implies an ethical turnaround, the reorganization Primary Care broadens and deepens the path of this impact. That is because its effectiveness is not just a new configuration of technical-assistance team, but the new work process marked by ethical and human bound to the exercise of citizenship [7]and that favors the quality of interpersonal relationships within the SUS context.

This article is justified by the importance that health professionals can reflect on the ethical issues part of the working process with the ESF, in the sense of aiding the solution for problems established in interpersonal relationships between providers and users of public health services. Given the above, it was aimed to discuss the state of the art about the professional-user relationship in the issues related to caring and health education in the context of ESF, and analyze relational patterns by using the contractarian model. In addition, it is proposed to suggest a tool to confront the ethical conflicts of professional-user relationship service in the ESF.

Methodological path

It is about a research on narrative and critical review of the literature. The study is characterized as a theoretical reflection on the subject and professional relationship user in the ESF, with the discussion driven by the question "which are the ethical issues related to the user/community relationship and professional of family health?". It was used as a theoretical landmark the contractarian model in bioethics, because that is the one which best fits in the discussion of the relationship between health professional and user of health services [8].

The contractarian model in bioethics is a current that considers the complexity of relationships in society. Among these we highlight the relationships at three levels: between medical professionals and patients; between physicians and society and between doctor-patient and society [9]. In this study the discussion of relational ethical conflicts will be grounded in the four physician-patient relationship models proposed by Robert Veatch in 1972: priestly, engineering, collegial and contractual [8].

As for relational models, the priestly model refers to dominance of the professional on the service user, unlike the contractual model in which professional and user share the power. In the engineering model the decision power is exercised by the user, although the professional preserves their authority. Finally, there is the collegial model, which refers to the vagueness of roles, both the user and the professional, in the relations between these social actors [8].

Although contractarian theory has innovatively been proposed to discuss the matters involving physician and patient, in this work the understanding of the theory will be extended to all professional staff of family health, as well as for all users, sick or healthy. Note that the discussion in this study was also extended to situations of conflict between professionals and family, since the focus of the discus-

sion occurred from the identified problems in family health context.

The search for literary material was performed on the database of Latin American and Caribbean Health Sciences Literature (Lilacs), Nursing Database (BDENF) and Scientific Electronic Library Online (SciELO). The combination of the following keywords was applied: professional-patient relationships; professional-family relations; health professionals; family health program; primary health care; bioethics; ethics; personal autonomy; community participation; health promotion and empowerment. In total, 79 articles were found, with 8 in the BDENF base, 10 in Lilacs and 61 in SciELO.

The selection of articles involved review of titles and abstracts, when they are included in the requirements, and the reading was fully met. Inclusion criteria were: publications from 2003; scientific articles fully available and approaching of the subject in question. We excluded studies that only provided the abstracts, as well as those that did not specifically address interpersonal relations of user and healthcare professional and ethical conflicts. The time frame was used based on the year of enactment of the National Humanization Policy, in 2003, which reinforced the need for humane practices within the SUS. Thus, after selection, 14 articles were selected for full reading.

The results were presented in three categories of analysis: 1) the ethical issues regarding family health care; 2) ethical issues regarding health education in family health; 3) welcoming: confronting of ethical issues regarding care and health education in family health. The first two categories have the ethical issues arising from the work process within the ESF context and the last category suggests welcoming as a coping tool to relational ethical conflicts within the ESF.

Integral ethical issues of caring in Family Health

Ethical problems arise from daily concerns of health care, such as issues related to users and families: difficulty in establishing the limits of the professional-user relationship; prejudgment of users by the team; disrespect of the professional towards the user; inaccurate clinical indications; prescription of drugs that user cannot afford; prescription of more expensive drugs with efficacy equal to the cheaper ones; failure in the information to the user to achieve adherence to treatment; omission of information to the user; professionals' access to information relating to the intimacy of conjugal and family life of users; difficulties to maintain privacy in domiciliary care and sharing of diagnostic of the user with the other members of their family [6]. All these questions are related to the priestly model of professional-patient relationship, based on the Hippocratic tradition. The priestly model leads to professional domination and consequently requires the user to submission [8].

In the ESF context the relationship between professionals of the multidisciplinary team and the user should not be restricted only to treatment of diseases, but they should be based on health promotion and perception of the individual as a biopsychosocial being that needs to be heard and understood in the physical, emotional and social needs [10]. Accordingly, the user of health services becomes an autonomous subject in their choices and co-participant in the construction of health care [11], allowing an interpersonal relationship based on contractarian model. In this model, the professional has the responsibility for technical decisions, basing themselves on professional competence. The user has to decide according to their lifestyle, moral and personal values. Decision-making occurs in information exchange and negotiation process, allowing benefits to all subjects involved in the interpersonal relationship [8].

The ESF provides for the formation of the bond between the team and the users and their families. It presupposes a dialogue relationship that takes place between people who recognize and respect themselves as subjects. The disrespect may threaten the relationship and compromise the bond of co-responsibility for the health of users [3]. If the intention is the participation of user in decision-making, joint efforts of all staff and managers will be required [12], which are inserted in an atmosphere of exchange information and commitment among the involved ones [8]. However, the ethical problems of the health care team with the users, such as the barriers that stand in this relationship, whether by negative social representation, discrimination or abuse of power professional, tend to be higher in family health, because of the peculiarities surrounding this working context.

And in this context of professional practice both aspects can be assessed: the user/family and professional. If, on the one hand, users and their families seek the resolution of a problem, of health nature or not, which is considered important, and bring themselves with secrets, fears, beliefs and expectations, on the other, the team, still inexperienced in dealing with situations arising from contin-

uous proximity to these subjects, remains attached to procedures, rules and routines of the service or to their technical understanding of what is best for them [7], perpetuating this way, the paternalistic attitude towards users [8] and vertical relationship where the health professional commands and the user health services obeys passively.

Another bioethical issue to be discussed in interpersonal relations, established in family health services, is related to negative social representations of professionals regarding the community assisted in the ESF. In this perspective, the population of the coverage area is seen as poor, helpless and disrespected, after a while the health team themselves feel in such way. This mechanism explains the production of impotence in series that many teams get ill [13].

It may also happen that, when they try to defend themselves from that nasty reflection, the staff closes itself to try to impose greater discrimination between itself and users. Thus, professionals rise high barriers and avoid their contact with the reality that afflicts them or may become aggressive and retaliators in their relations with users [13], maintaining professional behavior grounded in the priestly model, in a relation of domination by professionals [8] and passivity on the part of users. Note that in the case of frayed relationship, with losses to users, these, in general, do not have the autonomy to seek other healthcare professional. That is because they got not empowerment, which could secure the right to choose the professional they prefer in their care.

The word *empowerment* refers to the acquisition of technical and political power by individuals and community [12]. Then, returning to the issue of user right to choose their health care professional, the discussion takes place in the assessment of geographical and functional access. It must be considered that the user is willing to move to be met at the place where, although farther from home, they can be well-received by staff and where they experienced successful experiences [14]. Accordingly, the quality of the interpersonal relationship has a higher value for users of health services when compared to the ease of geographical access to services.

The action of care must be based on the user autonomy and recognition that it often requires construction in mutual aid and solidarity, overcoming the vulnerability of those who care and those who are cared [6], through the sharing of power, as advocated by contractarian model of the relationship between professional and user [8]. Consequently, the practice in family health team must be marked by humane care, citizenship exercise, respect for dignity and human freedom, as well as in understanding that conditions of life define the health-disease-care process of families [6].

The humanized relationship depends on respect, consideration and attention given to the user. The professional performance is expressed by the interest shown in the questions made, the guidelines offered and the solvability of the behavior adopted [14]. In this relationship, touching, physical contact, for example, can be applied in order to gain the trust of the user and, from them, hear them, talk to them and look them fondly can flow naturally without derailing the necessary technical assistance. So that touch can be understood as a *therapeutic touch*, in a physical and psychological significance which does not only act in the person's body, but affects their emotions, promoting healing and wellness [10].

Besides being a suitable mechanism to release tensions and fears of the user, which are provided by the uncertainty of the diagnosis, touching symbolizes the creation or maintenance of the relationship between the involved ones [10]. The detailed physical examination demonstrates the interest of professional for the client. For the user this means an increased accuracy in diagnosis and treatment [14] and signals the preservation of the authority of the professional, while keeper of knowledge and skills, but also the active participation of the user in line with their lifestyle and moral and personal values, according to the contractarian model [8].

Thus, taking as a guide the contractarian model [8], the participation of user should be incorporated, because it is part of the ESF philosophy itself. In this sense, the shift of care to the scope of residence allows the breaking of barriers to the formation of the bond, which approaches and establishes trust between user and professional. Thus opponents to participation are inhibited, such as the authority of the professional on the user [12], according to the paternalistic attitude that characterizes the priestly model [8].

Home visits and the role of community health agent (ACS) bring new challenges to the preservation of confidentiality. The user should establish he want to share from his private sphere, with the family, neighbors or close friends, even if they are health professionals [6]. The difficulty to maintain privacy in the home care setting and to what extent the private information of users and their families should be shared in the field of staff, especially in relation to ACS, which lies in the vicinity, are problems arising from the particularities that permeate relationships in family health [7,3]. Hence the importance of agreement between professionals and users of health

services and professional and service-user and community to know what information should be kept confidential. And the pact is an important feature of the contractarian model.

Privacy is not only restricted to the attitudes of workers who have access to information about the privacy of users and families, but also the architectural structure, daily relations and procedures and routines of the health unit and staff. In the internal organization of the unit flows, the physical and moral privacy of users and families should be preserved. The services must be structured so that situations which affect the privacy of individuals can be avoided [3].

In this sense, respect for client autonomy exposes itself when the confidentiality and privacy are preserved. It is advocated the user access to information, to ensure substantially autonomous decisions and commit citizenship in health care. But this will only be possible with mastering skills for conducting emancipatory and dialogical communication [6]. When professionals demonstrate little preparation for light and relational technologies and little knowledge of emancipatory communication skills, they fall into power relationship marked by accommodation, present in the engineering model [8].

In the engineering model, the health professional maintains his authority, despite relinquishing power, which in this case is exercised by the patient. The model is characterized by decision-making with low involvement of health professionals, which preserves the attitude of accommodation on service users. The patient is seen only as a customer, someone who demands the provision of professional services [8]. In this model decision is focused on users after all the information disclosure of the professional who is not involved in the decisions, only sells their services.

The simple transfer of information does not characterize involvement on the part of the professional, given that the engineering model assumes that the professional only takes the role of who disclosures information, almost as an instruction manual equipment. Although the offering of suggestions and alternatives without pressure contributes to gain the trust of users, who manifest objections, fears or concerns [7], the model is characterized by its low involvement and even the fact of taking professional attitude of accommodation [8]. Thus, before the divergence of views with the user or family, health professionals should try to reach an agreement through the explanation of the consequences of the action chosen by the user and the reasons why indicate another alternative [7].

The questions that the user is encouraged to make, the answers they get or spontaneous clarifications and guidance given to them and the appreciation of their way of life offer them security. Thus, they can deal with any doubts and difficulties, and increase the ratio of interpersonal trust [14], as indicated by the contractarian model [8]. In other cases, despite good material conditions of the health care unit and assistance, there is no proper qualification of the reception staff. Or, conversely, there is a good reception service, screening and pre-consultation, but these culminate in consultations marked by cold and dehumanized relationships [14], which are not covered by the contractarian model, but they are mostly common in the priestly model [8].

Ethical issues of care within the family health are many, as previously highlighted – paternalistic attitudes, negative social representation of professionals in relation to users/community, aggressive and slanderous attitudes against on the part of professional to users –, and they reiterate the urgent need of professional-user relationship to be guided in the communication process aimed at sharing decisions and life projects and is not limited to clarification of treatments and tests [3]. The incipient experience in the field of social participation of both professionals and users, both bonded to insufficient training from both parts outlines conflicting framework under the ESF context within close relationships between these actors [15]. In this scenario, it culminates in the collegial model, i.e., in relationships that the roles of professional and user are not differentiated [8]. Despite the decision power is shared between professionals and users, the criticism to this model is that it equals individuals equals in that which – necessarily – should be distinguished: the technical knowledge about the health-illness process. Thus, the purpose of the professional relationship and service users is lost.

Ethical issues of health education in ESF

With regard to the training of users to prevent disease and promote health, the health education practice has been used under the ESF context. However, it does not always happen in democratic perspective aimed at empowering people. It is necessary a broad plan for health education, oriented to awaken in people the skills to care for self, family and community [12], designed from the perspective of the relational contractarian model.

Health promotion requires collective efforts and exercises for developing health education strategies that enable and incorporate healthy practices. Such efforts and exercises are part of a democratic perspective that includes the members of society as active, autonomous and participatory beings. Health education is a process that, when makes the use of communication, seeks to give people knowledge and skills so that they can make choices about their health [12].

Health education also awakens the critical awareness, recognizes the factors that influence health and encourages the user to change the status quo, with grounding in respectful interaction with popular culture. However, often the health education becomes a failure because it is commonly a practice rooted in paternalistic authoritarianism [12], based on priestly model [8]. On this panorama, the need to seek empowerment is strong, which sets power and control of people about their destination in the production of concrete and effective actions in decision-making priorities in the definition and implementation of tactics aimed at improving health conditions [12].

When relations are anchored in contractarian model [8], the conscious change occurs with the effective user and his family involvement in the means of production of knowledge and skills to operate on health promotion, which is defined as empowering participation. This participation is instilled by conscious, critical process in which behavior change occurs through learning about health, the skills learned by understanding of the health conditions articulated to lifestyle and how ESF health services operate [12].

Educational practice is inseparable from the labor of the worker action. It has the goal of promoting changes both for users and for the professional and the work process in health. It is believed that health education has the potential to transform the current model of health. Health education held in the professional-user relationship is determined from the everyday act, which reflects the production of meaning entailed in relations of care practices [11].

In such practices the educational strategies are unstructured, but it has intentionality. However, this different way of doing educational practice does not reach all professionals, which mostly relate to the transfer of information, in which the worker seeks to transfer and inform, which reinforces their attitude control and imposition of knowledge which judges be correct. This reflects the lack of listening on the part of the worker who insists on a repeating posture and recovery as communication tactic in an attempt to tame and train, not appreciating the encounter with the user as an opportunity for dialogue, negotiation and learning [11].

In this scenario, what is observed is that often health education in their interface with professional-user relationship, still remains physician-centered, guided by biological complaint and the perpetuation curative model, establishing hierarchical relationship of transfer of information and control [11], in which the professional holds the transmission of information and the role of domination and the sole holder of power and authority, which characterizes priestly posture [8]. In order to change this model, users must have access to relevant enlightening information, receive directions or be persuaded to change unhealthy life styles. Persuasion is ethically defensible, unlike coercion. Likewise authoritarianism, paternalism, even based on beneficence actions, is contrary to promoting autonomy and citizenship of people [7].

In everyday interactions and relationships between workers and users, both must take the position of actors and subjects when producing educational activities in dialogue and bonds constructed according to worldview, society and health. In the ESF, the proximity of the professional environment and family dynamics provides contact with the needs of users, allowing practicing educational activities consistent with the reality experienced by the community [11] as the contractarian model assumes [8].

Health education effected in the informality of the professional-user relationship occurs in everyday conversations and guidance and permeates the various topics that cover the realities of users [11]. It should be mainstreamed in the axis of professional practice and be a vehicle to stimulate participation and behavioral change. In this context, community participation and health education are intrinsic activities to the work process of the professionals, which must act in promoting the health of the user, family and community [12]. Thus, we need greater investment in continuing education for health workers as a suitable instrument for change, implementation and reinforcement of educational activities implemented in moments of user-worker interaction and in their speeches during the assistance in health care [11], so they perform behaviors based on the model of contractualist bioethics [9].

Welcoming: confronting the ethical issues of care and health education in ESF

For welcoming it is understood the posture of health worker to put themselves in place the user to realize their needs and, as far as possible, meet them or direct them to the most appropriate point in the health system workers [14]. It is the dynamic and unfinished process, which is necessary for permanent evaluation and reorientation [2].

Studies around the *welcoming* theme are basically outlined in the structural and organizational domain with views to the transformations proposed by SUS. The studies that depict welcoming in ethical perspective are incipient. Welcoming is considered as the humanization device of health care services. It translates human action to recognize the subjective dimension of human beings, recognizing it as a historical and sociocultural subject. The attitude of welcoming presupposes the mobilization of subjects involved in all aspects of the relationships established in the context of public health and awareness of citizenship [16].

Welcoming makes the relationship less vertical, more contextualized and humanizing in which the practitioner uses less technical and more accessible language, strengthening the bond of co-responsibility and citizenship. Although there is still a long way to go, welcoming is not the only one, but it is an important resource in the effort to make relations more humane and horizontal, as the user is heard and considered in their subjectivity and not just as a symptom [2], in line with the assumptions of the Veatch's contractarian model [8].

In this context, welcoming is a strategy to overcome difficulties in the process of work in health, which brings new meanings in the professional-user relationship. The strategy, which aims welcoming, is something new, unknown and causes conflicts, by fostering changes in labor dynamics. However, there are users who find listening space, welcome, attention, directing their various problems and solidarity [2]. In the situations of diversity in the welcoming protocol and in the difficulty of access in health care contexts weakness in organization of family health teams and overcoming the challenge of solidarity by the need of users in their entirety are revealed [5,1].

Health professionals with personality focused on communication and welcoming, who are sensitive, involved and committed should integrate family health to overcome the hegemony of biologicist and fragmented vision [5,1]. Commitment attitudes consistent with the contractarian model are expected. Thus, the accommodation of the engineering model, the loss of purpose of the professional-user relationship of collegial model or the domination and imposition of priestly model [8] should be discarded attitudes.

Acting in the ESF requires redirection not only of clinical practice, but also of the ethical equationing, blurring it from the hospital-centrism which marks the conformation of the health system and training of professionals, requiring ethical discussion of interpersonal relationships between health professionals and users [7].

From this perspective bioethical discussions distanced themselves from the contractarian model in bioethics [9]. This reinforces the need for heightened sensitivity and ethical commitment of ESF professionals. Professionals should be guided by humanization, caring, citizenship and based on the understanding that the living conditions define the health-disease process of families [7].

Under this perspective, it becomes necessary to change attitudes and values of those who work in public health services, in order to encourage the user to effectively meet the health context and relate it to their rights. The dialogue established between ESF professionals and users can be conquest of the channel for possible participation and may also be able to reduce asymmetries in this scenario [12]. Given that the dialogue starts during the reception of the ESF user, preventing damage in the process of care and health education.

Final considerations

The professional-user relationship, specifically in the scenario of the Family Health Strategy, is broad and permeated by ethical aspects. This relationship is not restricted to the clinical environment, but it also involves the practice of health education. Relational bioethical issues in the ESF have interfaces with family, community and staff members of the family health.

Family health professionals should be guided in humanized relationship, in daily work, in search of contractarian relational model grounded in commitment to health service users. Despite preserving the authority of the professional because of their specific technical expertise, the contractarian

model ensures the user's active participation in decision-making as their moral values. Thus this contractarian model encourages commitment of professional and users.

This commitment basis can be established since the beginning of the contact by the welcoming process, as the adoption of a strategy to face inadequate relational models such as the priestly, the engineering and the collegial models, that show characteristics of domination, submission, negotiation and accommodation in the relationship between professional health and ESF users. Thus, the process of care and health education should be based on user autonomy and empowerment, as well as construction of health promotion in mutual aid and solidarity, overcoming the vulnerability of those who care and those who are cared for in welcoming process. Welcoming makes the relationship less vertical, more contextualized and humanized.

It is noteworthy that if the professional-user relationship truly becomes effective, positive impacts not only for users and enrolled community but also to the workers themselves will be gradually fostered. This is because, based on the critical reading of the articles found in this review, it was concluded that the contractarian relationship encourages the empowerment of those involved in the work process of family health.

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Participation of the authors

Cássio Almeida Lima worked on the study design, literature review, wording of the article and final revision of the version to be published. Ana Paula Soares Oliveira and Beatriz Ferreira Macedo worked on literature review and in wording of the paper. Orlene Veloso Dias worked in orientation, study design and revision of the final version to be published. Simone de Melo Costa worked in orientation, study design, theoretical framework design, wording of the article and final revision of the version to be published.

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