

Nurses' autonomy in Primary Care: from collaborative practices to advanced practice

Autonomia da enfermeira na Atenção Primária: das práticas colaborativas à prática avançada
Autonomía de la enfermera en atención primaria: de las prácticas colaborativas a la práctica avanzada

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Keywords

Professional autonomy; Professional practice; Family health strategy; Primary health care; Nurses

Descritores

Autonomia profissional; Prática profissional; Estratégia saúde da família; Atenção primária à saúde; Enfermeira e enfermeiros

Descriptors

Autonomía Profesional; Prática profesional; Estrategia de salud familiar; Atención primaria de salud; Enfermeros

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Abstract

Objective: To assess how Primary Health Care (PHC) nurses identify their professional autonomy in daily work and how this autonomy is perceived by other professionals of the multiprofessional team.

Methods: Exploratory, descriptive study in which the theoretical-methodological reference was dialectical hermeneutics anchored in the premises of the Sociology of Professions. Data were collected through semi-structured interviews with 27 nurses from the Family Health Strategy (FHS) and ten professionals from the Family Health Support Center (Portuguese acronym: NASF) in the city of São Paulo. The resulting empirical material underwent discourse analysis.

Results: The findings revealed the professional autonomy of PHC nurses is perceived in the following categories: the possible autonomy, the autonomy dictated by protocols and the subordination to medical work.

Conclusion: The study showed an expansion of the clinical scope of PHC nurses, and to a certain extent, it was closer to medical work. On the other hand, nurses are challenged to overcome such an approximation in the sense of interprofessional collaborative practice and advanced practice nursing.

Resumo

Objetivo: Verificar como enfermeiras da Atenção Primária à Saúde (APS) identificam sua autonomia profissional no cotidiano do trabalho e como essa autonomia é percebida por outros profissionais da equipe multiprofissional.

Métodos: Pesquisa exploratória, descritiva, cujo referencial teórico-metodológico foi a hermenêutica dialética, ancorada nas premissas da Sociologia das Profissões. Os dados foram coletados por meio de entrevistas semiestruturadas com 27 enfermeiras da Estratégia Saúde da Família (ESF) e 10 profissionais do Núcleo de Apoio à Saúde da Família (NASF), do município de São Paulo. O material empírico resultante foi submetido à análise de discurso.

Resultados: Os achados revelaram que a autonomia profissional da enfermeira da APS é percebida através das seguintes categorias: a autonomia possível, a autonomia ditada pelos protocolos e a subordinação ao trabalho médico.

Conclusão: O estudo revelou que houve a ampliação do escopo clínico da enfermeira da APS, a aproximando, em certa medida do trabalho médico, e por outro a desafiando a superar tal aproximação no sentido da prática colaborativa interprofissional e da prática avançada de enfermagem.

Resumen

Objetivo: Verificar de qué modo las enfermeras de Atención Primaria de Salud (APS) identifican su autonomía profesional en su trabajo cotidiano, y cómo es percibida dicha autonomía por otros profesionales del equipo multiprofesional.

Métodos: Investigación exploratoria, descriptiva, cuyo referencial teórico-metodológico fue la hermenéutica dialéctica, fundamentada en las premisas de la Sociología de las Profesiones. Datos recolectados mediante entrevistas semiestructuradas con 27 enfermeras de Estrategia Salud de la Familia (ESF) y 10 profesionales del Núcleo de Apoyo a la Salud de la Familia (NASF), del municipio de São Paulo. Material empírico resultante sometido a análisis de discurso.

Resultados: Los hallazgos revelaron que la autonomía profesional de la enfermera de APS es percibida según las categorías: autonomía posible, autonomía dictada por protocolos, y subordinación al trabajo médico.

Conclusión: El estudio reveló una ampliación del alcance clínico de la enfermera de APS, acercándola en cierta medida al trabajo médico y, por otra parte, desafiándola a superar dicha aproximación en pos de una práctica colaborativa interprofesional y de la práctica avanzada de enfermería.

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Introduction

In the last decades, nurses' professional identity has assumed new shapes in Brazil, especially since implementation of the Unified Health System (Portuguese acronym: SUS) in the late 1980s and the Family Health Strategy (FHS), in the following decade. Clinical actions of direct care to users were added to the administrative or managerial activities prevailing until then, which expanded the scope of nurses' practice in Primary Health Care (PHC) and produced impacts on their professional practice.⁽¹⁻⁴⁾

This is partly due to the rapid demographic and epidemiological changes currently taking place in the country that bring a triple disease burden, in which uncontrolled infectious and deficiency diseases coexist with increasing external causes and the hegemonic presence of chronic diseases.^(3,5) In view of the complexity of the population's health needs, PHC must implement effective forms of action by seeking the integration of knowledge and promoting collaborative interprofessional action in order to impact positively on health care.^(6,7)

The need to expand the population's access to qualified health professionals for working in PHC with quality, equity and completeness also offers possibilities for increasing competencies of the multiprofessional team, especially nurses' autonomy.^(8,9)

Autonomy is a component of professional practice and a prerequisite for higher professional satisfaction. It implies the freedom to make independent evidence-based clinical decisions, both in the specific field of the profession and in the context of multiprofessional work of health teams. It also involves a technical dimension through acquisition of scientific knowledge and its applicability in the care practice, and another policy related to power relations and the interests of professional groups.^(10,11)

However, the autonomy of PHC nurses in professional practice is exercised in spaces regulated by several legal provisions, among them the National Primary Care Policy,⁽¹²⁾ and assistance protocols of the Ministry of Health, such as guidelines from Primary Care Booklets. In addition, some municipalities have various legislations specific to the profession, such as Law 7498/86, which regulates nurs-

ing professional practice, and Resolution COFEN - 0564/2017, which establishes the Code of Ethics for Nursing Professionals, among others.^(13,14)

Because of the currently predominant biomedical assistance model, there is a gap between the determined work and the actual work performed by nurses in the daily routine that interferes with the health work process organization and, consequently, tends to restrict nurses' technical autonomy.⁽¹⁵⁾

The purpose of this study was to answer the following question: how do PHC nurses identify their professional autonomy in daily work and how is this autonomy perceived by other professionals in the multiprofessional team?

Methods

Qualitative, descriptive and exploratory study. Data were collected through semi-structured interviews with 27 nurses from the FHS and 10 professionals from the Family Health Support Center (Portuguese acronym: NASF) who worked in six Basic Health Units (Portuguese acronym: UBS) of a Technical Supervision of Health in the city of São Paulo. The inclusion criterion was a minimum of three years of practice in order to characterize an expressive work experience.

Twenty-seven out of the 31 nurses who worked in Basic Health Units of the FHS in the region participated in the study, since one was on medical leave and three did not have the minimum time of practice stipulated. The 10 NASF professionals were of the following professional categories: physiotherapist, nutritionist, psychologist, occupational therapist, speech therapist, physical educator, general practitioner, pediatrician, gynecologist and psychiatrist.

Interviews were conducted in the workplace according to interviewees' availability in a single and individual meeting with average duration of 35 minutes between December 2013 and February 2014. Interviews were tape recorded, transcribed, and subsequently underwent discourse analysis as advocated by Fiorin and adapted by Car and Bertolozzi.^(16,17) Transcriptions were read in full,

the most relevant excerpts were selected and re-composed in thematic sentences, which, in turn, were organized according to the degree of similarity, forming groups of themes. Then, the themes were reorganized into empirical categories and interpreted in the light of the theoretical-methodological reference of dialectical hermeneutics.⁽¹⁸⁾

The Ethical precepts related to research with human beings were followed, as established by Resolution No. 466 of December 12, 2012 of the National Health Council. The research project was evaluated and approved by the Research Ethics Committees of the Nursing School of the Universidade de São Paulo and the Municipal Health Department of São Paulo under protocol numbers 489.982 of 10/12/2013 and 456.720 of 07/11/2013, respectively.

Results

Regarding sociodemographic profile, 85% of nurses were female, and average age was 35 years. Of these, 25.9% had previously worked as nursing technicians, 14.8% as nursing assistants and 7.4% as community health agents; 96.2% had completed *latu sensu* postgraduate courses (specialization) and 3.7% were attending this course; 7.4% had completed *stricto sensu* postgraduate courses (master's or PhD), of which 3.7% were master's degree and 3.7% were doctoral degree. The average time since graduation was nine and a half years and the time of practice in the FHS was six and a half years. With regard to NASF professionals, 70% were female with a mean age of 38 years. The average time since graduation was 15 years, and time of practice in the FHS was five years.

The following empirical categories related to professional autonomy of FHS nurses emerged from interviews: the possible autonomy, the autonomy dictated by protocols and the subordination to medical work.

The possible autonomy

Autonomy was perceived positively. Some of the interviewees stated that nurses act independent-

ly within their specific professional competencies without the need for another professional in order to be resolute.

"I think we are 100% autonomous; we don't depend on other professionals to do, [the service] doesn't get stuck" (E17).

"We are quite autonomous, 'cause if we are not, we cannot do everything that's done. If it's interfering, then we'll reach our limit" (E2).

"The Strategy [Family Health Strategy] offers a chance of autonomy, of things one can do. We follow some protocols for all things we can do within our skills. We can prescribe and solve many things without necessarily needing a medical evaluation" (E22).

"The nurse is autonomous. Here in the Unit we follow all protocols. Our manager is an excellent person, calm, trusts our work, supports us. We have a very good autonomy to work, to solve the cases of the health agents with the assistants. Even things that are not our scope, we go there and resolve calmly, without problems" (E21).

"We have enough autonomy here in the Strategy; this is the differential. We have protocols for the drugs we can prescribe and that's quite an autonomy for us" (E14).

"One thing that helps is that in the Family Health Program, nurses can do more things than in other institutions, like asking for exams, checking exams. I think this increases the credibility of nurses' role as someone resolute" (NASF 7).

"Nowadays, nurses are much less subaltern and more resolute. We're less afraid of taking risks and saying: 'Look, this is mine'. In the old times, this was what was left for nurses, and nowadays this is ours" (E16).

"We joke that here, the Unit would function very well without a doctor, because nurses can manage a lot" (NASF9).

However, autonomy was associated with an individual component, a personal attribute, that is, nurses' proactivity:

"From the contacts I had with nurses working in psychiatry, I realized they are more proactive. Not to mention here in the Family Health Program! (NASF1).

"In general, nurses are very proactive, very independent. But that depends on the nurse's attitude" (NASF3).

A limitation was also identified in the population's understanding of the autonomous practice of PHC nurses:

"She also has to know how to handle the fact that the population is reluctant to have an appointment with her, explain it to users, and offer a consultation that makes sense to users, too, in order to justify it" (NASF 4).

"There is a lot of recognition from professionals, and clarity of power and limitations. Users are not used to a more active nurse; they still have the image of nurses helping the doctor, and that the doctor resolves and nurses do not" (NASF8).

"Some things are still missing for our work with more autonomy, which would make a lot of difference in how much the patient trusts what we are talking about" (E7).

Another limitation mentioned by both nurses and NASF professionals was the acquisition of competencies for autonomous action throughout professional socialization, either individually or as a professional category. However, autonomy is aspired by the professional group:

"We still don't have the 'I, nurse', but I think we have more autonomy" (E11).

"There are a number of variables that impact on nurses' autonomy: the training of other professionals

with them, the very formation of these nurses, the knowledge they bring from higher education institutions and that supports them, their experience and also what they have as work purpose" (NASF2).

"PHC and FHS ask nurses to [occupy] a place of autonomy, to take more responsibility. But all this has its price, right? This is also distressing, this 'place' I happen to have. But there is the bonus: a condition desired by the subject" (NASF2).

The autonomy dictated by protocols

In this empirical category, some interviewees mentioned that the autonomy provided by the protocols is sufficient and stressed the importance of the professional group's respect for the legal limits of the profession.

"I see autonomy the way it is in the protocols as a good thing, but sometimes colleagues end up doing more, asking for things that are not of our scope or competence. Autonomy is good as long as you can support yourself in order to exercise it. You cannot extrapolate, do beyond what your profession allows. Users are much more oriented than they were a few years ago; they have some channels to report, complain. So, we have to be very careful about this issue of autonomy" (E7).

"I do have autonomy, and I limit myself to what I can do, what is allowed by COREN, what is allowed in professional practice. As much as I know how to do other things, I will never do. I struggled a lot to have my COREN and I will not lose it" (E19).

"I graduated as a nurse, I graduated to take care; I did not graduate to prescribe and make medical decisions. If that was the case, I would have studied Medicine. It does not bother me at all [the limitation imposed by the protocols]. What bothers me is a nurse who wants me to do things that are not my scope and are not in the protocol, that are not related to what I studied" (E7).

"I think there is autonomy within the service, within the visits and I think nurses can prescribe some medications" (NASF 2).

Other interviewees made reference to the rigidity created by the protocols that legally limit the technical competencies for practice. They even rebelled against the limits imposed.

“[Here] the nurse has autonomy, much more than in other work environments. But at some points, it is still limited by protocols. COREN limits a lot, sometimes the Regional Council of Medicine gets involved by trying to veto something. Compared to a hospital, we cannot compare the autonomy we have here, but even so, it is an illusion to say we have it. Are we totally autonomous? No. We are still subordinate to agencies, protocols and councils” (E4).

“The protocols make Nursing very difficult, hinder our judgment. We have a very good background for making judgments. The issue of protocols coupled with the social construction that we are hierarchically dependent on doctors greatly impairs our judgment capacity, and even of being professionals, because this ends up making nurses themselves insecure” (E10).

“You have the autonomy to be able to prescribe a certain medication, but the protocol does not give you autonomy of judgment. If there is a big problem in the Collective Health nursing, this autonomy is relative” (E12).

“Sometimes I rebel, because I see I have scientific knowledge to make a decision, but given the governing rule above me, I cannot do it. You want to take a step forward, but you cannot do it” (E11).

“You cannot be a nurse stuck to protocols. We have protocols for everything! But we must have that critical sense and feel safe enough” (E3).

“I think there are a lot more things we could do and by the protocol, we cannot. These protocols should be expanded, so we could do things beyond what we do today. Many times, I feel very stuck to these protocols. I wish I could do more, I have the knowledge to do more, but I cannot” (E14).

“Although nurses have a good autonomy, most people out there are not aware of this. Autonomy still needs to walk a lot. There is autonomy in terms; I guess there is a lack of legal support and even an awareness from professionals in other areas that nurses have the capacity and can do some things. No one has taken it from nowhere, no one is conducting illegal professional practice” (E24).

Subordination to medical work

Some speeches have shown that nurses' limited autonomy leads to the technical subordination to doctors' work. Nurses evaluate the case and make clinical judgment but, given the lack of legal and institutional support, they must submit to the doctor's authority.

“An issue that annoys me is, because of the service demand, often having to make the prescription, then taking it to another person to get a stamp. In doing so, you go up and down [the stairs] 500 times a day; if you don't do it, it's even worse. Is this autonomy? Yes, but very fragile” (E15).

“Sometimes, I have to leave my office and ask the doctor to sign something. I think this disrupts my consultation; I hate doing this! I did everything, then, I'll leave so someone will stamp a prescription, and come back There's a lot we do all the time, and it's crystal clear it's ours. People end up covering this, I don't know why. I think it doesn't interrupt it, but makes it more difficult” (E12).

“Sometimes, I realize how much the nurse turns out to be the doctor's secretary: you make the prescription, do this and that, and doctors just go there and 'tum', stamp it. So, I don't know how far is it autonomy... They often question the conduct, I've seen it, mainly from doctors” (NASF 10).

This situation demonstrates the identity of nurses and their position as doctors' assistants, as illustrated in the following excerpts:

“Nurses don't have an active voice, it is often the doctor who dictates the rules and they only com-

ply; 'task doer', in fact. In some services, nurses can have more autonomy than in others. But often, the community has that stereotype of the nurse being a mother, a caregiver, and often not only playing the role of nursing; doing everything, being a social worker, serving" (NASF8).

"At graduation we are led to see the nurse as a doctor's assistant and I imagine that in some settings, it still works a bit like this, especially in the hospital environment" (NASF1).

"The community sees nurses as the doctor's helper; they don't see the nurse as someone who is caring for their health" (NASF 2).

"In another Unit, we perceive a more submissive attitude towards the doctor; the doctor doesn't give as much autonomy and the nurse also cannot conquer this space" (NASF3).

"If we are in this small world of ours, in here, there is no problem. But who guarantees that our users, who transit here, will not go to the other side of the city, to an expert 'X' that sometimes the network itself referred them to, and take a prescription with a nurse's stamp? I find this very complicated. Within Basic Care, I think this is clear, outside that space, I think [autonomy] is very fragile indeed" (E22).

Discussion

The results of the investigation showed that nurses and NASF professionals perceived an increase in the professional autonomy of PHC nurses, notably through clinical practice supported by care protocols with the possibility of requesting and evaluating complementary exams and prescribing medication. However, these same protocols that broaden nurses' scope of action were also perceived as limiting their potential clinical skills. The persistent subordination to medical work was mentioned along with PHC nurses' autonomous work.

PHC nurses' practice is based on care protocols. The Law 7498/86, which governs the nursing

professional practice and is regulated by Decree 94.406/87, states that nursing consultations and the prescription of nursing care are part of nurses' role. As a member of the health team, they are also responsible for prescribing medicines established in public health programs and in routines approved by the health institution.⁽¹³⁾

The National Primary Care Policy assigns to nurses the nursing consultation, assistance and educational activities in group, procedures, request for complementary exams, prescription of medication and referrals to other services, although emphasizing the need to regulate such actions in federal, state or municipal protocols.⁽¹²⁾

Therefore, in the current practice scenario of PHC in Brazil, care protocols have an essential legal character that guides nurses' actions. They provide a detailed description of how to approach the user, perform consultations, the nursing history, physical examination, diagnosis, prescription of care or medication. Some protocols also define the concepts and professional values that should support the practice, the functioning of health services and the roles or attributions of each nursing team member. They also describe the nursing techniques or procedures, as well as care goals, when they exist, which includes the number of consultations and visits by professional category.⁽¹⁹⁾

Although in Brazil, PHC nurses' clinical practice is based on protocols that detail procedures, tasks and responsibilities, nurses can sometimes be unsure of the work they do. Part of the insecurity stems from lack of institutional support.⁽²⁰⁻²²⁾

Another aspect refers to limitations imposed by protocols that interfere with nurses' competencies and lead to their underuse. PHC nurses working in highly vulnerable regions with a shortage of human resources in health could play their role with greater autonomy, thereby contributing to reduce mortality and morbidity, especially in remote areas.⁽²³⁾

Since nurses are the most present college-level professional in PHC health teams, they are the most linked to the commitment of solving the problems of users and their families. In the absence of a doctor in the team, they are responsible for responding to the families' health needs.⁽²¹⁾

PHC nurses also assume the position of integrating the work of health teams, which is mostly an invisible role that ends up re-signifying nurses' professional identity.⁽²¹⁾ Such particularity of work must be recognized in public health policies in order to strengthen its resolving competence, enable greater institutional support and strengthen nurses' professional identity by making the invisible evident and legitimate.

Regarding the subordination of nurses' practice to medical work, some statements suggested the existence of real conflict between these professionals in routine work, in a kind of 'competition' for the professional exercise. This issue concerns the professional group of nurses or PHC nurses internally, and must also be understood in the wider context of social and economic division of health work, in a neoliberal and rationalizing public health cost model adopted by the State, in which even doctors are autonomy.^(24,25)

In Brazil, between the 1980s and 1990s, the access to health services increased and individual health care was expanded in order to include collective health actions. Nurses' work was structured for the service organization in a way that enabled medical care and the performance of actions such as vaccination and epidemiological surveillance. Nurses' performance gained greater prominence as a member of the multidisciplinary team, based on the nature of their own body of knowledge for providing care to users, which has expanded widely and impacted on professional practice.⁽²⁾

The collective characteristic of PHC work, in which the sharing of knowledge and decision-making leads to less professional boundaries or limits, means there are many common and shared competencies among the different professionals. General or common competencies are performed in all or many professions, and result in a similar professional behavior in a particular sector, in this case, of health. Specific or complementary competencies distinguish the singularity of a profession and are not easily transferable to another. Collaborative competencies concern what can be shared between professions and the agents involved in the professional action.^(6,26-28)

The Pan American Health Organization (PAHO) emphasizes collaborative practices as a strategy for increasing universal access to health in Latin America and maximizing the practice scope for each profession. Advanced Practice Nursing (APN) is another health innovation considered by PAHO as having potential to transform training and practice scenarios with the aim to expand access and improve population coverage.^(24,29,30)

Advanced practice nurses are empowered to make complex decisions supported by clinical competence and expertise gained through post-graduate studies, usually the master's degree. The International Council of Nurses (ICN) lists five types of autonomy in the list of clinical activities expected from advanced practice nurses, as follows: to prescribe, request medical examinations, perform advanced health diagnoses, indicate treatments, and make referrals and counter referrals of users.^(3,29-32)

International experiences of advanced practice nurses, especially in the United States and Canada, have identified positive impacts on the quality of care provided in PHC and on nurses' professional satisfaction.⁽³²⁻³⁴⁾

According to PAHO, advanced practice nurses are a key step in strengthening PHC and expanding access to health services. Strategies to this end include developing collaborative networks of APN for increasing the number of nurses taking leadership positions and maximizing the potential of their practices. They also include joint efforts of training institutions, policy makers, decision-makers, and interprofessional work groups for strengthening intersectoral actions and community participation.⁽²³⁾

PAHO proposes the following roles for APN in Latin American countries: 1) Nurse practitioners, nurses with master's degrees, whose work is directed to diagnose acute and chronic acute diseases. 2) Nurse case manager, whose main focus is to integrate patient care between the different levels of care and 3) Advanced practice nurse specialist in obstetrics, whose care is aimed at pregnant women.⁽²³⁾

In the context of Brazilian PHC, advanced practice nurses could contribute to the development of the profession and evidence-based practices with solid technical and legal bases, and thus increase

the achievement of goals projected for the Brazilian health system. Five strategies are proposed for implementation of APN in the country: investment in professional training, promotion of continuing education, incorporation of evidence-based practice by PHC nurses, regulation of legislation that guides professional practice, and changes in the health system for expanded practice.⁽³⁵⁾

Conclusion

The study revealed an increase in the clinical scope of PHC nurses, which, to a certain extent, brought it closer to medical work. On the other hand, the expansion of interprofessional boundaries required by the work process in PHC, and the growing need for new competencies, allowed nurses to take over some actions that were previously exclusive of doctors. Modern nursing was structured by having the hospital as reference and Medicine as a hegemonic profession. This approach to the medical model provided the substrate of scientificity that gave meaning to nurses' actions and interventions. Initially, nurses assumed the role of assisting doctors in the organization of the hospital space, then, later in the organization of public health services by assuming management and control functions. At present, there seems to be a paradox linked to nurses' practices in PHC. From a broader historical point of view, the approximation to medical work has brought meaning and legitimacy to nurses' practice. More recently, PHC nurses have been moving away from subordination to Medicine and seeking to establish themselves with greater autonomy in individual clinical care, in spite of limitations imposed by care protocols. In addition, they continue to act in the management of service and nursing teams, and integrate the other professionals. Therefore, two ongoing challenges exist in PHC: the implementation of interprofessional collaborative practices and the increase of nurses' professional autonomy in the proposal of advanced practice nurses. Thinking about the new competencies required from nurses for the work in PHC means taking into account the policies developed for the

sector and for health professional training, and also the autonomy they achieve in their concrete daily practice in health services.

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Collaborations

Pereira JG and Oliveira MAC declare they have contributed to the project design, analysis and interpretation of data, article writing, critical review of the intellectual content and final approval of the version to be published.

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