Configuration of Social Networks to Support People with Cancer: a View from the Perspective of Information and Communication in Health

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Abstract

Introduction: Head and neck cancer encompasses several types of tumors. Notable types include cancer of the larynx and cancer of the oral cavity. Laryngeal cancer is the most common of such cancers and is the second most common type of respiratory cancer worldwide. In Brazil, it is the eighth leading type of cancer among men. Mouth cancer ranks 15th among all cancers and is the fifth most common cancer in Brazil. Both types of cancer mainly affect men over the age of 40. Objective: To identify how forms of communication, information flows, and knowledge appropriation are constructed by cancer patients under treatment at the Head and Neck Clinic of the José Alencar Gomes da Silva National Cancer Institute and registered with its social networks, from the perspective that such resources are fundamental to deal with the changes and necessities imposed by their illness. Method: This was a qualitative study, based on the methodology of collecting oral life histories, using narrative concepts and social networks as theoretical support. Patients were interviewed at three different stages of treatment. Conclusion: The process of information and communication that patients configure on their social networks is fundamental for the construction of support strategies and social protection throughout the course of treatment. Such knowledge becomes fundamental in the interaction with public policies, in view of the possibility of participation and the broadening of rights.

Key words: Health Communication; Neoplasms; Social Networking.

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INTRODUCTION

Cancer is a public health problem, especially in low- and middle-income countries; in the coming decades, such countries are expected to account for 80% of the more than 20 million new cases estimated for 2025. Head and neck cancers include various types of tumors, chief among which are cancer of the larynx and cancer of the oral cavity. Laryngeal cancer is the leading head and neck cancer and the second leading cancer of the respiratory tract worldwide. In Brazil, it is the eighth most common type of cancer among men. However, among all cancers, cancer of the oral cavity ranks 15th worldwide and 5th in Brazil. Laryngeal cancer and cancer of the oral cavity both target mainly men over 40 years of age.

The term cancer is used generically to represent a set of more than 100 types of neoplasia, including malignant tumors in various locations. Surgery, radiotherapy (a medical specialty that uses ionizing radiation as a form of treatment), and chemotherapy (a method that uses chemical compounds in the treatment of diseases caused by biological agents or of illness caused by various types of cancer) are the main treatments used in order to combat and control cancer.

According to Alvarenga et al., head and neck cancer is a collective term to denote and describe malignant tumors of the upper aerodigestive tract. The region includes the oral cavity, pharynx, and larynx. A larger subgroup of head and neck carcinomas, specifically those appearing in the mucous membranes of the mouth (lips, base of tongue, tongue floor of the mouth, or hard palate) and pharynx (oropharynx, hypopharynx, or nasopharynx), are collectively referred to as oral cancer. About 40% of head and neck cancers occur in the oral cavity, 15% in the pharynx and 25% in the larynx, and the rest in salivary and thyroid gland regions.

Among cancer types, approximately 80% to 90% are associated with external causes, such as smoking. Head and neck cancer mainly affects men of working age and is associated with alcohol consumption and smoking. The use of alcohol and tobacco products can cause cancer of the mouth, oropharynx, or larynx.

As a consequence of the treatment, the alteration of the body image, specifically changes in the appearance of the face and neck, is seen as recurrent and contributes to further impairing the life of individuals with head and neck cancer, due to the post-treatment limitations that can impede their reintegration into networks of social relationships and into the workforce.

The challenges posed by cancer are many, especially in low-and middle-income countries that have low public spending on health, where chronic diseases and infectious diseases coexist, creating a context in which efforts are still being made to increase access to early diagnosis and to improve treatment in the early stages of the disease, a situation that has already been ameliorated or resolved in high-income countries.

The estimates of the Instituto Nacional de Câncer José Alencar Gomes da Silva (INCA, José Alencar Gomes da Silva National Cancer Institute) for 2012 make it clear that there is concern to address the social dimension of cancer in Brazil, considering its devastating impact on family organization, because the affected individual is often the head/provider of the family and other family members are often forced to interrupt life projects such as study and work to perform caregiver activities within the family.

Having cancer is a complex experience that encompasses the objective and subjective dimensions of life. As an objective dimension, it is a disease of long duration, involving invasive treatments, and that will require palliative care in cases of incurable cancer. The subjective dimensions translate to difficulties in relation to the psychological aspects of dealing with the disease, socioeconomic difficulties to manage the material conditions for the treatment, and difficulties in relation to weaknesses of the social ties and fundamental support for the promotion of the care required. The treatment/care process will require the assistance and support of individuals or groups that make up the social relationships of the patient (hereafter referred to as patient social networks), in the sense of relationships that can be constructed over a lifetime or that can be developed in this context. The concept of social networks is polysemous, being employed across several areas of knowledge, and there is as yet no theory related to social networks. As explained by Acuini, the concept arises from the field of social anthropology and is based on the ethnographic analysis of networks of kinship structures. Other areas of knowledge may focus on the study of social networks within the scope of social relations and their connections with individuals and institutions from a perspective of social structure. However, according to some studies, especially those published since the 1980s, the technological use of networks, especially related to advances in information technology, has garnered attention in electronic forms of connections as a means of accessing information. In all of these different approaches, it has been shown that there is a direct correlation with the information, understanding information as a continuous process of exchange.

In this study, we seek to increase knowledge of the social networks of patients regarding their social
networks. According to Griep, a social network can be care can be called social networks or social support the same author, it should be borne in mind that social to the dimension of social relations. According to the terms of understanding social phenomena, because networks represent a great advance in studying networks that refer to the space of interactions and connections in the technological/virtual environment.

It is considered that, from the perspective of illness, networks can mobilize around the need to protect and care for individuals with chronic diseases, providing resources and possible responses to extreme situations, an issue that requires constant organization and reorganization of these groups and their relationships.

Conceptually, networks of patient protection and care can be called social networks or social support networks. According to Griep, a social network can be defined as the social structure through which support is provided. Such a network is made up of individuals with whom the patient has a bond, usually being family members or belonging to a formal network of relationships. Social support networks can be defined as the assistance received by individuals or groups, without formal ties to the patient, which can generate important social exchanges and have positive effects for both. In other words, there are actions and resources in motion in social networks that stand out in the constitution of knowledge and that acquire value in social relationships.

Based on that movement, network analysis, as a theory of social network analysis, allows us to look at three analytical definitions constituting social networks: the resources they produce and circulate; the social structure into which they are inserted; and the actions that propagate in networks. In this aspect, the morphology of the networks can provide access to knowledge that conditions the social and political practices of the subjects.

With respect to social networks, Martelete stated that studies on networks represent a great advance in terms of understanding social phenomena, because they allow the focus to be shifted from the individual to the dimension of social relations. According to the same author, it should be borne in mind that social networks move from the foundation of constructions around information and communication (i.e., within the possibilities of learning, the exchange of knowledge, and the collective actions of the individuals in the network), potentially providing some clues to the roles played by social ties and sociocultural organization, as well as their expressions in health care work processes.

In the hospital setting, it is inevitable that health care professionals and institutions participate in the everyday life and care of individuals with cancer, because the hospital becomes a living laboratory of experiences around the meaning that the networks mobilize, incorporating information in a more interactive manner, producing and sharing knowledge for care management. This underscores the idea that the analysis of social networks is par excellence in an interdisciplinary field that crosses several areas of knowledge.

As an example of the work with networks, we can reference what occurs at the INCA Head and Neck Clinic, especially regarding the intervention of social workers, together with the health care team, as well as the patients and their family members. With regard to the interaction with the health care team, the professional acts in the continuous search aimed at giving visibility to the living and working conditions of the population served, as well as their dynamics in the social structure and in the scope of their networks of social relationships, seeking to promote interaction with these networks in order to mobilize existing resources, with a view to minimizing vulnerabilities, thus guaranteeing access, participation, and the right to health care.

Working with networks has always been part of the scope of intervention of the social worker, although it is little discussed within the category. From the current perspective, it gains new dimensions, because, in view of social changes, the weakening of community forms of life and the increase in social mobility become evident, at the same time that the challenge for the construction of institutional responses to the complexity grows in response to the demands. Such questions raise the importance of understanding these dynamics from the perspective of the construction of knowledge about social networks and their forms of interaction with the changing social structure.

Therefore, we seek to understand the movement of social networks to support patients in their interactions with other networks, especially with the institutional and public policy networks, considering their limitations and potentials in the search for solutions to complex situations that present as everyday challenges.

The space of the INCA Head and Neck Clinic is a fertile field of research, since in this space, the social and relational status of the patients and their support networks gain visibility, as well as the repercussions of this reality for the treatment process.

Research involving the scientific production around the theme of social networks in health has identified no previous studies addressing the narrowing of the gap between the treatment process and the social reality of cancer patients, in terms of the interaction with their social networks.
The current empirical knowledge allows us to perceive that the risk factors associated with head and neck cancer are related to the limited access to health promotion and disease prevention, as well as to poor working conditions, poverty, low levels of education, weak social bonds constructed throughout life, and other social determinants. Therefore, it is fundamental to understand this reality, through scientific research, in order to determine how social networks and their possible interactions influence the cancer treatment process.

Based on those considerations, the objective of this study was to identify the role played by social networks of assistance and support for patients with head and neck cancer, in an attempt to comprehend the flow of communication and information, as well as the bases on which the appropriation and the elaboration of knowledge are constructed, with the understanding that such resources play a significant role in dealing with the changes and necessities that arise in the setting of disease.

METHOD

This study was conducted at the Head and Neck Clinic within Cancer Hospital I, the largest of the INCA hospital branches. The clinic has the distinction of being one of the largest surgical clinics within the INCA system.

The study employed a methodology involving interviews based on the oral life history of the interviewees, encompassing aspects of their life history and placing within them the context of becoming ill from cancer illness and of the role that their social networks play in this experience.

Oral history taking is a technique that creates a form of knowledge in that it brings to light individual and collective human experiences. In that respect, there is concern not only with the registration of knowledge and stories but also with the intention to disseminate and publicize them as experiences that can be shared.

The process of collecting oral life histories allows the use of open interviews, resulting from narratives, which encompass probable and improbable aspects of life, all of the accuracies and inaccuracies contained in the experience of the individuals and that, therefore, provide significant clues for the research.

Regarding the concept of narrative, Canesqui points out that the experience of chronic illness tends to be biographically informed through the narratives of the sick individuals and has some important aspects: altered self-image; the idea of a biographical break; and the question of stigma and collective identity. Within this process, the experience of sickness simultaneously encompasses individual and collective aspects that intertwine in a network of perceptions and meanings. The dialogue between those two dimensions and the knowledge generated in this process can be expressed by the narratives.

Therefore, the concepts of narrative and social networks were fundamental as theoretical references in our study. Those concepts designate the meaning of the experience as knowledge that is woven into movement in search of a new interaction with life in response to changes and challenges that may arise, such as those imposed by illness.

The fieldwork focused on interviews with three individuals (two women and one man) enrolled at the INCA Head and Neck Clinic and in different stages of treatment. The two women were 42 and 70 years of age, respectively, whereas the man was 49 years of age. One of the women was a resident of the city of Rio de Janeiro, the two other interviewees residing in other municipalities within the state of Rio de Janeiro. The interviewees were selected from among those included in social services flow at the clinic, without concern for gender distribution. In one patient, the treatment plan had yet to be defined, another patient was awaiting surgery, and the third patient was in the control phase. This choice was justified by the need to conduct in-depth interviews at different stages of treatment, with the objective of knowing the main issues in each one, especially about the coordination of social networks and their possible transformations throughout the treatment process. Because of the quantity of information and reflections, the interviews were extensive, being processes that require the interviewees to elaborate on different phases of their lives, seeking to contextualize the life experiences in relation to the experience of illness. In addition, the time constrained to the completion of the research also influenced the maintenance of this choice. Each patient was interviewed separately, in a closed room, the interview being initially recorded and later transcribed. Each interview lasted an average of 40 minutes.

The interview script was based on the construction of the following structured categories to meet the goals of the study and considered central to understanding the role played by the social networks of the patients: antecedents (personal and family milestones); illness and treatment (perceptions and discovery of the disease, as well as the trajectory and understanding of the disease proposed); existing and acquired personal ties (support
networks already in existence or established during treatment); institutional ties (reception and exchange of knowledge with the institutional environment); and participation and the right to health (perception of the role that common interests and the right to health play in the context of treatment).

The research project was submitted to the Research Ethics Committees of the INCA and of the Oswaldo Cruz Foundation-Institute (CAEE nos. 05748212.5.3001.5274 and 05748212.1.0000.5248, respectively); it was approved in January 2013. This study respected all of the terms that govern Brazilian National Health Council Resolution no. 196/96 on ethics in research involving human beings. All participants gave written informed consent.

RESULTS AND DISCUSSION

ANTECEDENTS

The interviewees reported issues that they considered central to the structure of their family relationships, referring to important phases of life, aspects of family coexistence, and the meaning of family.

In the narratives, we noted that, in the childhood phase, within the context of lives marked by poverty and alcoholism, the patients had become distanced from the family network (parents and siblings), having been raised by other relatives or other families with better financial conditions. This aspect emerges as a common practice among families who could not raise all of their children and therefore sought help from other families, relatives and acquaintances, until their living conditions improved and the estranged children could return to the bosom of their family of origin. Their narratives revealed considerable suffering in relation to the estrangement from parents and siblings. They reported feeling like they had not had a childhood, because in reality they had to work for those other families, with whom they had no affective bond, as compensation for having been taken in.

Despite the estrangement, their efforts were channeled into the possibility of a future rapprochement with their family of origin. In the specific case of our interviewees, there was no effective rupture of ties, because, even in the absence of the family network, the ties were maintained (some more fragile than others), and they emphasized the commitment derived from consanguinity and the obligation of the family to provide protection, an aspect that was underscored in their narratives.

This discourse underscores the sense of the family as a biological unit and its strength in that sense, while reiterating its significance as a social and cultural phenomenon; that is, in addition to being a biological phenomenon, the family is conditioned by the differences and social inequalities that influence its social relationships. The concept of family has undergone substantial transformation. However, within the poor population, the idea of family has taken the form of a network that extends to several homes, with the objective of guaranteeing the survival and organization of the world of its constituents.

In interviews, the construction of the significance of family as the main axis of support was underscored by the interviewees in the sense that the family is the institution through which support is provided. Even if the ties are fragile, this network is characterized as formal and legitimized by the social structure to generate care.

DISEASE AND TREATMENT

The phase of identification of the illness and definition of the diagnosis is a time marked by many doubts and anxiety. The arrival at the health care facility for treatment is often late, thus precluding the possibility of a cure. At the same time, concern with the disease is associated with the difficulty in administering the care and attention required by the treatment. Regarding the delay in starting treatment, interviewee A stated the following:

[... ] The disease began with a cold sore in my mouth, and I took medicine for that . . . I went to Andaraí Hospital and they gave me medicine . . . The doctors [outside of the INCA] said that it was no big deal . . . I didn’t care, because I believed them . . . and it kept growing . . . I believed the doctors . . . I was illiterate and they were doctors . . . and then it happened . . . the pain increased and I ran . . . as long as I was taking a pill and the pain was going away, it was okay . . . I didn’t think it would get to that point . . . The situation was getting worse and it moved from the tongue to the part above [jaw] and that was the last straw . . . a biopsy sample was taken and I was referred to the INCA.

In this case, the narratives also present themselves as a possible space of registration to denounce such situations experienced by the patients in their trajectory toward treatment.

Regarding the treatment, the patients also reported being afraid of the surgery because of the possibility that it would alter the appearance of their face. Interviewee A also stated the following:
. . . when I heard that they would have to ‘cut’ my neck and the doctor said that there was a 99% chance that they would have to put in the device for breathing (tracheostomy) . . . that’s when I started to cry.

Interviewee C stated the following:

I thank God that I’m going to do radiotherapy and I’m not going to get ‘cut’ any time soon . . . God willing, chemotherapy and radiotherapy will resolve the problem so they won’t have to cut my face. I think that’s it . . .

The significance of cancer, contained in the narratives, resides in the individual and collective aspects of the fear of the disease, the possibility that surgical interventions will alter the body image, and the interruption of life projects, previously in progress, that have to be put on hold due to the illness, which inevitably involves individuals closest to the patient and their support networks.

Another relevant aspect presented in the narratives was the way in which respondents attribute meaning to cancer in their lives. The emergence of cancer appeared as another fact that could be overcome, as can so many other difficult-to-manage facts, such as unemployment and violence. In this process, the patients sought means of adapting, maintaining balance, and preserving normality in the interaction with other the dimensions and demands of life, as a strategy to guarantee the support necessary to deal with the situation.

Establishing a relationship with work, as a way to overcome the difficulties and organization of life, appeared in the narrative of two interviewees. The following narrative illustrates that topic:

Life is a lot of work and a lot of trouble [. . .] having to take care of small children, going out to work, it was a very difficult life! There was no one to look after the children . . . no one to help! As for the disease . . . I didn’t let it get me down, I don’t care about it . . . living in a community, our lives are at risk every day, the disease is just another risk! Now, being stuck in a bed [. . .] working in the trailer and not even being able to open a bottle! That’s what kills me!

In this narrative, work occupies an important place as a way to avoid stress, in constant activity, with the mind in balance. Being active is better than being sick or giving in to the stress of daily risk.

According to Valla, the possibility of support provided by social networks and institutions can “function as a kind of buffer against the harmful effects of stressful and unexpected life events, such as hospitalization, separation from a spouse, and loss of employment.” Therefore, faced with so many adversities of life, individuals in the lower socioeconomic classes (re)signify illness as another event to be managed, among so many others.

**Existing and Acquired Personalities**

Interviewee A pointed out that, even though it was possible to resume contact with the family, there was no real rapprochement that could generate effective support at that point in life. In this case, the interviewee found support for coping with day-to-day issues, including illness, in other networks. Social networks that are not anchored in the family include those composed of neighbors, friends, church members, or other groups; such networks can provide social support as a form of health protection and to guarantee survival by individuals in the lower socioeconomic classes, who manage to maintain their existence through such support.

Although those networks of assistance or support are based on social exchanges and provide significant support, most place themselves in a position of not being obliged to guarantee social protection exclusively and can play a central role in the support required in the setting of illness. That type of support can play a role in the participation of individuals and other networks by providing new contacts and exchanges of knowledge, including the outreach by the health care clinic and its teams. This flow of information and communication that is constructed motivates various actors involved directly or indirectly with the support, fomenting the combination of material and symbolic resources aimed at guaranteeing survival. In the narratives collected here, this question has arisen, from the circulation of material help from work friends to the initial expenses related to treatment, the collective recognition of their own value in social groups gained from the experience of cancer, as well as the situation in which individuals from different social backgrounds interact, sensitized by the condition of illness of the other.

People from outside the community appear in my trailer, people from city hall, legislators who hug me and say ‘stay strong, my dear!’ are people who want to know me, who help me, and who are always present in my life.

This brings new interpretations of the experience of illness that can contribute to the strengthening and organization of these groups.
What has been identified in this process is that the family and the networks not anchored in the family both present the possibility of promoting care from the perspective of non-abandonment and cooperation among those involved. Interviewees B and C reaffirmed the centrality of the family as the main group providing support and care in the face of difficult situations, among them the moment of becoming ill.

For networks not anchored in the family, the insertion and circulation of the individual will also depend on the posture assumed by its members, through valuation mechanisms that take into consideration the other and the possibilities of exchange that have value for all involved. In cases of illness, the examples of perseverance and overcoming obstacles highlighted in the group can be converted into feelings of recognition and belonging, legitimizing the group itself. Those aspects are strongly present in the narrative of interviewee A:

After I separated . . . by the testimony I gave (in the church) . . . people faced with a problem sometimes come unraveled, do things they shouldn’t do, out of despair, but I turned to the church . . . and that was a surprise to people . . . they thought it was only temporary and that I would leave the church after my problem was resolved. I’ve been in the church for 5 years . . . And now everyone respects me and greets me with the peace of God!

In this narrative, religiosity and faith appear as forms of sustenance, as important resources to be mobilized, revealing the interactions between human networks and invisible (spiritual) networks in the sense of seeking greater protection, a sense of stability and strengthening the identity of the individual in order to deal with the disease. In that same vein, Valla\textsuperscript{22(325)} explained the following:

Among individuals in the lower socioeconomic classes . . . religious practices have provided a central path for those in search of a different mental state, capable of allowing glimpses of exit strategies, as well as for the creation of collective spaces in which knowledge and emotions can be exchanged, potentially indicating ways of overcoming the circular reasoning that the consideration of so many negative facts brings [. . . ] That has prompted individuals to find unified and creative forms of coping with the difficult situation in which they find themselves.

**Institutional Ties**

Outreach to patients entering the institutional network for treatment is an important tool and makes an effective contribution to the process of the insertion of patients into the hospital space, facilitating their acclimation and the retention of the process from the perspective of producing autonomy and participation. The host fosters sociability and information exchange by encouraging the construction of knowledge around experience.

For interviewee C, entering the institutional network is understood as the initial moment of appropriation of new information about the possibilities of treatment and cure, being confronted with doubts and concerns about the concrete conditions for its achievement:

But we didn’t know this (that there are resources that can facilitate the access to and continuity of treatment – that a person with cancer has social rights guaranteed by law), and we’ve spent a lot of money up to this point! Here, they told me that I can get a transit pass! Is that true? (Free Pass).

The communicative process and the access to this information during the treatment contribute in many cases to the reaffirmation of citizenship, because, throughout the process, knowledge is consolidated on the basis of the experience of the individual in interacting with the other actors, a factor that mobilizes individuals to participate in collective actions and to stand up for their rights. In some situations, those who have been excluded from their basic rights of citizenship throughout life, because of poverty and social isolation, end up finding, in the setting of illness, the possibility of exercising their right of participation, when faced with the experience of suffering individually but also collectively, and can even re-signify the meaning of their actions in the world, in which shared information exchanges and identification with others can drive creative actions and actions challenging the status quo.

Outreach within the institutional network is characterized by the interviewees as an important and decisive factor to broaden access to their fundamental rights and to information that can enable the continuity of the treatment\textsuperscript{21}.

We have found that health care organizations are often structured on the basis of a technical hierarchy that tends not to recognize the importance of care and the ethical dimension of care as fundamental to the development of health care work processes. According to Caillé\textsuperscript{22(358)} “. . . in every organization, the overall effectiveness appears to depend on the capacity of its members to give and to ‘deliver’. Nothing can work if they do not continually help each other by providing technical advice, affective support, and information of all kinds.”
PARTICIPATION AND THE RIGHT TO HEALTH

The narratives show that the experience of illness is expressed individually as knowledge that can be shared. In the narrative of interviewee A, we can see the strength derived from the sense constructed around the sharing of experiences:

Everyone trades information about the disease . . . and they say . . . we’ll get out of this! I made some good friendships here (with relatives and patients). I talk to them on the phone, and I ask about the patients . . . if they’re doing okay . . . They’re people who are hospitalized and their companions.

Interviewee B stated, “This serves as a life lesson, showing that I can help other people as well.” In this case, knowledge gained from experience is considered to have value, a resource that can be shared with individuals and institutions, promoting the continuity of movement within networks.

CONCLUSION

Our findings reveal the centrality of the family network as the main reference in the narratives of the interviewees regarding their upbringing and how much they refer to family life to explain their ways of coping with the difficulties that arise throughout life. Through the family, we grasp the symbolic order of the world around us, learning the basic rules of coexistence from family discourse. In that regard, some individuals develop their own opinions, often in opposition to those of the family (considering their respective realities and inherent difficulties) at the same time that they are adopting their own perceptions, signaling their own choices and knowledge that are based on this trajectory and that influence the construction of their own networks from those reference points. The social networks of patients are thought to play a fundamental role in guaranteeing care and social protection and have the potential for coordinating information that can be broadened so that the institutional network operates from the perspective of outreach. Such care should encompass a willingness to understand the unique characteristics of these subjects, their life histories, identifying the existing social ties and bonds, as well as those that can be re-established or constructed through the need for care and assistance.

The information generated in our study can lay the groundwork for new research projects and interventions. The communication and information flows that play a role in patient support networks can and should be better understood within the institutional network. We also observed the difficulty that health care professionals, who generally come from the middle class, have in understanding the speech and behavior of individuals in the lower socioeconomic classes.

This reflection is fundamental, because health care professionals will thus ensure that the knowledge constructed by patients and their social networks will open opportunities for communication within and outside of the hospital setting. Such communication can expand the dialogue with public policies aimed at constructing rights that are aligned with the real health care needs of these groups.

The data obtained in the present study not only have the potential of expanding the technical knowledge of health care teams but also could help those teams to gain entry into and transit through different areas of knowledge that can favor creative interventions, considering the social diversity in Brazil, together with the general and singular aspects of each particular situation. This circulation of knowledge is vital to the health care process. It improves the flow of information, communication, participation, and care.

AUTHOR CONTRIBUTIONS

Both authors contributed equally to all stages of the manuscript preparation process.

DECLARATION OF CONFLICTS OF INTEREST

Nothing to Declare.

REFERENCES


