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Listening and valuing clients: conceptions and practices in the care management in the Family Health Strategy

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Abstract *We aimed to analyze the practices of receiving, bonding, and shared responsibility in producing care in the Family Health Strategy. This qualitative, exploratory study in the dimension of hermeneutics-dialectics was conducted from August and November 2021 in Iguatu, Ceará, with 25 professional coordinators of the Family Health Strategy teams. A semi-structured interview was adopted to collect data. We identified different conceptions among the coordinators about reception and bonding. We shared responsibility: conceptual aspects linked to the experimental care practice mode the team experienced, the aspects that intervened in these processes, and the relationships built through care management and production. We evidenced contributions to evaluating and improving care management and production in the Family Health Strategy and the Unified Health System (SUS). Reception, bonding, and shared responsibility were proven potential tools in qualifying care management in the Family Health Strategy. Improving professional skills and investing in relational technologies are required for humanized health practice.*

Key words *Unified Health System, Family Health Strategy, Humanized Care*

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Introduction

The daily healthcare practices express the historical transformations in care assistance and management. In human relationships, this process is enhanced by using devices – reception, bonding, and shared responsibility. The object of study was delimited in the conceptions and practices of care management in the Family Health Strategy (ESF) territory.

Care dimensionality through devices requires reflection and criticality. To this end, it is necessary to be sensitive to developing practices considering interconnections and intercurrences in the care process[1]. Management and assistance are inseparable in care management.

Care management is dynamic and complex but can modify the work process. It is an indispensable care system to qualify assistance, which crosses the different health contexts, enhances the coordinated action between professionals, and relates the social and political issues of the territories, with implications for clinical practice. Care is produced from meetings between workers and clients – central care components – aiming at autonomy for shared decision-making. Thus, care planning focuses on resolution, bonding, shared responsibility, equity, and comprehensiveness[2-4].

Understanding reception, bonding, and shared responsibility became necessary to improve care actions in the territory. Such processes enhance the care toward the care resolution and intersubjective practices, promoting affective human relationships in health. Although applying the devices is recommended by the National Humanization Policy[5], the daily practice of services must include this clinical expansion, care diversity, and social participation.

Reception recognizes the legitimacy and uniqueness of what other people need. Exercising it requires qualified listening, commitment, and bonding between the players involved. It is a crucial strategy to promote change in the work process, restructuring of health services, and care resolution, enabling harmonious relationships[5-7].

Bonding is also an essential device in work processes, which aims at interpersonal affinity and a good relationship between professionals and clients, encouraging autonomy in the therapeutic process. However, bureaucratic services and overwork threaten the visualization and appreciation of professionals, which should exist as a requirement for the service's functioning regarding accountability and care longitudinality[8,9].

Shared responsibility is a care qualifier that implies the involvement of health professionals, clients, and their families in therapeutic plans and actions and articulating health and support services. The need for one of these stakeholders in the care process reiterates the fragmented care[10,11].

Receptive care practices can promote bonding, and shared responsibility directs care resolution and comprehensiveness. Barriers in these processes hamper the provision of essential guidance, alleviating the anxieties and doubts of clients and their relationship with the team, weakening and disqualifying health care.

By recognizing the weaknesses and strengths in actions during care management, it becomes possible to improve integrated, singular, holistic, and uniform care, positively impacting the quality of services and client satisfaction[12-14]. Care production is operationalized with relational devices that can enhance comprehensive health. We aimed to analyze the reception, bonding, and shared responsibility in producing care in the Family Health Strategy.

Methods

We opted for qualitative research in hermeneutics and dialectics, with a methodological proposition in exploratory research. The qualitative method identifies multifactorial aspects in the data's nature – from subjective to relational – focused on experiential intensity[15].

The study was conducted in Iguatu, a municipality in the Center-South region of the state of Ceará. This municipality has 100% ESF population coverage, with 36 operating teams. It innovated by implementing the "Family Health Program" in the 1990s, resolving reach in the local health system. It pioneered the territorialization method in 1987, supported by the Pan-American Health Organization (PAHO)[16].

The participants were the coordinators of the ESF teams in the municipality, performed by the nurses who are part of the teams. They were invited to engage in the study under the inclusion criteria of having a minimum experience of six months in the ESF and at least three months in the current ESF, and being in the entire exercise of the profession during data collection.

Thirty-eight coordinators of the ESF teams in the municipality were invited to participate in the study. Eight were excluded for not meeting the inclusion criteria, and five did not participate

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because they exceeded the maximum of five attempts to schedule an interview. Finally, the sample consisted of 25 coordinators. The participants were named UBS Manager 1, UBS Manager 2, and so on, until UBS Manager 25.

Data were collected from August to November 2021 through a semi-structured interview. The collection instrument belongs to the research "Production of Care in the Family Health Strategy: practices, affections, technologies, and evaluation", from which relevant information was used to manage care in the Family Health Strategy, emphasizing reception, bonding, and shared responsibility. The interview roadmap was structured with questions related to care production in the ESF and chronic health conditions, two of which were used in this study. The statements were recorded through recordings previously authorized by the participants.

Data were analyzed and interpreted in the light of hermeneutics-dialectics through a comprehensive and critical interpretation of reality and elaboration of ideologies. Dialectic-hermeneutics proposes valuing the convergences and divergences of the statements and their complementarities and differences. While hermeneutics seeks to achieve meaning and agreement, dialectics emphasizes what is different, the contrast, and criticality[15,17-19].

Operationally, the analytical process followed the following steps: organization, classification, and final analysis of the data.

The material was identified by transcription and reading during data organization, horizontally visualizing the findings. The statements were heard and read several times to identify the units of meaning. Each unit's vertical and horizontal synthesis was performed in the classification from textual excerpts of the statements that grounded the syntheses. The statement fragments were grouped in envelopes, metaphorically representing the "drawers" in the light of Minayo[15].

Subsequently, the analytical categories were established through horizontal syntheses in converging and diverging movements, complementarities, and differences. The study's empirical data were obtained from the cross-sectional reading of the content of the established analytical categories and horizontal synthesis. Data final analysis revealed the statements' content with the reference material available. We adopted techniques associated with the authors' contribution, researchers' experiences, knowledge, and experiences.

The research complied with the requirements of Resolution No. 466 of December 12, 2012, and the National Research Ethics Committee (CONEP) guidelines, in its Circular Letter No. 1 of 2021, with guidelines for research of any stage in a virtual environment[20,21]. Participants accessed the Informed Consent Form, complying with ethical principles. The research was approved with the consent of the Municipal Health Secretariat of Iguatu, in URCA's Research Ethics Committee (CEP), under Opinion No. 4.498.440.

Results

We analyzed the conceptions of 25 coordinators of the units about the management of care in the ESF. All were nurses, three males, and 22 females. Twenty-four coordinators worked for over a year in the respective health units, and only one worked for less than a year. Regarding the title, twenty participants had specialization in Family Health or Collective Health, three had the same level of title in other areas of activity, and one had only a degree.

Important aspects emerged in the debate on the ESF in the SUS. The spoken productions were interpreted and categorized to contribute to the evaluation and improvement of care management and production in this context.

Reception as a meeting and listening in search of resoluteness

Reception was evidenced as satisfactorily receiving the client in the service. This indicator was understood as a process that started when the client entered the unit and continued in all subsequent appointments, timely to build trust, guide, and encourage behavioral adherence:

Reception is when the client arrives at the health unit [...] how you receive and give guidance (UBS 4 manager).

Reception is that client's first contact with the health unit, who will receive him/her, how he will receive him/her, how he/she will be followed up. [...] how he/she will be oriented and directed (UBS 17 manager).

[...] I understand reception as receiving clients satisfactorily and attentively, seeking to meet their needs (UBS 24 manager).

[...] I think the reception is important because it gives grounds to generate client trust with the services. It is even easier for this client to have a good behavioral adherence [...] (UBS 5 manager).

The participants conceived that reception occurs through qualified listening, which can value

what clients bring as a demand. The way of receiving must be associated with seeking resolution. In this sense, the importance of feedback to the clients regarding their needs was considered:

I understand reception as qualified listening, with attention and respect, valuing what clients bring (UBS 1 manager).

[...] it is necessary to have someone listening and embracing the problem or demand of that client and attempting to solve it or referring it to some other service, or directing to some appointment, vaccine, dressing, according to the client's demand (UBS 7 manager).

Even if we cannot solve it, we should accept that complaint and try to provide the client with an answer somehow (UBS 9 manager).

It is received and directed, depending on the demand (UBS 24 manager).

Furthermore, the conception of the reception process emerged as a tool for the health service to organize care, which should provide an equitable and resolute relationship in the provision of care, attentive to the needs and demands of each client:

I understand reception as a tool for organizing the waiting list, where clients who need it most will be served with priority and not on a first-come, first-served basis (UBS 23 manager).

Reception in the construction of bonds and healthcare accountability

In convergence, reception was perceived as a multidisciplinary posture in collaborative work processes:

Any professional can perform reception (UBS 19 manager).

The attendant is the first person the client sees as soon as the client arrives. [...] She does all the reception and refers to the area's doctor, nurse, technician, and health professional (UBS 4 manager).

Reception is an essential and timely bonding device. How professionals received the clients, and their availability to meet their demands established the bond, mediated by respect and trust between professionals and clients:

The client perceives in us the receptiveness and the desire to help him/her, so we establish this bond of respect and trust (UBS 1 manager).

Reception is when we receive the client, generating trust so that he/she can express his/her real need and be directed to the necessary care (UBS 10 manager).

Building relationships mediated by empathetic, affective, and reliable behaviors was understood as a bond. The approximation between the enrolled population and the health professionals established a link between the recognition of the assisted clients and the responsibility assumed by the team in the unit:

The bond consists of building relationships of affection and trust between a health professional – in this case, a nurse – and our clients (UBS 23 manager).

[...] The bond is closeness with the community and everyone (UBS 2 manager).

The bond we have with all these clients, as far as possible, is getting to know the people who are assisted by the team [...] (UBS 11 manager).

A bond with responsibility is established from reception (UBS 18 manager).

Moreover, the weakened bond between the team and clients in care is caused by the frequent turnover of professionals, sometimes proposed by management attitudes:

The bond is crucial because it carries trust and is one of the most essential tools in the strategy. However, the management values this bond less because there has been a proposal to rotate almost yearly. So, I don't see this appreciation on the part of the managers (UBS 5 manager).

Shared responsibility is understood not only as inherent to the work team or care professionals but also as a multidimensional sphere based on the participation of multiple stakeholders in care. The clients, the team of professionals, the family, management, and the community were the leading players responsible for sharing the several responsibilities in health care:

Shared responsibility: the health team is responsible for treating the clients (UBS 24 manager).

Shared responsibility occurs between health professionals and clients. It is a joint construction of care (UBS 23 manager).

[...] and shared responsibility is remembering that everyone is responsible for that person's health problem, not just the nurse or the doctor, but the health secretariat, the client, and the community (UBS 2 manager).

Shared responsibility... One thing is intertwined with the other. When you create that bond, you create that correspondence with the clients, that responsibility to receive the clients, assisting and providing them with the correct information (UBS 12 manager).

In clinical practice, shared responsibility is the process apex. It is more easily set when reception is offered, and bonding is established, making one process dependent on another.

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Discussion

The findings on the conceptions related to reception, bonding, and shared responsibility were exposed in their weaknesses and strengths. In daily work, care production unfolds between everyday practices and the relationships established in care management. We presented the criticism reflected in the meanings expressed by the Family Health Strategy managers and the insufficient reach of the organizational principles with the praxis in the SUS.

In a communicative dimension, the reception was only related to receiving the clients in the unit as the teams' action during their practices, impoverishing the broader sense of what reception is, as it should transcend and be present in all care relationships. The receptive posture should occur in real encounters – in the act of receiving, listening, and directing – not only in receptivity, where interest in the clients' demand is crucial, fully assuming the responsibility for them[22].

We complement that the first contact, when well conducted through effective listening and resolution, satisfies clients with the service, and humanization and decision-making are essential. It provides opportunities for reflections on the importance of expanding technical-scientific skills and competencies to improve the attitudes and behavior of professionals during the first contact in search of effective and resolute listening to peers[23,24].

In contrast, persistently signifying reception with qualified listening interferes with the scope of resoluteness. However, the professional must commit to listening. From this perspective, the PNH considers that adequate access to the clients' needs can be guaranteed, and the likelihood of effective care is increased through it. Humanization occurs, and the subjects' social, ethical, educational, and psychic circumstances are more easily visualized[5,25-27] through qualified listening.

Although reception can modify the services' practices, it has yet to be exercised due to aspects that hamper actions. Risk classification is a valuable tool to humanize care, making it receptive and resolute. Continuing education and health education strategies potentially transform this reality[28,29].

Dialectically, the strengths and weaknesses of care production were noted with approximations and distances from the reception advocated by the PNH. Reception proposes to invert the health service's organization and functioning logic when some principles are considered, such as shifting from a central axis to a multidisciplinary team. Thus, it can adequately meet the demands of individuals and their singularities as the effective comprehensiveness of client assistance and problem-solving are expanded[5].

Challenges such as higher than recommended demand, the lack of environment to conduct qualified listening, lack of primary resources, and team humanization are considered intervening situations. Health workers face them to develop reception in the units[30].

Different from what is advocated in the PNH guidelines, reception actions centered on a professional category generate fragile and fragmented work processes. The SUS worker must recognize the expanded conception of client reception and the political-institutional guidelines in the interprofessional organization of practices. Change and innovation in PHC care processes[31-33] are expected by proposing continuing education initiatives in care, management, social control, and training.

Coherently with the findings, reception is a performance of possibility for establishing and preserving the bond. In a causal multiplicity, the client-professional bond is more easily established by sharing and receiving the team in clients' situations of anguish and frustration in the face of dissatisfaction with the health services. This practice enhances trust in relationships and receptive meetings[34,35].

Regarding fragility, the turnover of ESF team professionals interferes with bonding relationships, as this situation implies disrupting the client-professional relationship, reduces longitudinality, and weakens healthcare. It is imperative to evaluate SUS services with analysis, participation, and critical reflection on these daily conditionalities[36,37].

Shared responsibility for the managerial dimensions of health actions also stands out in care management. Management decisions traverse the weaknesses of health teams in their work processes, and they can mainstream the healthcare potential for care quality and comprehensiveness. Recognizing these practices and appreciating the work improves the care offered. Continuing education becomes relevant for transforming this context and its social stakeholders[33,35].

When addressing shared responsibility, we observed that the participants need more understanding of multidimensional care. If the health-disease process were recognized as complex – then one would understand the need to expand the clinic and share care between the team, service, management, client, and the family[5,38].

Studies have identified that flexibility in care practices and expansion boost shared responsibility and favor bonding and qualified care, although care protocols are essential for the work routine. Thus, shared responsibility emerged as a proactive dimension to make the protocol work routine more flexible and build bonds, and was a transformer and qualifier of practices and knowledge[10].

We have provided evidence on humanization when enunciating the difficulty of sensitizing the involvement and responsibility of the stakeholders in the therapeutic plans and actions that still reiterate the fragmented work. Thus, the clients' suffering can be maximized, and their ability to cope with problems is discouraged. Power and care relationships expressed in reduced client autonomy[11,39] reflect fragmentation.

Finally, as in interweaving, reception, bonding, and shared responsibility are interconnected in the experiential process of care practices, driving each other in care management and production. They can provide opportunities to produce differentiated care, mediated by live work built on light/relational technologies, and reorient the care model towards comprehensiveness[40,41].

In interpretive senses of everyday life complicated by healthcare relationships, the ESF unveils a possibility for comprehensiveness in its management and care practices. However, the operational limitations based on the possible teams' actions still demand expanding toward the multiplicity of a health perspective.

Final considerations

The conceptions about reception, bonding, and accountability identified showed that health unit managers understood reception as a process, albeit ineffective. This situation stems from the slow and irregular pace at which it is operationalized due to weaknesses related to the daily aspects of health work during care production.

Shared responsibility emerged in the statements as a theoretical assumption but without appropriation in professional practice. The bond and the bonding process were centered on building relationships between the team, community, and territory. Belonging operationalized by registration triggers these relational aspects, which complement each other in care management and production.

A limitation of this research is the narrative dimension pointed out only by the coordinators of primary ESF units, which indicates the development of studies with expanded participation of teams and clients. Methodologically, we recommend continuing the participatory nature with the strategic dimension of planning.

A Family Health team can incorporate reception, bonding, and shared responsibility as potential tools for qualifying care management in the ESF. Planning becomes an indispensable tool for care practices in the territory with social participation.

"Humanization" conceptions must be re-signified for applicability in the health work context. We should recognize people in their life relationships, and perhaps the most significant challenge is to qualify care practices with comprehensiveness during care production in the ESF. The devices intensify the application of the PNH recommendations in the daily lives of teams in their care and management relationships.

Collaborations

TGFM Januário worked on the conception, design, analysis and interpretation of data, writing and final review. LD Varela worked on the conception, design, analysis and interpretation of data, writing and final review. KNS Oliveira worked on the writing and final review. RS Faustino worked on the writing and final review. AGA Pinto worked on the conception, design, analysis and interpretation of data, writing and final review.

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