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ESSAY

Paulo Freire's contributions to improving the doctor-patient relationship

Contribuições de Paulo Freire para a melhoria da relação médico-paciente

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ABSTRACT A 'good' doctor-patient relationship is essential for effective clinical practice in the Unified Health System. Communication problems, authoritarianism and a certain disregard for the patients' existential situation and agenda are common in clinical practice. Paulo Freire addressed similar issues in education, and his ideas were less used for teaching and practice of conducting medical care. This essay aimed to synthesize the contributions of Freire's ideas for building/improving the doctor-patient relationship in an outpatient clinical context. Methodologically, a literature review was performed coordinating doctor-patient relationship aspects and Freire's ideas. The analysis consisted of reading and free synthesis of selected works on the clinical relationship and the ideas contained in Freire's main books, considered relevant to this theme (first and second topics of the article), was followed by a synthesis of Freire's contributions, organized into five themes: reinforcing the challenge of avoiding patient objectification; emancipatory, critical and participatory conception of the doctor-patient relationship and its educational aspects; importance of the patient's lifeworld; centrality of opening and maintaining dialogue; handling power dynamics well. Freirean ideas are still very relevant and contribute to the teaching and improvement of outpatient clinical practice.

KEYWORDS Physician-patient relations. Health education. Medical education. General practitioners. Primary Health Care.

RESUMO *Uma 'boa' relação médico-paciente é fundamental para uma prática clínica efetiva no Sistema Único de Saúde. São comuns, na prática clínica, os problemas de comunicação, o autoritarismo e certa desconsideração da situação existencial e da agenda dos usuários. Paulo Freire tratou de temas similares na educação, sendo menos aproveitado para ensino e prática da condução dos atendimentos médicos. O objetivo deste ensaio foi sintetizar contribuições das ideias freirianas para construção/melhoria da relação médico-paciente em contexto clínico ambulatorial. Metodologicamente, foi realizada uma análise de literatura articulando aspectos da relação médico-paciente e ideias de Freire. A análise consistiu em leitura e síntese livre de obras selecionadas sobre a relação clínica e das ideias contidas nos principais livros de Freire, consideradas pertinentes a essa temática (primeiro e segundo tópicos do artigo). Seguiu-se uma síntese das contribuições freirianas, organizadas em cinco temas: reforço ao desafio de desviar da objetificação do usuário; concepção emancipadora, crítica e participativa da relação médico-paciente e dos seus aspectos educativos; importância do mundo da vida dos usuários; importância de abrir e manter o diálogo; 'bem' manejar as dinâmicas de poder. As ideias de Freire continuam muito relevantes e contribuem para o ensino e a melhoria da prática clínica ambulatorial.*

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Introduction

The quality of outpatient medical care and its education is relevant to public health, as Primary Health Care (PHC), via the Family Health Strategy, should be the first (non-emergency) contact of citizens with the Unified Health System (SUS), besides structuring and coordinating its services. However, the approach to the doctor-patient relationship in medical education is often marginalized and placed in subjects of psychology, sociology, or medical anthropology[1].

There is some consensus on the need to shift the spotlight from the doctor-disease dyad to the patients and their relationships with the professionals[2]. The relevance of the therapeutic bond and more horizontal communication has been recognized, and techniques have been developed for this purpose[3]. However, resistance to change is observed in clinical practice and education, perpetuating paternalistic attitudes that view the patient as a passive subject[4]. There is a need to change the meaning of being a doctor[3] because even an excellent management plan is useless if the patient does not commit to it[5]. Criticism of the patient objectification[3], authoritarianism[4], disregard for the patient's perspective[5], and claims about the relevance of dialogue[6] are common. Similar issues were addressed by Paulo Freire (1921-1997), an educator who redefined pedagogical practice[7] by creating an adult literacy method recognized in Brazil and worldwide[8-10]. His writings address several themes: dialogue, critical reflection, awareness, freedom, emancipation, and autonomy[11].

In Brazil, Freire's work influenced the field of health[12], especially initiatives in health education that are still innovative today[13]. The Popular Education in Health (EPS) movement[13-15] stood out, which began in the 1970s and whose purpose was to "bring the contribution of Freirean thought to the field of health"[16(53)]. From 1991 onwards, the Popular Education and Health Network (REDEPOP) gathered health professionals and famous leaders nationwide. A Thematic Group for Popular Education in Health has existed within the Brazilian Association of Public Health[17] since 2000.

In 2003, REDEPOP became the National Articulation of Movements and Practices of Popular Education in Health (ANEPS). That year, the General Coordination of Popular Actions in Education in Health was established within the Ministry of Health[18]. In 2013, the National Policy for Popular Education in Health (PNEPS-SUS) was enacted with the following principles: dialogue, lovingness, debate, shared construction of knowledge, emancipation, and commitment to constructing a democratic and popular project[19].

Freirean and EPS ideas are more discussed in specific health education actions[20,21]. When discussed in the clinic, they are in a very generic sense or aimed at 'strengthening popular care practices'[19]. For example, Alves[13] affirms that EPS seeks to reorient work, especially in primary care, regarding management practices, social control, education, and care. EPS helps to "debate reality [...] in clinics [...], educational actions in territories, community spaces, and schools"[22(11)]. Vasconcelos[23(126)] considers that EPS is

> [...] fundamental in the historical construction of comprehensive medicine, in [...] expanding the interrelationship between the different professions, specialties, services, patients, family members, neighbors, and social organizations [...]. This redefinition of medical practice occurs [...] through the articulation of multiple, different, and even contradictory initiatives [...] in a process that mainly values [popular] knowledge and practices.

The EPS allows for the

> emergence of new patterns of addressing health problems marked by integrating technical knowledge with widespread knowledge and mutual collaboration[15(30)].

In a literature review on EPS[24], no specific discussion was found on how or in what ways Freirean ideas can influence/improve medical appointments and intra-office doctor-patient relationships. There is little discussion on its contributions to teaching/improving medical care conduct, whose technical learning is generally relegated to teaching semiology and tacit learning commonly conducted in hospitals (wards and outpatient clinics). Freirean ideas seem more widespread in other professions, especially nursing[25-27]. Although there are some studies with a generally restricted clinical focus – for example, Borges and Porto – Freirean contributions to teaching and outpatient clinical techniques and building a good doctor-patient relationship are hardly explored. This study attempts to narrow this gap by immersing oneself or zooming in on the specific potential of Freire's contributions to conducting community outpatient medical appointments.

This work aims to summarize the main contributions of Freire's ideas to the construction and improvement of the doctor-patient relationship in individual care from the viewpoint of outpatient clinical practice. Methodologically, we analyzed selected works on the doctor-patient relationship and Paulo Freire. As they are essential for understanding his ideas, Freire's analyzed texts were: 'Education as the practice of freedom'[29]; 'Pedagogy of the oppressed'[30]; 'Extension or communication'[31]; 'Education and change'[32]; and 'Pedagogy of autonomy'[33].

Regarding the doctor-patient relationship, some reference books used in teaching family and community medicine were selected due to their relevance and because this medical specialty has advanced further in proposals for improving clinical performance: 'Clinical Interview: Communication Skills for Health Professionals'; 'Person-centered Medicine: transforming the clinical method'[3]; 'The inner appointment: how to develop an effective and intuitive consulting style'[5], and 'Skills for communicating with patients'[4], besides referenced articles.

The analysis of the two sets of texts consisted of free-floating reading and synthesis of the content most relevant to the objectives. Subsequently, an analysis was conducted to detect and synthesize Freire's main contributions to improving medical performance in outpatient care based on the authors' clinical experience in primary health care. No systematic analysis procedures were adopted, but rather free-floating reading and discussion of the ideas and their synthesis to allow their formatting in an article. Theoretical and philosophical issues were not discussed beyond their brief mention when indispensable due to the focus on clinical practice.

Regarding the doctor-patient relationship

The doctor-patient relationship has been studied for decades. In the 1950s, Parson[34] approached it by emphasizing the 'sick role', incapable of performing social activities. Illness would be a threatening deviation from the social order, and doctors would be responsible for regulating/controlling patients so that they could return to their activities[35]. In 1950-1960, psychoanalyst Balint[36] analyzed reports by English general practitioners emphasizing disagreements and relational difficulties from a psychodynamic perspective. Sociologists such as Luc Boltanski (1940-...)[37] addressed this relationship, and its anthropological aspects were discussed by medical anthropologists (for example, Kleinman[38] [1941-...] and Helmann[39] [1944-2009]). More recently, this relationship has been studied, covering care personalization, humanized service, the right to information[40], the person-centered approach[3], and the communication skills necessary for a good relationship[6].

The doctor-patient relationship was modeled. In 1956, Szazs[41] proposed three basic models: activity-passivity, cooperation-guidance, and mutual participation. The latter was based on the relationship between two adults

(the doctor helps the patient to help himself) and was deemed more appropriate. Another proposal saw four patterns: paternalistic, informative, interpretative, and deliberative. In the last, most desirable, the doctor would be a friend or teacher who offers information, helps the patient to know himself, and suggests what he considers best[42].

When patients seek medical help, they seek to reduce pain and suffering, but they also seek to give a name and meaning to their suffering and improve their control over the situation. When seeking care, people are vulnerable, in a 'one down' position, with a problem that they cannot solve on their own, affecting their self-esteem. They should not leave the service 'two down'[5].

An appointment begins with accepting the patient's demands, continues with the anamnesis and physical examination to collect information and develop diagnostic hypotheses, and finally generates a management plan to be agreed upon. To be effective, a doctor must understand something of the patient's meaning, aspirations, beliefs, ideas, expectations, and suffering[3], as there is a greater likelihood of misunderstanding[4] if they avoid or inhibit the patient's ideas.

Empathetic support and cordiality generate a positive response since the professional must be the bridge so that the fear common in illnesses is directed towards a rational account[6]. During the appointment, it is crucial to recognize and value the patients' viewpoint and not to disregard their ideas and emotions. Recognizing beliefs, perspectives, and feelings and encouraging them to be expressed allows for a more practical approach by facilitating a common ground between doctor and patient[4].

Sometimes, doctors ignore patients when they express their worldviews, which has been associated with worse outcomes in research[3]. Patients and doctors may disagree about the illness, or the latter may feel afraid of not controlling the appointment: letting the former speak makes it uncertain where the conversation will go. Doctors often interrupt patients early and ask closed questions, keeping patients passive and controlling the situation.[4,43]

This situation also happens due to communication barriers arising from differences between doctor and patient (age, gender, race, class, education, cultural particularities)[6]. However, sharing the other person's life experience is not necessary. It suffices to approach and try to see the problem from the perspective of the subject experiencing it and communicate one's understanding without pity or concern[4].

We have two voices in an appointment: the medical (scientific) voice and the patient's voice about the world[44]. Barry et al.[45] noted that the best outcomes occurred with a mutual lifeworld, in which the professional and patient used the voice of the lifeworld to highlight individual experience. Doctors must be sensitized to pay attention to the life concerns brought to them[3]. We should approach the person's perspective, beliefs, and expectations[6] to gather information and reason clinically. There are some strategies for this: an open-ended question about how suffering affects life and encourages expressing feelings and thoughts[4]. Another is to try to understand the difference between health and the experience of illness for the patient[3] and ask about their prior knowledge[4].

When patients ask questions and express their concerns, preferences, and opinions, doctors can better understand their beliefs[3]. If there is a lack of understanding and divergent views, the professional has often not discovered the patient's angle or engaged in dialogue with them[4]. At the end of the appointment, the doctor is advised to express himself confidently, without falling into aggression or passivity[6], avoiding medical jargon, which can cause communication problems and inhibit questions[4].

When treatment is not followed, talking about 'non-adherence' is expected. In

patients with more impoverished socioeconomic status or who are older adults, this fact can create stereotypes[6]. Poor adherence can be a disagreement in which speaking openly[3] is inhibited. Placing the blame for non-adherence or misunderstanding on the patient is often a mistake since the doctor should agree on the therapeutic plan[5].

The patient can only clearly understand the treatment if the doctor is clear about the former's responsibility[5]. The management plan must fit into the lifeworld of the person being treated[3]. Patients do not take the data received during consultation and process it like a computer; patients and doctors are sociable beings living in a community[6]. Their relationship is not a test of strength. The doctor does not need to agree with the patient but must propose his explanation and treatment in a way that is minimally consistent with the person's vision, which must make sense from their perspective[3].

The professional is just another influence in the patient's life, like the media, friends, and family, and will influence the patient to the extent that the patient allows it. Therefore, it is not adequate to unilaterally order measures[6]. It is necessary to build commitment to the therapy. This is the challenge of the final part of the appointment. A negotiation process begins in which the greater the understanding and agreement, the greater the commitment. This negotiation must be a dialogue not left in the hands of the patient nor unilaterally ordered by the doctor. The objective is not to convey the truth but to jointly and responsibly seek the best plan of action[6].

In shared decision-making, widely advocated in the literature, doctors and patients share all decisions two-way, including information, concerns, and expectations[4]. Doctors do not do everything requested; they bring their knowledge to the discussion of managing suffering/illness[3]. Patients are entitled to disagree, and when this happens, they should activate the professionals' genuine curiosity and dialogue, making the relationship more fruitful[6].

Paulo Freire's ideas

"Freedom [...] is an achievement and requires constant pursuit"[30(22)] because those who fight for it are those who do not have it. Nevertheless, Freire highlighted the need to balance freedom and authority because "a rupture of this balance could generate authoritarianism or licentiousness"[33(89)]. He highlighted that the challenge of authority is the need for generosity. When an educator uses arrogance and bossiness, he undermines his authority because democratic authority understands that "true discipline does not exist [...] in the silence of the silenced but in the commotion of the restless"[33(56)]. Authority must seek a friendly and respectful relationship[30] to avoid degenerating into authoritarianism.

Autonomy is something built as someone acquires experiences. No one is responsible for anyone else's autonomy. Educational practices should promote experiences that stimulate decision-making and responsibility while respecting freedom. The practice of a critical professional who addresses people is to create this responsibility in training without "encouraging impossible dreams... [and without] denying those who dream the right to dream"[33(144)]. Through the balance between authority and freedom, students can build autonomy with materials they prepare or borrow from the educator. Thus, autonomy is built through freedom, which "fills the space previously inhabited by their dependence"[33(94)] and is based on their responsibility.

Freire opposed verbose education, which only makes statements instead of communicating. He argued that only dialogue communicates. When the two poles of dialogue are connected, they become critical in the search for something[29]. Dialogue is an encounter in which reflection and action are shared. This gesture does not deposit ideas in another person who is supposedly ignorant, which Freire called 'banking education'[32].

There is no dialogue when someone is alienated from their ignorance, seeing it only in

the other and never in themselves, and when one closes oneself off to the contribution of the other. The "educator teaches and learns dialogically with the student because there are neither absolute ignoramuses nor wise men. Some men seek to know more"[30(33)] in communion. For this reason, Freire opposed anti-dialogue, a relationship of 'A' over 'B' in an unloving, arrogant way, which breaks the relationship of empathy that dialogue produces[32].

Freire approaches the interaction between students and educators as co-intentioned in a dialogue between subjects who critically know reality to recreate knowledge based on reflection. The more critically the capacity to teach/learn is exercised, the greater the construction of an epistemological curiosity[32]. The author advocated an education that encourages reflection on reflection itself, developing this student's potential. Such critical education recreates the subject's relationship with reality and results in being within reality and with it through creation, recreation, and decision. He saw as a dehumanization symptom someone who is accommodated to what is imposed on them as a recipe, without the opportunity to discuss it. This drowns people in massification and sacrifices their creative capacity, reducing them to an object[29].

Freire states that social workers who opt for change must 'demystify' reality, see the people they work with (in the case of doctors, the patients) as subjects, and contribute to overcoming the structure that reduces them to the condition of objects. They must act and reflect with those they work with to become aware of their reality with them. There is an increasing need to expand one's technical know-how and knowledge about the objective limitations one faces in one's 'what to do'[32]. When professionals ignore the obstacles, the historical, political, and social experiences obstructing the self-knowledge process, they work in favor of them. Therefore, one cannot defend humanity abstractly and must constantly fight against any oppression[33].

If awareness places someone critically in a system of relationships and overcoming themselves, it grounds deeper and becomes awareness. Contrary to dehumanization, awareness results in someone confronting the world in its concrete reality[31]. By understanding their reality, they can seek solutions themselves and thus transform their reality, self, and circumstances. Freire believes educational work involves escalating and dialogizing the relationship between the subjects and their experienced reality. The educator must approach this reality and perceive relevant and significant aspects for the students to build new knowledge through dialogue, targeting critical awareness.

In 'Pedagogy of the Oppressed', Freire defends the dialogicity of his method as "the essence of education as a practice of freedom"[46(9)]. This method uses dialogue to identify human-world relationships, the 'generating themes', which are words and expressions from the literacy student's universe used as a starting point, by allowing the understanding of their context to extract from everyday life the vocabulary used in literacy and the programmatic content of education[47]. Thus, his method addresses people's experienced world to depart from it, according to their experience and perspective through dialogic work, and reach the intended educational objectives.

Paulo Freire's contributions

Five central themes were identified around which Freirean ideas improve relationships in clinical care, making them more effective and emancipatory (*table 1*).

Table 1. Freire's main contributions to improving the clinical relationship

1	Reinforcing the challenge of avoiding patient objectification
2	Emancipatory, critical, and participatory conception of the clinical relationship
3	The importance of patients' life world
4	The centrality of opening and maintaining dialogue
5	Handling power dynamics well

Source: Prepared by the authors.

Reinforcing the challenge of avoiding patient objectification

One problem in the doctor-patient relationship is the tendency to approach the patient as an object, resulting from the focus of medical knowledge and technique on the individual's biological dimension and illness (or risks). This fragments the subject and leads them to neglect their other dimensions, removing their complexity and reducing them to an object. Some justify this by claiming that a critical distance is necessary for better diagnostic judgment, a euphemism for supposed neutrality[48].

Furthermore, social barriers (cultural differences and differences in class or social group) make it easier for professionals to transform their competence into prejudice and arrogance, ignoring the complexity of one person's life and placing them as passive[6]. This makes the patient feel suspended, leading them to judge their world differently[29]. After repeatedly hearing that they are incapable, they convince themselves of this. "They talk about themselves as someone who does not know and about the 'doctors' as those who do know"[30(28)].

If the professional imposes an objective by prescribing treatments (curative or preventive), he will objectify the patient in a domestication relationship[31]. By acting as a 'doctor', not exploring the patient's contextual and personal complexities and singularities, the professional becomes less sensitive to their humanity, commits to their dehumanization, and dehumanizes themselves as well[32]. Freire reinforces this old challenge of medical training and practice. Accepting patients, their beliefs, knowledge, emotions, and subjectivity is necessary to establish a humanization-based relationship. Acceptance does not mean agreeing with them, but listening to and recognizing their emotions, knowledge, and subjectivity, appreciating their perspective, and building a dialogical and participatory relationship[4].

Emancipatory, critical, and participatory conception of the clinical relationship

Freire was against banking education, which is based on oppression, in which ignorance is found only in the other[30]. Suppose professionals consider themselves members of an elite of savior specialists, owners of knowledge to be given to the ignorant. In that case, they diminish themselves as professionals and human beings, alienating themselves from their role[32]. To oppose this, professionals must build a relationship in which both are subjects of the process, overcoming the banking method's authoritarianism.

A critical professional cannot be a mechanical memorizer who does not realize when there is no connection between what he/she has read and what is happening in the reality of his/her country, city, neighborhood, or patient. It is necessary to understand better the readings of the world that the social groups with

whom he/she works make of their context and not disregard their knowledge. "Reading the world" precedes "reading the word"[33(27)]. No neutral techniques can be transferred from one context to another, and the professional's alienation sometimes prevents him/her from realizing this[32]. Communication requires subjects who focus their 'admiration' on the same object. Since both have words that express this admiration in common, a similar understanding of the object is born, the process of which is not exempt from sociocultural conditioning[31].

Freire believes that respect for the student's (user's) reading of the world does not aim to generate sympathy. It is a way of working with the student (not on him/her) to overcome a somewhat naive way of relating to the world and adopt a more critical way of relating to it. When such a reading is respected, it can be taken as a starting point for the role of curiosity as a driver of knowledge construction. When this reading is disrespected, denoting an elitist taste, the other person is not listened to or spoken to[33].

One should not think for or for others. The investigation of how people (patients) think should be done with them as the subject of their thinking. If they have a naive thought, it will be by reflecting on their thinking that they will overcome it. Such overcoming is not the consumption of ideas but rather the act of producing them and transforming them into action and communication[30], built via epistemological curiosity and fostered by critical learning[33].

> To achieve this, educators and students must jointly engage with reality as subjects to understand it critically and recreate this knowledge[30(31)].

This message from Freire reinforces that the challenge of the clinical relationship is to offer precise information in dialogue that arouses interest, trust, and critical reflection[32]. Communication is an interactive and dialogical process involving feedback on how the message was interpreted, whether it was understood, and what its impact was. Dialogue is essential, enabling a meeting where the professional encourages the subjects to reflect. However, one cannot dialogue when one is closed to the input of the other's perspective[30].

Thus, the professional's task is to practice the construction of knowledge: to gently and dialogically challenge people to produce their knowledge. No intelligibility is not fused with dialogicity[33]. The professional and patient share the intention of experiencing illness/suffering contextualized in the lifeworld and meet as subjects to critically understand and recreate such knowledge[30], aiming at care.

The importance of the patient's lifeworld

Barry et al.[45] conducted a qualitative analysis of medical appointments and observed three types of relationships: a) ignored lifeworld, in which the doctor ignored the patient's perspective; b) blocked lifeworld, in which the doctor's perspective suppressed this perspective; and c) mutual lifeworld, in which the patient and the doctor use the former's life perspective to highlight the unique aspect of the patient's experience. In these analyses, the worst outcomes occurred in the first two types and the best in the last. The authors concluded that doctors need to be sensitized to pay attention to the lifeworld concerns the person brings.

The lifeworld varies with each person and at different times. The explanation and treatment must be consistent with the patient's angle and make sense in their world[3]. A democratic relationship occurs when doctors make their knowledge available, and patients use it to their advantage[6].

Freire argued that educational work needs to start from the world of people's experienced lives to critically reinterpret that world and act within it, which broadly aligns with the guidelines that have called for people-centered clinical approaches for decades. The patient's

lifeworld is quickly abandoned in the classical clinical method influenced by the hospital environment. This situation sacrifices dialogicity and distances the patient's perspective, values, concerns, and explanatory models. It inhibits the dialogue that allows for a greater critical understanding of the situation and more engagement and participation in the treatment. Thus, the relationship tends to reproduce hierarchy and domination.

The quality of clinical action and its educational component depends on dialogicity and its focus on the person in the family, occupational, and psychosocial context. On the other hand, the superficial perspective of improving the doctor-patient relationship humanization (empathy, trust, bond), aiming only at greater adherence through training in interview techniques, is very limited given the complexity of building greater critical awareness; the difficulty of opening and maintaining a genuine dialogue with greater horizontality and empathy in the context of medical care; and the pitfalls of the power dynamics involved in clinical relationships. This situation becomes more evident when considering the increasing need for patients to participate in their care due to chronic illnesses and increased longevity.

The centrality of opening and keeping a dialogue

"Dialogue is an existential requirement, [...] education is communication and dialogue, a meeting of subjects who seek the signification of meanings"[30(42)]. This dialogue centrality must be perceived in the doctor-patient relationship. As long as the medical practice is "verbose, wordy, welfare-oriented, and tutelary, it will not communicate but rather make announcements"[29(94)].

Some strategies and tips facilitate dialogue. One is reducing and avoiding medical jargon because when technical language is used, the person may not understand and feel inhibited in asking questions. However, the primary communication strategy is to pay attention to the patient's perspective when he/she conveys his/her belief system, perception of the problem, and its context. By recognizing this perspective, doctors can more appropriately bring their belief system and offer it as a possibility to benefit the patients. Thus, the appointment aims to bring these two portions of belief systems to interact dialogically so that, when the subjects separate, each will have changed a little: the doctor will have acquired new information about the person, and the latter will have made some progress in resolving/managing their health problem[5].

The appointment's central leading figure is the patient, and the professional must act as a facilitator, offering recommendations and guidance. Therefore, it is crucial to use negotiation, which differs from persuasion, since both parties want something through dialogue in a negotiation. Agreements reached through honest dialogue are almost always more effective than initial proposals if there is sincere listening and acceptance that the patient can add something to managing the condition[6]. An indicator of the patient's space in the appointment is the percentage of time taken up by the patient's speech during this event.

Accepting the patient's ideas, especially those that disagree, without judgment, may not be easy at first. However, this establishes a common ground through a shared understanding of the patient's perspective. The professional acknowledges that the patient's ideas and emotions regarding their condition are essential and uses them to improve the diagnosis and therapeutic proposal and, additionally, creates a feeling in the patient that their needs are being met[4].

An effective dialogue requires silence. The act of listening should attempt to enter the internal movement of the patient's thoughts. Authentic listening does not prevent the professional from disagreeing. On the contrary, listening allows accessing the patient's viewpoint[31]. Part of the construction of dialogue

is encouraging questions and critical reflection on these questions. The stance should be dialogic and inquiring, with respect for the person's knowledge, which can be overcome, if necessary, through epistemological curiosity[31] awakened/reinforced through dialogue interested in their condition in a critical way[30].

Healthcare professionals do not start from scratch. They are trusted due to their social prestige, technical knowledge, or assertiveness, the latter of which depends on their ability to communicate confidently. However, it is necessary to balance clients' trust in the professionals. A power dynamic that overshadows the objective of the patient's well-being and growing autonomy should not be allowed.

Care when handling power dynamics

In the power dynamics of an appointment, sometimes the patient does not distinguish between asking and demanding, which may occur due to the person's lack of education. However, it may also be due to previous authoritarian experiences with doctors, in which they learned that their opinion is only valued when they impose it aggressively[6]. Since the appointment is not a test of strength, medical skill consists of presenting a suggestion that makes sense within the patient's set of habits and beliefs so that they become an ally in the search for well-being[5].

During the appointment, the patient provides several 'hints' about the complexity of his/her belief system verbally and non-verbally. However, professionals often fail to capture them, which is fueled by their tendency to pay attention only to the parts of the patient's speech that can be related to their disease(s) or risks (disease(s) in the biomedical sense), ignoring their relationship with it (them). This situation may occur due to the professional's search for control through closed-ended questions that limit the patient's contributions[4]. Another way is to not provide complete information about the diagnostic situation unless the patient requests it, reinforcing the power hierarchy and sacrificing the opportunity for health education[6]. If the difference in the level of knowledge between the doctor and the patient is reinforced by the professional, technical knowledge is mystified, and the patient's knowledge is devalued, hindering the creation of autonomous and informed patients. It is essential to break with this power dynamic and not dominate the appointment[3].

What defines a professional's appointment, however, is not their use of power but their commitment to the individual's suffering. Patients value these emotional aspects the most. Thus, the appointment aims to create an environment in which both parties feel comfortable and the patient's autonomy is respected so that it is always kept in mind that professionals only influence patients to the extent that they allow, without the need for sermons. It is hard to dialogue in an atmosphere of antagonistic relationships, in which professionals only impose or give in and do not dialogue with ideas or beliefs and, therefore, do not transform them. Adapting scientific knowledge to the patient's beliefs does not mean relativizing technical knowledge, which must be offered in the best possible way. The patient's autonomy cannot be an excuse for the doctor not to work toward building health knowledge[5,6].

Professionals seeking to escape the ideology of oppression must break with the (supposed) neutrality in their actions. The discourse of neutrality is a convenient way of hiding the option of denouncing an injustice; 'washing one's hands' in the face of oppression is to reinforce the oppressive side. What is required of democratic professionals, aware of the impossible neutrality, is knowing that their practice is not the key to social transformations, nor does it reproduce the dominant ideology. Therefore, they should know that when someone inserted in a context of deprivation or injustice adapts to pain, hunger, and discomfort, this adaptation shapes up as resistance to the offensive neglect to which they are subjected. Such adaptations are

necessary resistances for physical survival. However, in the resistance that keeps them alive, it is necessary to consider the future as a problem (with the possibility of resolution), not as inevitable.

In the vocation to 'be more' as an expression of human nature, we must base ourselves on rebellion, not resignation, to achieve change in the face of offenses that destroy or oppress the being. Rebellion is an indispensable starting point for seeking change, but it is not enough. Change implies a dialectic between the denunciation of the dehumanizing situation and the announcement of its overcoming, which is fundamental: change is hard, but it is possible. This motto can guide the actions of the democratic and critical professional, whose task is to support the patient to overcome his/her difficulties in understanding the problem[33] when relating to the other (patient).

There must be a balance between authority and freedom: when in harmony, there is discipline. With imbalance, the relationship degenerates into licentiousness or authoritarianism. One sign of imbalance is "eagerness for command"[33(89)], which medicine could contextualize as a mania for sermonizing and prescribing. A relationship incorporating the patient's perspective, lifeworld, and agenda based on encouraging them to participate and express themselves in dialogue in constructing a common diagnostic interpretation and a shared therapeutic decision is an antidote to the common authoritarian imbalances in the clinical relationship.

Final considerations

There is consensus that the doctor needs to adopt attitudes and master essential skills in the doctor-patient relationship for an effective appointment: seeking to humanize the appointment, greater sharing of ideas and decisions, and a better understanding of the patient's perspective so that the therapeutic plan is agreed upon and adapted to their beliefs, expectations, and life situation. Paulo Freire's ideas dialogue, enrich, and intensify such attitudes and skills by deepening the critique of the patient's objectification, highlighting the relevance of dialogue and investing in it from the beginning to the end of the services, emphasizing the need to start from the patient's perspective in their lifeworld to build critical knowledge with them and expand their autonomy, without reproducing authoritarian and passive power dynamics.

The Freirean framework brings concepts and ideas rarely discussed in theory, practice, and education in outpatient clinics but that make sense and are relevant in this context. This framework brings a perspective of a 'democratic professional', questioning concepts of neutrality and authority in the clinical relationship. Furthermore, it reinforces the need to understand the patient's socioeconomic, family, and psychosocial context to promote autonomy, critical awareness, and involvement in care. Brazil's multicultural population is exposed to intense differences, violence, and inequalities. It is rich in diverse health practices/knowledge, which implies greater knowledge and use of the care resources of people, their communities, and knowledge commonly ignored by professionals in their therapeutic proposals. Such ideas redefine the work of doctors and improve their clinical performance, and can also strategically guide their training.

Collaborators

Carmes BA (0000-0002-2595-9539)* collaborated in the design, literature analysis, writing of the first version, critical review, and writing of the final version of the manuscript. Tesser CD (0000-0003-0650-8289)* and Cutolo LRA (0000-0003-3102-3195)* collaborated in the design, critical review, writing of the final version, and manuscript supervision. ■

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