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Learning the clinic of social suffering: narratives of Internship in Primary Health Care

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Abstract *In Brazil, the mismatch between medical education and care needs in primary health care, especially for the most vulnerable populations, required changes in the National Curriculum Guidelines of the Medical School, with an increased workload of the internship in PHC. This work is exploratory, qualitative research, which investigated documents of the formative evaluation of the Integrated Internship in Family and Community Medicine and Mental Health of the Federal University of Rio de Janeiro, which serves vulnerable populations in the city of Rio de Janeiro. The documents produced by 55 students were analyzed, and dialectical hermeneutics was used as a method of analysis. The investigation showed different levels of sensitivity to social distress experienced by users of Family Clinics during the 22 weeks of internship. The narratives were grouped into five axes: highlighting the Medicine-society split; extreme vulnerability and health; daily structural violence and health; health service as a resource or intruder; territory as the power of life. The internship contributed to improve clinical views focused on users' needs, and further studies are required to evaluate the effective incorporation of these competencies into professional practice.*

Key words *Medical education, Internship and residency, Primary health care*

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Introduction

According to the Alma-Ata Declaration, PHC-based systems are essential to the development and social justice[1]. In Brazil, the expanded PHC hindered the provision of specific skills to doctors to assist more socially vulnerable populations[2]. Learning Medicine in these contexts is challenging[3,4] and adds to the persistence of substantial social disparities in the distribution of doctors and medical schools in Brazil[5]. Public policies have sought to induce training in community settings, as stated in the National Curriculum Guidelines (DCN) of the Medical School[6] to overcome these problems. However, much resistance to the expansion and qualification of medical education in PHC[7] is observed.

Even so, there is a tendency to increase the participation of community services in the formation of health professions[8,9], which placed the centrality of the context in the curricula[10]. These new challenges for medical education, once viewed as a purely individual process or centered on teacher-student interaction, have led to factors such as the role of the health team[11], patients[12], and communities[10] to gain prominence. Moreover, the emphasis on the hospital may hinder the acquisition of skills and the formation of professional identity[13].

Besides hospital centrality, the hegemony of the biomedical paradigm in medical schools contributes to the inadequate profile of doctors trained in Brazil. A mechanistic view of biosciences in medical practice promotes the alienation of doctors[14], health care[15] distortions, and authoritarian forms in the power relationships between doctors and users[16]. Proposals for overcoming the biomedical paradigm include the recovery of the caregiving realm of health practices[17], the relational dimension of care[18], and the revival of the centrality of the suffering subject[15].

Family and Community Medicine (FCM) advocates the centrality of practices in the suffering person, rather than subordinating them to a body of knowledge abstracted in a group of diseases or specific techniques[19]. The experience of falling ill and the recognition of people's (psychic, family, occupational, and social) context are fundamental to the epistemological perspective of the specialty.

The medical education process can be understood as training the eye or sensitivity[20], which implies the perspective of overcoming the biomedical paradigm, by understanding individual suffering as inseparable from the social[21] and, in particular, how social distress is aggravated by structural violence[22]. Cultural competence is one of the attributes of PHC[23] that addresses these issues, although there are criticisms of reductionist views of the concept[24]. Competence-Based Education[25] is also criticized for using the concept of competences as a natural development of scientific progress, without understanding them as socio-historical constructs permeated by power relationships[11].

The critical review of cultural competence learning can be based on two approaches that value contextual uniqueness and practical and collective learning: The Theory of Cultural Historical Activity, which seeks to grasp the intrinsic social and cultural complexity of health work, focusing on clinical learning set in the contradictions of health work, incorporating the students into their living and learning social environment[26]; and the Sociocultural Learning Theory, which understands learning as a sociocultural process, in which students become members of their professional community legitimized by the medical school and the health service. The production and reproduction of knowledge, skills, and attitudes takes place in a dialectical process between learners, teachers, and health professionals[27].

This paper investigates the relationship between these issues and the introduction of long periods of internships in Primary Health Care. This is exploratory, qualitative research that studied formative assessment documents of the Integrated Internship (FCM) and Mental Health of UFRJ/Fundão Campus. It will focus on the interns' experience of assisting social distress: the embodied experience of pain and the ways of suffering in social relationships; the cultural and moral models that condition the sufferings of the subjects; finally, the discourses by which institutions (such as Medical Science) classify and legitimize the different experiences of distress[28].

Methods

This is an exploratory, qualitative documentary study that sought to understand the influence of contextual aspects on the learning of UFRJ medical interns in the PHC network of Rio de Janeiro. This work is nested in the doctoral thesis of one of the authors. We studied a database with formative evaluation material of the discipline collected in 2017, with students from the 10th and 11th periods. The course lasts 22 weeks and takes place in 13 Family Clinics (RJ PHC Units), and

Ciência & Saúde Coletiva, 25(4):1251-1260, 2020

optionally in Psychosocial Care Centers (CAPS) and Street Clinic teams (CNAR)[29]. This equipment mainly serves highly vulnerable populations. This internship format was facilitated by the Rio de Janeiro PHC Reform[30] and sought to develop FCM-related competencies. Some of the objectives are listed in the Chart 1.

Internship evaluation methods include field diaries and final reports and focus groups. Field diaries and final reports are formative assessment methods based on the reflective writing of cases attended and situations experienced in services, in the light of People-Centered Medicine[19], PHC attributes, and SUS principles. The former are written weekly by all interns and submitted to university supervisors, with feedback in weekly supervisions. The latter are delivered at the end of the internship.

The Focus Groups were introduced in 2017 as a tool for assessing the pedagogical improvement needs of the discipline[31], to privilege the dialogue between students. They were established at the beginning and end of the round to access students' learning experience with patients, and their conduction and audio recording featured internship teachers with experience in qualitative research. The audios were then transferred to the database of the discipline, and focus groups whose transcription had good technical quality were employed in the investigation: the transcripts in which the 55 interns participated were included.

The material analyzed refers to five focus groups at the beginning and another five at the end of the round. In the Focus Groups, interns were prompted by two questions ("What did you just see?"; "What do you think happened?") after viewing videos of common situations in PHC related to the care of highly vulnerable and complex patients and families. The teachers interfered as little as possible in the development of the groups.

Data analysis followed the dialectical hermeneutics approach[32], which seeks to understand the other through communication, especially text comprehension – in this case, the narratives produced by the interns. Alterity, understanding, and misunderstanding are universal possibilities in the scientific field and the world of life. It is a procedure that seeks, at the same time, the contextual as an expression of the totality, by revealing what "the other" sets as truth: in short, understanding implies the possibility of establishing relationships and drawing conclusions in all directions. But understanding always ends up being understanding oneself[32]. The analysis, described below, is illustrated in Figure 1.

For the analysis, we selected 20 field diaries/final reports from four family clinics and the transcript from 13 focus groups, which included students from all internship fields. In all, 12 field diaries/final reports were chosen for analysis by criteria of good reflective capacity, gender and course semester equity, and balance between internship fields. Two were excluded by saturation. Three focus group transcripts were excluded due to poor technical quality. The final grid was applied to this sample, and the primary categories

Chart 1. Selected objectives of the internship.

Selected objectives of the internship
Increase practice scenarios for medical education, as per orientation of the DCN, establishing a mandatory internship in the area of Primary Health Care – Family Health Strategy.
Develop knowledge, skills, and attitudes for family medicine practice, with a comprehensive approach and interdisciplinary, in line with the principles of the SUS.
Realize actions of prevention, diagnosis, and treatment of health problems of the individual, family, and community, considering life cycles, the different social realities, and emphasis with mental disorders.
Perform home visits for clinical orientations, health promotion, prevention, and disease screening.
Perform collective activities with social groups, families, and communities, aiming at health protection and promotion actions.
Perform interdisciplinary work in the ESF, recognizing the capacity and responsibilities of the local network and team members.
Recognize the psychological distress in many users, contextualizing it, and accepting it within a medical visit.

Source: Internship Manual[29].

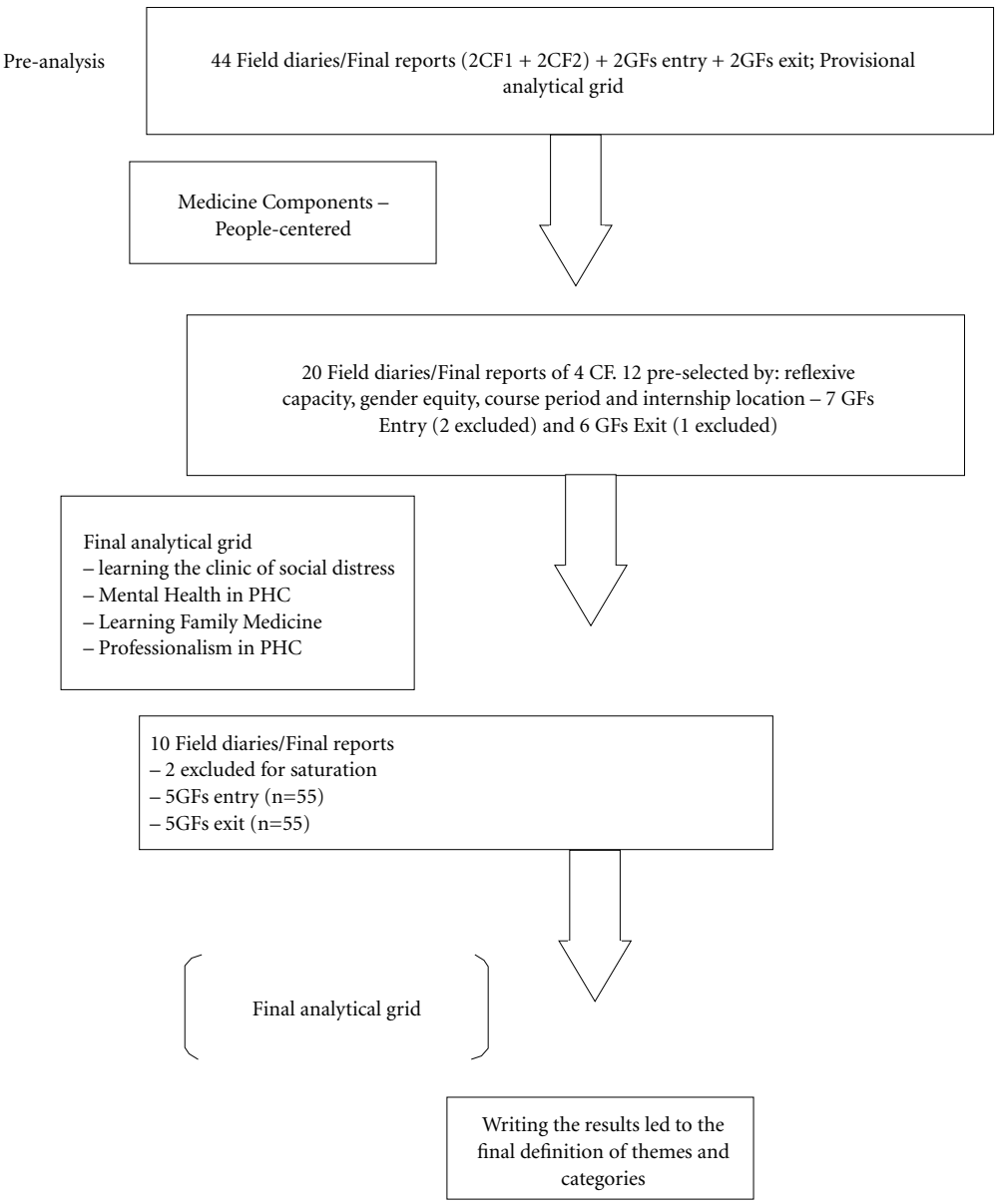

Figure 1. Data analysis process.

Source: Authors, 2019.

were maintained, with a minor reworking of the themes.

The analysis of these texts was based on four major categories: Learning the Clinic of Social Distress, Learning Family and Community Medicine, Learning Mental Health in PHC, and Training of Professional Identity outside the hospital. The production of this work is traversed by the eyes of one of the authors, university professor and family doctor of Rio de Janeiro's

Ciência & Saúde Coletiva, 25(4):1251-1260, 2020

SUS network, who seeks to build bridges in these fields of work and training that closes the gap between the world of future doctors and SUS users. The themes that emerged in the narratives were analyzed from the perspective of criticism of biomedical hegemony and the focus of cultural competence. All reported names of people and places are fictitious. The study was approved by the Research Ethics Committee of the Institute of Psychiatry of the Federal University of Rio de Janeiro (UFRJ).

Results/discussion

The themes found in the analysis of the texts were: *highlighting the Medicine-society split; Extreme vulnerability; Daily structural violence; Health Service: Resource or Intruder? Territory as the power of life*. Below is a discussion of these results in light of the methodology used.

Highlighting the medicine-society split

In the universe of early internship reports, the terms clinical, biological, and technical appear in opposition to social and human. They represented a split worldview that, by separating medicine from society, would hardly agree that all medicine is social[16]. Since the onset of the internship, the need to classify symptoms according to the biomedical method has clashed with the perception of the relevance of psychosocial components in managing the perceived distress in videos, especially when discussing the limits of psychiatric medication use for cases where the context is decisive for the treatment. Faced with the narrative of the psychotic actor-patient, the interns question themselves about biomedical epistemology and its effectiveness:

How can we completely forget this rather social bias, the influence of society on the development or not of a disorder? (Female student, GF 4)

The life stories of users, their socio-cultural context, the singular experience of suffering illness were gradually entering the narratives, living side by side with semiotechniques, and guidelines. The network of patients treated, staff, artifacts, and resources of the territory woven by the students in the daily life of the internship was crucial for the balance between the disease, experience of illness, and the context of users in the reports of interns. Views of the health-disease process have come to take social determination into account: *There is a process of evolution (in primary care, in particular), in which health and disease are thought of as a gradient across socioeconomic classes. (Raul, RF)*

With the advancement of the internship, it was common to refer to the practices experienced as a "*new type of medicine*" or "*humanized medicine*", dating back to the monistic epistemology of FCM[33]. Still, the Medicine-society split persisted in some narratives. In one case, it was mediated by the real challenges of the clinic and not a preconceived view of the practice. But in general, the theoretical and practical tensions of the reports have given rise to the medicine-society dichotomy as an anomaly of the biomedical paradigm[19].

When we have to investigate, besides his personal history, the history of his illness, this demand for time grows enormously (William, S14).

We forget, but medicine is a social science, not an exact science (Male student, GF10)

Extreme vulnerability

We could observe in the previous item that the experience lived in the internship was like an eye-opening event into essential aspects to the PHC clinic and that are nonexistent or ancillary in the curriculum. By understanding medical education as education of sensitivity – or the eye – to the various aspects of illness[34], narratives focusing on the diffuse and intense suffering of the most vulnerable patients gained prominence in the interns' lenses, challenging the unicausal or even biomedical perception of getting sick. Two sets of narratives stood out: the territory as a perpetuator of poor health conditions and access to services, and that of sick lives in these contexts. The first arises from forays across the territories during Home Visits, CAPS, and Street Clinic internships, and, to a lesser extent, the travel of the interns. Possible reflection of the elitized selection of a significant part of the students, many were amazed to see how slums' geography aggravates the difficulties of access to public services. The impressions about the relationship of the territory and living conditions with the illness, more than flashing in the eyes of the interns, also reveal different understandings about this process. For some, there is a macrosocial, engaged explanation: society must be subverted to ensure minimum health conditions. Others emphasized, in guilt-like fashion, individual or family responsibilities. Interestingly, these almost antagonistic perceptions have a common denominator: problems are the focus, and not territory powers. A

particular ethos of diagnosis may persist, even if regarding socially referenced diagnoses.

In encounters with users in extreme vulnerability, the students' suffering overflowed. The complex nature of the situations and the dense streams of affection put the biomedical arsenal at stake and paved the way for uncertainty. Reports such as that of the woman mourning for the death of her daughter by lupus, who could no longer take care of her terminally ill husband, from whom she suffered violence for decades, humanize student and patient, creating communion in pain and care and, for a brief moment, matched:

During several moments of our conversation, she cried and wondered how she could end the pain that afflicted her so much. I had no answers and maybe never will. (Juliana, S8)

Immersing in the daily lives of the most vulnerable people, the almost complete lack of reference to the intersectoral network in the management of these cases revealed the profound ignorance of these resources for the care of vulnerable people. Even with the support of reference mental health teams, only one student referred to the Social Assistance equipment, which still reflects the strength of the biomedical model and the form of the PHC community of practices in the context of Rio de Janeiro[35].

Daily structural violence

The deterioration of public security policies in the city of Rio de Janeiro was felt in 2017 with the increased number of robberies and shootings. This qualitative change directly influenced the daily life of the PHC network, whose implementation took place in the context of relying on Pacifying Police Units as a public policy located in the territory, to combat the so-called illegal markets, seeking to overcome the rationale of confrontation.

The increasing violence was captured by the daily work in the units, in the patients' suffering and the social life in general. One could to see how much the structural violence[22,36] condenses the suffering and care processes in the network. Sometimes it has been noticed by the service's troubled relationship with users:

[...] *How can you expect people to have a calm, tranquil, and peaceful reaction when what they have learned in life is not to be calm, tranquil, and peaceful? (MS, GF 6)*

On the one hand, armed violence is part of the daily life of services and territories. On the other hand, the risks inherent in this setting have led many clinics to adopt the Safer Access risk classification[37], which monitors potential outbreaks of conflict and, based on this, decide whether operational conditions are available or the clinic should be evacuated. The reports on these occasions are very significant. The tension that the imminent risk of armed conflict caused in the students evoked complicity with the community, resignation, or willingness to give up the city and even fear of dying.

Much to my internal colleague's extreme [...] *misfortune, she saw one of those involved in the confrontation carrying a gun, right beside her, running immediately after the shooting. She was bewildered, despaired, and burst into tears. (Jean, S18)*

Possibly reflecting a scenario of change in the university environment, in which collective groups advocating for the rights of women, LGBTs, and blacks proliferate, a minority highlighted situations experienced by particularly vulnerable groups: tragedies often produced solidarity, but sometimes suffering and conformism in interns. The narratives had a dual function when reporting stories with many layers of violence: witnessing the essential role of family clinics and the SUS in assisting the suffering of structural violence and identifying and legitimizing social distress as a relevant issue of medical practice:

[...] *while caring for her mother [who suffers from dementia] and preventing her from going to the streets at the height of the conflict, she was hit by a stray bullet in the shoulder. He recounted the despair of the moment, unsure whether to take care of his shoulder or the mother who wanted to sweep the sidewalk. (Carolina, S5)*

Besides the daily violence on the hilltop, police violence, and trafficking, this user had to address homophobic violence and the marginalization of the sex profession. (Jean, S14)

[...] *a patient who was suffering a lot because her son* [...] *bought drugs from another gang and murdered him, and prevented her from mourning on the hilltop.* [...] *So she would go to the clinic to cry and talk about her grief. (EF, GF6)*

Health service: resource or intruder?

Although Home Visits are part of the daily work of teams, most interns hardly knew them.

Ciência & Saúde Coletiva, 25(4):1251-1260, 2020

Entering the territory following community health workers, nurses, and doctors, many perceived them as an indispensable tool to access issues that do not appear in traditional settings:

[...] *inside the office, you explain* [...], *and the patient leaves as if he were going to do that. You come to his house, and it's nothing he says he understands; he's not doing any of that. (EF, GF10)*

The tone of surprise and even fascination with the power of the visit to facilitate understanding of the context and adherence to treatment marks a substantive difference in the hospital setting. On the other hand, the sometimes ostensible presence of the teams in the territory made the reports uncomfortable with a specific invasive posture:

Gabriel's situation was reported to the team by the area community health worker (ACS), and we started going there without any request or invitation. We have broken into their house, his room. What is the limit of care in these cases? (Jean, S13)

Unlike the hospital, where the sovereignty of medicine over patients' bodies is practically unquestionable, the unsolicited presence of the health team in a home makes explicit the view of Medicine as a tool for molecular control of bodies[16,38]. The empathy of students who do not conceive of such intrusive action in their own homes spells out the clash between views of privacy and intimacy in the various strata of society, as ACS report on visits to "hilltop and asphalt" territories. In many narratives, the tension between being resourceful and an intruder could be solved by the meeting of interns in the territory and their patients' homes. Respect for people's way of life was highlighted as a requirement for bond building and therapeutic efficacy:

[...] *we were able to go to his house ... we went, sat down and talked to him, saying 'we want to help you, we won't talk bad things about you'. And a week later, he showed up, and even his aunt said 'my God, what's going on?' (EF, GF10)*

Territory as the power of life

The adversities of care for vulnerable populations predominated in the narratives. Realizing their saturated clinical practice of social distress of great magnitude, limits, and weaknesses of care with the popular classes emerged. In some narratives, however, life responded with its living presence. This vibration emerged from situations where *everything in the community speaks* in Nina's words. Or the catharsis of a team, which, having traversed a territory full of armed people, returns from a visit to an end-of-life patient who nonetheless planned her birthday party:

[...] *our ACS started to cry because she remembered a similar case that happened to her friend. We all started crying in the middle of the street. We hug each other. We walked up the street laughing and crying at the same time, reflecting on the moment we spent there, how much we learned in such a short time. (Juliana, S2)*

Solidarity practices, such as neighbors helping each other after surgery and hospitalization, have not escaped observation by intern Leila. On another occasion of discoveries, she went to Quinta da Boa Vista, a leisure point for the Rio de Janeiro-born, in which she rediscovered her childhood. During the visit to the National Museum, the CAPS "madmen" become full citizens of knowledge and curiosities. Realizing the therapeutic role of moving around the city, she experimented with the peripatetic clinic[39], where rubbles lie today:

I had only been there when I was very young. So I thought it was cool to be able to go there again. [...] *It was interesting to note how different things caught their attention and how they have hidden knowledge about some random things. (S4)*

There have not always been successes. After failing to propose an educational group, Lucas makes a reflection, after hearing the community: "*Because of the negative experience we had in the realization of the site* [...], *we decided to move the group's location to the court, next to the Residents' Association*" (S7). Marília – victim of a severe episode of armed violence in a community a few months earlier – recounts a glimpse of a citizen's view of someone outside the favela, when the clinic was closed again:

It feels terrible to see those doors closed and the disguised despair that settles in people. [...] *I left, once again distressed, thinking of the people who live there. (S10)*

There were epiphanies in the most magical moments of care. On one occasion, Nina accompanied CNAR staff, who drove around a distant neighborhood looking for a lost user, and the ACS recognizes her:

A man who was unrelated to a skinny black man in a jacket backward in the middle of a street KNEW EXACTLY WHO SHE WAS! How is that so? My eyes filled with tears as that black community worker came desperately out of the van in

the middle of the street to wrap his coat and hug around her. (S15)

Final considerations

This work could study the narrative of the interns about the experience lived in their learning process. By experiencing common situations of Primary Care in the offices and the territory, they managed to improve their sensitivity to many forms of suffering "not classifiable" by the canon of biomedicine, but vivid, saturated by the violence – and the power – of the territories and social vulnerability. These findings are relevant because they explain how students inserted themselves in the care of these populations and were able to experience high degrees of accountability at a crucial moment in the formation of their professional identity. We have yet to identify Brazilian studies that focus on learning cultural competences with emphasis on psychosocial distress during the internship period, at least in the last ten years.

By reflecting on complex situations, students could experience practices centered on people that sought care under the supervision of university professors and service professionals and produce meaning – effectiveness, achievement, frustration, criticism – in their clinical learning. The transition from biomedical to a broader and more comprehensive view of medical practice was not univocal. A persisting Medicine-society dichotomy was observed for some. There was a single mention of the intersectoral network and the sensitivity to the suffering of the most vulnerable groups. This indicates the need to apply more homogeneous teaching and assessment methods throughout the internship to ensure minimum learning of so-called cultural competences.

Another point to be highlighted is the role of the team: preceptors and residents, nurses, ACS, and managers appeared in the narratives with positive and negative models, capable of inspiring effective clinical practices and professional attitudes, situated in the contexts of those populations. This way of learning to become a doctor is fundamental in the setting of significant changes in health practices, which require solid skills for collective work[11]. On the other hand, there is no guarantee that awareness of social distress will be in line with the needs of those populations, nor will it be sustained over time. Subsequent studies will be required to assess whether these skills have been incorporated into professional practice.

By highlighting the centrality of the psychosocial component in the Primary Care clinic, the findings of this study corroborate both the critique of the notion of competence as a measurable and deterritorialized endpoint and the critique of the technicist reductionism of cultural competence, when disconnected from the real needs of users[24], especially when it comes to meeting people from such disparate social universes. Beyond competence, the concept of cultural humility[40] can inform educational practices in community settings, helping to train physicians identified and committed to unattended sectors, and reducing inequalities in access to health services.

Collaborations

FM Cardoso e GWS Campos participated in the conception, analysis, drafting, and review of the text.

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