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Abstract

In this article we wish to establish the relationship between discourse, as a special form of communicative action, and the humanization in health care organizations. This whole discussion has strong references in Jürgen Habermas's theories of communicative action and discourse. It starts with the criticism of the bureaucratization of health organizations done by medical rationalization, which creates a profound asymmetry between health professionals and patients. This inequality implies loss of the human dimension in health care. It focuses on the issue of power and the possibility of rational reconstruction of relations from a discourse ethics. It discusses the issue of health policies in the public sphere. We wonder how the average citizen can effectively participate in the discussion of these policies, if they do not have the expertise of physicians. The same asymmetry between health professionals and patients is reproduced in the public sphere, creating a political issue in democratic societies. A rational reconstruction of a health policy requires a form of deliberative decision. The loss of the human dimension in health care and the health policy decision-making problem seem to find space in the complexity of health care. The discussion about quality involves considering the indicators produced by specialized medical knowledge, however, they require the mediation of interests of healthcare professionals and patients. This diversity of perspectives requires procedures that provide understanding between the parties for the construction of rational agreements for common action. These procedures progress between ethics and politics. We believe that these procedures should be based on discourse.

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Key words: Discourse. Communicative action. Humanization. Health care organizations. Habermas.

LINGUAGEM, DISCURSO E HUMANISMO NAS ORGANIZAÇÕES DE SAÚDE

Resumo

Neste artigo pretende-se estabelecer relações entre o discurso, como uma forma especial de ação comunicativa, e a humanização nas organizações de cuidados com a saúde. A argumentação referencia-se fortemente nas teorias da ação da ação comunicativa e do discurso de Jürgen Habermas. Inicia-se com uma abordagem crítica da burocratização das organizações de saúde pela racionalização médica, criando uma profunda assimetria entre profissionais e pacientes. Esta desigualdade implica na perda da dimensão humana no cuidado com a saúde. Focaliza-se a questão do poder e na possibilidade de uma reconstrução racional das relações a partir da ética do discurso. Discute a questão das políticas de saúde na esfera pública. Indaga-se como o cidadão médio pode efetivamente participar na discussão destas políticas uma vez que não possui a *expertise* dos médicos. A mesma assimetria entre profissionais de saúde e pacientes se reproduz na esfera pública, constituindo uma questão política em sociedades democráticas. Uma reconstrução da política de saúde requer uma forma deliberativa de decisão. A perda da dimensão humana no cuidado com a saúde e o problema das decisões em política de saúde parecem encontrar espaço na complexidade dos cuidados com a saúde. As discussões sobre qualidade devem ter em conta os indicadores produzidos pelo conhecimento médico especializado, entretanto, requerem mediações entre os interesses dos profissionais de saúde e dos pacientes. A diversidade de perspectivas requer procedimentos que provenham entendimento entre as partes para construção racional de argumentos para ação em comum. Estes procedimentos avançam entre ética e política. Acredita-se que estes procedimentos podem ser baseados no discurso.



Palavras-chave: Discurso. Ação comunicativa. Humanização. Organizações de saúde. Habermas.

1 Introduction

This paper describes my learning process as a professional in health organizations, initially as a physician and later as an administrator. We use such learning to refer to the theories of communicative action and discourse of Jurgen Habermas (1987,1990), in particular their use in the construction of practical arrangements for solving problems related to health policies in democratic and pluralistic societies. Finally, we would like to show the relationship between discourse and humanization in health organizations.

This learning process started with an uneasiness created by the feeling of powerlessness against the epidemics of HIV/AIDS in the mid 80s. This restlessness implies a better understanding of the human and social dimensions of medical work. Understanding medicine as a social practice results in understanding the limitations of individual clinical practice and requires critical social approaches for health and disease problems in society, especially in unequal societies. These approaches are not restricted to epistemology, and achieve social action, whether professional or not.

In the late 80s, I discovered Jurgen Habermas, when he visited Brazil to launch the translation of his book "Moral Consciousness and Communicative Action" (1990). At that time, I had the opportunity to take a course related to his work, with his Portuguese language translator, Flavio Beno Siebeneichler. I have been imbued by this reading with a materialistic approach that breaks with the philosophy of consciousness and showed me all the possibilities of philosophy of language in its pragmatic approach. It was a profound turning point in my understanding of reality, giving rise to the material reality of interactions mediated by language.

In the 1990s, I dedicated myself primarily to professional work as an administrator of health organizations, working mainly in public health services. At that time, I worked on outlining an understanding of communicative action focusing on systems as part of the living world. In this sense, speech is a possibility within healthcare organizations. The option for speech is an ethical decision, by the administrator, although its implications are stronger in the morality of social groups.

It is worth mentioning that during all this time I worked in health organizations and studied. In the 1990s, I received both master and doctoral degrees in Business Administration and a master degree in Information Science. This simultaneity led me to a better relationship with theory and practice. I always try to do better theorizing, and always submit my action to theoretical criticism. This relationship clarifies things that I study, while it induces a sharply criticized action in my professional work.

Habermas (1987) teaches about the co-origin between subjectivity and inter-subjectivity. I cannot learn without interacting with others, and I cannot do things better without learning. Understanding someone else's place in the formation of inter-subjectivity, and the place of inter-subjectivity in the formation of subjectivity, has profound consequences to the management of organizations. The administrator who understands the place of others, leaves the observer's perspective and looks for the perspective of participants in organizations. This understanding requires a clear ethical choice by discussion, by the willingness to interact and argue, by the definition of practical arrangements in the best arguments.

Finally, we highlight the importance for a critique of functionalism in organizations, in order to understand how they process reducing their internal complexity, in relation to its surroundings. Luhmann (1996) highlights how the system is basically a difference to the environment, built from the choices of ends and means for its realization and reproduction. This complexity reduction is also a reduction of interactions mediated by language, which are replaced by structured information flows.

Therefore, the choice of discussing problems in organizations with their participants, and even with their users, is going against the process of reducing the complexity that originated them. It should be noted that this reduction is not carried out for moral reasons, but for pragmatic results. The administrator should always check on how the organization supports entropy, so that all may benefit by expanding the discourse of rationality and by rational reconstruction of practical arrangements.

2 Medicine, bureaucracy and human dimension of health care

While discussing about the birth of social medicine, Michel Foucault (1992) argues that medicine is always social, and it is only in the relationship between the medical doctor and the patient that it holds some individual characteristics. He states that medicine is part of a political strategy to control the bodies and the governments of

populations. Thus, medicine is also an exercise of a power disseminated by society, mediating the relationship of people with their own bodies and the bodies of others.

Working as a doctor specialized in infectious diseases, in the city of São Paulo in the mid-80s, while the HIV/AIDS epidemics emerged, it was not difficult to understand this dimension of the exercise of power in medicine. Firstly, the very nature of infectious diseases, which are transmitted from one person to another within society. Secondly, for all scientific, moral and political conflicts around epidemiological surveillance of these diseases. AIDS has brought about questions on blood and sex, whereby HIV flowed socially.

The height of dehumanization of health organizations in relation to the AIDS epidemic was the denial of care for people with that disease. Despite the high mortality of the disease, which required hospital care and intensive care units, there were many cases of organizations and health professionals that refused to serve the needy. This refusal is intertwined with the denial of the very *raison d'être* of these organizations. Some health officials even suggested the social exclusion of people with AIDS, reproducing the classic medical model of leprosy control.

The AIDS epidemic showed me something that remained opaque throughout medical training: the strong content of bureaucratic rationalization of existing life in medical professional action. Each small action of a medical doctor has its mediation content. Being born, eating, crying, growing, walking, interacting, learning: everything is mediated by thousands of scientific, bureaucratic models, interfering deeply in the human dimension of existence. Human dimension seems to be emptied and replaced by a bureaucratic reason. Such issue pushed me into a social science approach to medicine (LIMA, 2005).

One of the main consequences of this critique of bureaucratic rationalization in medical practice is the evidence of the need to go beyond a discussion of the major social conflicts. The critique of power in medicine involves the development of theories and methods that take into account the distribution of actions, reactions and conflicts in society. The victims of the epidemic disease defend its leading role in the struggle for life and health as a positive representation of welfare. People come together to protect privacy, confidentiality, right to information, anticipation of social benefits, access to procedures for lymphocyte count and viral load measurement, and access to anti-retroviral therapy (LIMA, 2005).

AIDS placed sex in the center of the debates of society. Something so deeply intimate and personal became part of the agenda of public reason. Early AIDS is grossly used as an instrument against freedom of sexual orientation, as if HIV transmission were associated with orientation options and not having multiple partners. Later, AIDS became the center of a gigantic effort of ordering sexual action by scientific models. The popularization of the use of condoms is just about to change the way society relates to their sexual dynamic.

The question that made me pursue a social science approach to medicine was: considering that medical technology is effective for solving some problems of individuals and society, it is necessary not only to organize the victims of the epidemics of HIV/AIDS to defend their interests, but also to rebuild medical rationale in terms of interests that are broader than those established within the professional corporation itself. This reconstruction of medical rationality implies expanding the universe of actors who discuss their assumptions, their methods and their applications (LIMA, 2005).

The reconstruction of medical rationale, guiding actions in health care organizations, has become necessary. First, victims of HIV/AIDS built their own organizations, based on their personal and collective demands. These self-help organizations developed their own rationality which clashes with the established traditional medical rationale. The medical fraternity broke up, and soon there were actors willing to talk to patients in a friendly manner. This conversation flowed toward a public discussion about the use of medical rationality, which diminishes its dark aspects and includes patients' interests.

It should be noted that communication and information sharing within society were extremely important in this dynamic processes of operational and organizational change. Medicine and healthcare organizations changed. In a sense, one can say that the epidemics of HIV/AIDS produced a third epidemic: the epidemic of information. The first relevant information produced by the outbreak of the disease was exactly the discrimination of those involved. We cannot minimize the problem of social exclusion for inclusion in this group of patients.

The ethical question of ownership of medical information emerges with great force after the epidemics of HIV/AIDS. Information about the condition of a person with HIV or AIDS becomes relevant because the high lethality of the disease in its early years made it a burden, so social groups, enterprises and governments wish to avoid it.

Knowing if someone is sick or a potential carrier of the virus is an instrument to prevent losses. The control of this information becomes a powerful tool of social control, for inclusion or exclusion (LIMA, 2005).

Medicine as an institution produces a line based on fear of death. This fear is used to induce people to behave "correctly". If you act properly, you are protected from HIV and AIDS. Gradually, this speech will become more sophisticated and it will soon acquire the face of a debate to discipline people's relationships among themselves, with others, and with things. Selective dissemination of information is part of the medical strategy of bio-political control. The information seems to be exactly what the critics of the cultural industry said to reduce the possibilities of representation and expression.

The victims of HIV/AIDS produce their own speeches. Initially it is a defensive speech, which seeks to highlight its role as victims and their concern about causing this serious social issue. Gradually, this speech will form an agenda of social and human rights and it will soon set up a body of moral and political interests. It is a discourse strongly anchored in defense of human dignity in its strict sense. Insofar as the epidemic progresses and differentiates, these speeches will include new demands and expanding agreements in advocacy.

The proliferation of speeches in the public sphere implies the definition of methods for the construction of practical arrangements. The traditional medical rationalization seems not to respond to the human dimension of the epidemics of HIV/AIDS. However, this rationality is not simply replaced by another: we must amplify their humanistic bases. This conflict can also be understood as a contemporary version of what is called struggle for cultural hegemony.

My perception of the social process of the epidemics presents two major problems: first, the epistemological question of understanding this dynamic; and second, the practical question of how to equate the demands created in ethics and politics. In both cases it seems that the communicative action and discourse theories of Habermas may be useful to think rationally and seek solutions. This was my starting point in the study of philosophy of language, especially the studies of Habermas's pragmatic approach (HABERMAS, 1990).

In epistemological terms, the solution I found was to think about this discussion on medical rationale of the modes of action in the epidemics of HIV/AIDS as a language game. The accommodation of the interests in a humanistic rationality reconstructed by the actors can be thought of as a grammar of the way of life in

pluralistic and democratic societies. The agreements do not involve practice built in an effort to change people's consciousness, but simply to offer viewpoints and arguments that support them.

3 Health policies in the public sphere

In the early 90s, I was working in the city of Joinville, in southern Brazil. This urban center of half a million inhabitants was founded by German descendants and more than a third of its population was working in the metallurgical, mechanical and plastic material industries. At that time, I was making the professional transition from clinical medicine to administering health organizations. My concern about the interaction of health organizations with society became increasingly stronger (LIMA, 2007).

Working with outpatient medicine in a public health center in the outskirts of the city, my disability became clear, as I was making use of individual medical clinic skills to solve the major health problems of that small community. Such anxiety was shared with other colleagues working in other public health centers. The social processes of health and disease were much stronger than our ability to intervene and solve problems in health centers. It was poor medicine for poor people.

Interestingly, this city possessed one of the very rare medical residencies in community general medicine in Brazil, trying to prepare students with the same skills of general clinical practice of NHS in England. This residence has functioned since the mid-80s, and has faced great difficulties to survive. I was fortunate to be invited to work with the young medical residents, teaching courses in epidemiology and health services administration. It was an extremely important learning process about the possibility of overcoming the fragmentation of medical work at the level of primary health care.

Aggregating the experiences of outpatient medicine in a public health center in the periphery with teaching residency in community general medicine, I began an extremely important dual dialogue. On the one hand, I was talking to other health professionals who were dissatisfied with the results of their work every day. On the other hand, I was meeting with organized sectors of the local society, especially in the suburbs. These meetings involve associations in poor neighborhoods and groups of pastoral health of the Catholic Church.

These conversations showed to me the dynamics of exclusion of the poor and peripheral populations of the discussion on health policies in the city. It was extremely painful to realize how 400 doctors working in the city were mainly focused on the defense of their corporate interests, formally in the form of cooperative work. Most of the workers in local industries had private plans for health assistance. Thus, the public health system did not have much relevance to the formal economy of the city and remained working at a precarious level.

In this context we started working on two levels of action to change health policies in the city of Joinville. On one level, articulating health professionals to carry out experimental work of primary health care in one of the poorest neighborhoods of the city, in an occupied area of mangroves. On another level, participating in a circuit of meetings and discussions with neighborhood associations and pastoral groups on the need to change health policies as part of a strategy to defend human rights.

The articulation of health professionals resulted in an experimental project called "Health Factory", which aimed at developing appropriate technologies for primary health care. Its main line of action was the discussion between different health professionals, and those with society, to define practical arrangements for common action. This project involved an agreement between two institutions of higher education in the city. We never came to a formal agreement with the municipal government. We achieved important results in concrete terms locally and, above all, created evidences to show that the public health centers could operate differently.

On another level, we participated actively in the rich social dynamics of building a most articulated joint group in defense of the deployment of the National Health System in the city. This health system was an innovation in social security in Brazil determined by the Constitution of 1988, which was only regulated by law two years later. The joint group started by the local Center for Defense of Human Rights and involved other groups of pastoral health of the Catholic Church and the federation of associations of residents of Joinville. Later this articulation gained membership of trade unions and associations of health professionals.

The regulation of the Health System in law envisages the creation of permanent collegiate councils, with the participation of governments, service providers, health professionals and 50% of representatives of different user segments. The institutionalization of those informal conversations between health professionals, community leaders and union leaders in the form of a city health council becomes the

major political confrontation in the city. The intervention of the public ministry to defend the diffuse collective interests was important for the success in the creation of this health council (LIMA, 2007).

This experience showed that society was not expecting a change in the public health system from its internal actors. The regulatory agencies of power and money make the system a player of interests, unable to meet the health care needs of the majority in an unequal society. Only outer organized action provided a change toward the health system. However, there is always a need for mutation in the internal systems providing consequence to the efforts of society. This internalization of demands requires direct participation in government and administration of health services.

We can understand such network of interests as an effort around a point of view with good arguments. There was not and there could not be a desire to break the assumptions of any of the participants of this broad alliance. The goal was not to educate each other according to the assumptions of one, but pragmatically interacting in defense of common interests. The dynamic expansion of the community involved in the discussion also reflects the expansion of power of that same community (LIMA, 2007).

In this case it seems to have been a change in the morality of the city around the human right to health, which implies the need for a change in the public health system. The discussion around this morality resulted in the confrontation between two policies. On the one hand, an elitist policy, exclusionary, led by great entrepreneurs in association with a local conservative government. On the other, a democratic policy, inclusive, that emerges in poor neighborhoods, but with the strength to win allies among the middle classes and health professionals.

In mid-1992 the city council approved the creation of the city's Health Council, but it only took office at the end of the year. Around the same time a new government for the city was elected, which, despite being politically liberal, expanded its program to implement the National Health System. This facilitated the institutionalization of decisions of the city's Health Council, with greater investment in primary health care and a real strengthening of the community general medicine model.

The legitimacy provided by the city's Health Council allowed the Department of Health managers to make major changes in the management of their resources and their organizations: its annual budget corresponding to 1/3 of the general budget of the municipality, and the Department, had 3 own hospitals and 50 health centers of different sizes scattered throughout the city. The city became a pioneer in the full local

management of the National Health System in Brazil, with all funds deposited and managed in a city Health Fund.

Another important aspect in this process of change in the public health system in the city of Joinville is that this was one of the first twenty Brazilian cities to implement the program of family health. This program aimed at strengthening primary health care with multidisciplinary health teams and the inclusion of community agents. It contains elements of community general medicine and that technological adaptation required in the "Health Factory". One of the characteristic features of the family health program is the discussion with society about the local solution of practical problems.

In more abstract terms, this experience in Joinville showed that the perception of social relations as interactions mediated by language has methodological advantages. Thus, this experience shows a conflict that can serve, at the same time, as a discussion to build understanding and make practical arrangements. Breaking the monopoly of the medical fraternity speech was very important for effective health policy discussion in the city. The incorporation of the speeches of other health professionals and the speech of the common man expanded the community of communication involved and required better arguments (LIMA, 2007).

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4 The quality of care in health organizations

In the mid-90s, I went to work in the implementation of the AIDS National Program in the Ministry of Health of Brazil, facilitated by the loan of 160 million dollars from the World Bank. At that time this was the largest loan of the Human Resources Division of the Bank worldwide. The Brazilian federal government was strongly committed to the World Bank agenda "Investing in Health", published in 1993. The implementation of the AIDS program was part of that commitment (LIMA, 2005).

I worked in the planning division of the AIDS national program, reviewing the first operational plans from 27 states and 50 priority municipalities. Our focus in this work was the integration of the program in permanent actions of the National Health System, especially its inclusion among the activities of the family health program. This work was successful, and helped the Brazilian program to become a world reference in the control of the epidemics of HIV/AIDS.

One of the most embarrassing situations in my life happened when I was working in the AIDS national program of the Ministry of Health of Brazil. Some state

and local coordinators of the program were requesting authorization to use funds transferred for the purchase of antiretroviral drugs. It turns out that at this time the economic profitability of these drugs was low, and the World Bank did not recommend its acquisition by poor and middle income countries. The Brazilian government should follow this recommendation. Our division declined to reproduce this recommendation, for it was considered contrary to human rights.

Working in the national AIDS program and aware of these problems, I decided to make my work my doctoral research topic in management. So I worked on the issue of the quality of health care organizations of persons with HIV/AIDS as a thesis. My assumption was that the focus of interest in quality between health professionals and their patients is not the same. I understand that health professionals are more interested in technical aspects and patients in interactional aspects and amenities. I made my qualification in mid-1995. And, fortunately, I was wrong (LIMA, 2005).

At the beginning of 1996, some medical researchers presented their first results of combined antiretroviral triple therapy. These results changed the entire strategy for the health care of people with HIV/AIDS. This strategy was based on palliative care and psychosocial support and now is focused on tests for lymphocyte count and viral load, and consequent access to medication. The National Congress of Brazil approved a law guaranteeing free access to antiretroviral drugs. All this under the watchful eye of mobilized people with HIV/AIDS and their self-help groups.

Around that same time I worked with the group that made the first testing of the hospital accreditation method in Brazil, which is a quality certification from the control items. This testing was sponsored by the Pan American Health Organization - PAHO. It evaluated 23 public hospitals in the metropolitan region of São Paulo. Only one of them had the minimum quality recommended by PAHO. After this group work, I went to manage the worst hospital in terms of quality, among those which were tested.

The “worst” hospital was the largest public hospital in the East Zone of São Paulo’s metropolitan region, with 500 beds, in poor physical condition and with serious management problems. The axis of the management was discussing with its two thousand workers and society representatives about the problems detected in the hospital accreditation process and seeking practical arrangements regarding the priorities for action and the means to be used to improve quality.

Gradually, the solidarity between health professionals and users of this public hospital was being transformed into results. We increased the total minimum

requirements of hospital quality identified in a year from 20% to 80%. There was priority investment in the improvement of all working processes, due to the fact that in order to improve the structure of the hospital, outside budget decisions were involved. The flattening of the problems in discussions enabled the involvement of all workers in solving the problem, reducing the time to get it resolved.

The most important lesson I had in the general direction of this public hospital was realizing that list items can act as control subjects for the discussion on quality improvement in health care organizations. Indicators can be worked like thematic areas for discussion. This was the method used when UNAIDS, Joint United Nations Program on HIV/AIDS, carried out a review of the deployment of triple antiretroviral therapy in Brazil in 1997. Discussing is not only the best way to make the diagnosis, but also the best way to find solutions and make arrangements for its implementation (LIMA, 2005).

In evaluating the deployment of triple antiretroviral therapy in Brazil, the seven pillars of quality defined by Avedis Donabedian (1980) were used: efficacy, efficiency, effectiveness, acceptability, legitimacy, profitability and equity. Around these pillars we tried to discuss with the protagonists of the social process: coordination of the AIDS national program, state and local coordinators, health professionals and people with HIV/AIDS. This discussion allowed gaining possession of different viewpoints and building a narrative that enables the understanding of what happened (LIMA, 2005).

This rich learning process of evaluating organizations contributed to a better understanding of what instrumental rationalization is. The understanding that discourse reconstructs organizations differs from the simple choice of effective ways to do things. The discursive reconstruction implies the inclusion of the perspective of the agents, and the definition of practical arrangements around the best argument within organizations.

Niklas Luhmann (1996) teaches us that organizations are built from the reduction of complexity in relation to the environment. Thus, an organization is always choosing means for performing an aim among many possibilities. This reduction of complexity in organizations happens particularly by reducing the communication within, with structuring information flows around the choices made. The rationalization in organizations is always a choice, geared for one purpose, noting the imperatives of power and money (CARVALHO; LIMA, 2009; LIMA; LIMA; KEMPNER, 2010).

A rational reconstruction through discourse implies that people in organizations can interact and communicate more than what was defined in reducing the complexity that originated them. This complexity reduction began with the choice of means and

went with the effective coordination of resources for their implementation. Doing more, doing better or doing differently also means increasing the complexity within organizations, increasing the number of interactions and communication among people. Arguing is increasing the complexity of an organization (CARVALHO; LIMA, 2009; LIMA; LIMA; KEMPNER, 2010).

5 Final Thoughts

Habermas (1985) in "Technique and science as ideology" discusses how the young Hegel speaks of the ontology of being, to discuss the relevance of relationship between work and interaction. Hegel remarked that the constitution of the human being passes through three intertwining dialectics: the use of language, the relationship with others in family and community life, and the use of instruments to work in social production. Each of these three dialectics has its role in the formation of the social being, and the use of language precedes the interactions and the use of instruments. Our humanity is related to these dynamics.

Habermas (1985) mentions Marx followed Hegel's intuition when building his theory about the working society, and the place of work in the formation of the human being in society. Marx acknowledges that on more than one occasion in his work. However, there are many and obvious signs of exhaustion of such working society. It should discuss where and how human dimension of existence can be redeemed.

This question seems particularly relevant when the traditional means of social regulation, money and power, cannot be equated to a more socially just life and to human dignity. The society that built their systems, institutions, organizations and groups from interactions mediated by language, seems to have some difficulty in finding the conditions for a good and less threatened life.

The theory of communicative action and discourse of Habermas (1987, 1990) can be valuable in this context. Thinking of the formation of the human being from interactions mediated by language results could be thinking of the redemption of the human dimension of existence, inside and outside of organizations, within this same dynamic. So discussing in organizations implies increasing its complexity in relation to the environment. This increased complexity is the space where it produces and reproduces the humanity of those who work, expressed in their speech, their arguments and their practical arrangements.

One of the issues that may be specified as an objection to this understanding of the discourse theory is whether this kind of communicative action can be performed within the systems. Firstly, it should be noted that the systems are part of the living world. Secondly, Habermas (1990) differentiates the strength of the communicative act depending on contexts. One can say that speech has limitations within organizations, but they are not possible.

What this learning process demonstrates is an opportunity, although it does not intend to submit a list of operational procedures for the communicative action within organizations. A list like this may not be very useful, because in discourse, the other can always say no. What seems important is to know which procedures contribute to more interaction, cooperation and discourse within organizations, and which do not. Such distinction allows us to evaluate the relationship between administration procedures and their contribution to maintaining or increasing the organization complexity.

If the administrator is interested in promoting technological innovation within organizations, for example, he must, first of all, understand that structured information flows contribute to the execution of repetitive cycles of production and imply reduced complexity. So when one wishes to innovate there is not enough information for efficient cycles. It is necessary to increase the possibilities of interaction mediated by language, including this special mode that is discourse. Working toward increasing these possibilities of interaction is an ethical option (CARVALHO; LIMA, 2009; LIMA; LIMA; KEMPNER, 2010).

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