Alternative experiences rescuing knowledge for working processes in health*

EXPERIÊNCIAS ALTERNATIVAS RESGATANDO SABERES PARA OS PROCESSOS DE TRABALHO EM SAÚDE

EXPERIENCIAS ALTERNATIVAS RESCATANDO SABERES PARA LOS PROCESOS DE TRABAJO EN SALUD

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ABSTRACT

This descriptive study was performed using a qualitative approach, with the objective to understand the working process of nurses and physicians of the Family Health Strategy (FHS) in João Pessoa-PB, and identify the alternative strategies and procedures they developed. The material was analyzed according to the discourse analysis technique. It was shown that the elements of the working process were disconnected, allied with a possibility of change by overcoming the invisibility of the subjects and their knowledge in healthcare services. In conclusion, the identified alternative strategies and procedures are in the embryonic stage in terms of the transformation of working processes and overcoming of hegemonic healthcare models, therefore demanding a continuous problematization of concepts and practices.

DESCRIPTORS

Family health
Primary Health Care
Health personnel
Public health nursing

RESUMO

O presente trabalho trata-se de um estudo descritivo de abordagem qualitativa, que objetivou compreender o processo de trabalho de enfermeiros e médicos da Estratégia Saúde da Família (ESF), do município de João Pessoa-PB, e identificar as estratégias e táticas alternativas desenvolvidas. O material foi analisado por meio da técnica de análise de discurso. Evidenciou-se a desarticulação entre os elementos do processo de trabalho aliada à possibilidade de transformação pela superação da invisibilidade dos sujeitos e seus saberes nos serviços de saúde. Conclui-se que as estratégias e táticas alternativas visualizadas constituem embrião para transformação dos processos de trabalho e superação dos modelos de atenção à saúde hegemônicos, demandando problematização contínua de concepções e práticas.

DESCRITORES

Saúde da família
Atenção Primária à Saúde
Pessoal de saúde
Enfermagem em saúde pública

RESUMEN

Estudio descriptivo, de abordaje cualitativo, que objetivó comprender el proceso de trabajo de enfermeros y médicos de la Estrategia Salud de la Familia (ESF) del municipio de João Pessoa-PB e identificar las estrategias y tácticas alternativas desarrolladas. El material fue analizado mediante la técnica de análisis de discurso. Se evidenció la desarticulación entre los elementos del proceso de trabajo, sumada a la posibilidad de transformación por la superación de la no percepción de los sujetos y sus saberes en los servicios de salud. Se concluyó en que las estrategias y tácticas alternativas visualizadas se constituyen en un embrión para la transformación de los procesos de trabajo y superación de los modelos de atención de salud hegemónicos, demandando problematización continua de concepciones y prácticas.

DESCRIPTORES

Salud de la familia
Atención Primaria de Salud
Personal de salud
Enfermería en salud pública

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INTRODUCTION

The Brazilian health system, historically marked by a curative, hospital-centered model of care was in need for profound changes that became effective through the implementation of the Unified Health System (*Sistema Único de Saúde* - SUS). The SUS promoted an important break with the prior political pattern, establishing a commitment of a broad, fair, and democratic social protection, through which the government has the duty to promote healthcare through social and economical policies that guarantee a universal and equal access to services for the promotion, protection and recovery of health.

By reaffirming the SUS principles, the Family Health Strategy (FHS) has significantly contributed with the improvement of health indicators in the country. Current evidence point to a satisfactory development of the strategy, particularly compared to the activities of traditional units, as in incorporates new practices focused on the family and the community, territorialization, greater attachment, community involvement, and following program priorities with the objective to affect the social determinants of the health/disease process[1].

Notwithstanding, the advancements made so far did not cause significant changes in the health model, particularly regarding the working processes, which, because they have maintained the same logic, focused on the disease, and, consequently, establishing weak relationships with the clients' real life and health conditions, determine the insufficient development of the features and possibilities of this level of healthcare and of the system as a whole[2].

The identification of these limitations has, until not, been an encouragement for discussions and analyses aiming to understand exactly where the potentials to overcome these difficulties are located. For some authors[3-5] they lie within the reality of health institutions that experienced the limitations and difficulties involved in the implementation of the SUS and where the healthcare models are constantly questioned and improved, promoting fundamental experiences for transforming and creating new health realities and new possibilities of caring and learning to care.

In view of this panorama, it can be affirmed that the implementation of the SUS, through the development of actions that promote a positive effect on the quality of life of the population, would depend on the capacity to formulate alternative proposals to understand health and its practices[6].

In this sense, several experiences alternative to the hegemonic logic have been introduced to the daily practices of health services, showing there is possibility to develop and incorporate different fields of knowledge and practices in the health actions, setting up new forms of organization of the health service, in a contra-hegemonic direction. Health production by means of differentiated actions also allows for the use of work technologies aimed at the production of care, favoring the creation of new relationships between workers and clients. Once outlined in this perspective, these actions comprise a counterpoint to the crisis of the efficacy and efficiency experienced by the health sector, pointing to a new pathway to be pursued in order to overcome the crisis[7].

It becomes, therefore, clear that there is a need to understand and experiment with proposals that are more comprehensive than those founded on current healthcare models, as well as to clarify the existence of these alternative experiences managed by professional practice and used empirically in the working processes of healthcare professionals. By clarifying these experiences, it would be possible to identify what is being developed in the daily practice of services, as well as the strengths and weaknesses of these practices to transform the working processes in health.

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The present study resulted from a master's dissertation that had as its general objective to understand the working process of nurses and physicians of the Family Health Strategy and identify the alternative strategies and skills developed in this process. Based on this objective, we aimed to map the health interventions within the working processes of professionals, nurses and physicians of the Family Health Strategy, in Health Districts III, IV and V in João Pessoa/PB, revealing the foundations of the care produced using the identified strategies and skills alternative to the hegemonic model.

The importance of the present study lies in the possibility of problematizing the working process of nurses and physicians of the Family Health Strategy, with the purpose to clarify the alternative healthcare rationale, which would allow for exchanging information about successful experiences and the construction of new agreements between professionals and health teams, and between them and the community.

METHOD

This exploratory-descriptive study was developed in João Pessoa/PB, more specifically in the Health III, IV and V. The theoretical-methodological foundation of the present study is guided by the Praxis Intervention Theory in Collective Health Nursing, which is supported by Dialectic Historical Materialism, aiming at the dynamic concreteness of social transformations[8].

With the purpose to identify alternative strategies and skills in the working process of nurses and physicians, questionnaires were applied, and the analysis of the answers showed that a significant number of professionals developed some type of alternative rationale through their health interventions. According to the inclusion/exclusion criteria established in the study, only five professionals (five nurses and one physician) were categorized as the executors of health interventions considered as alternative in their work environment.

To perform an empirical analysis of the material, the transcripts of the semi-structured interviews were carefully read with the purpose of extracting the working process elements (Object, Purpose and Instruments). To do this, the texts were grouped according to each of these elements, with the purpose to analyze them under the light of the analysis categories chosen for the study (Working Process and Healthcare Models). Through this analysis it was possible to relate the positions identified in the texts, in terms of agreement and disagreement with the literature, according to the orientation for the discourse analysis[9].

The chosen analysis method and the identification of the nurses' and physicians' attitude regarding their working processes and healthcare models allowed for the identification of the theme *Alternative Strategies and Skills comprising new healthcare models* as the empirical category of the study.

The study was reviewed by the Research Ethics Committee of the Health Sciences Center at Federal University of Paraíba - *CEP/CCS/UFPB* complying with the formal demands stated by Resolution 196/96, of the National Health Council/Ministry of Health, about human research, and was approved under Review number 0148.

RESULTS

Alternative strategies and skills comprising new healthcare models

Entering the reality of the studied healthcare services revealed the different forms of work by the professionals in face of the demands that emerged in their everyday practice. In this context, their coping has often materialized into insufficient practices to reestablish clients' health, which encouraged the professionals to search alternative strategies that permit them to overcome the difficulties they find and meet the real health needs of the community. The following statement proves this:

> The final outcomes, that is, the resolvability of the complaints is unsatisfactory. They perpetuate and the patient goes from one specialist to another and nothing is solved. So I looked for alternative practice, study alternative practices (...) (INF01).

Also in this sense, the professional continues the statement reporting the conduct of indiscriminate drug prescription in case of tensional pain, common in this context, and the search to overcome this problem by implementing massages.

> There is a pernicious practice by the *superpharmacy*. Drug interaction occurs, the patient is intoxicated by the medication and comes with a problem and then other drug is prescribed to solve that problem from the first drug (INF01).

This panorama of the health professionals' working process invites us to reflect about health care, which should occur from the perspective of the meeting between healthcare professionals and clients, and presupposes a shift of focus, from health practice aiming to cure pathologies to the care of subjects[10].

On the counterpart of the perspective reported in the previous statements, those below indicate the possibility of overcoming the curative focus of health interventions by strengthening educational actions initiated through the literacy of adults in the community.

> (...) it all started with our physician's restlessness. Because they often have to sign the book and they had to leave in their finger print and it was very embarrassing for the client to print their thumb in the 21st century. So she proposed a literacy program for the clients and the team agreed (INF04).

> That way they feel included. He might even be considered a formal illiterate individual, but he is not socially illiterate. So for us it is very important, this has an effect on health (INF04).

Another important consequence of the reductionist view in health, in the biomedical model, refers to seeing the medical-scientific knowledge as the only source of the *truth* about the disease, the patient, and the treatment[11].

Opposite this understanding, on of the interviewed professionals reveal to be open to the inclusion of other forms of practice, as observed in the following statement:

> (...) we made room for those people that are healers, whatever their religion, they will be welcomed (...) They are community leaders and community healers (...) we want them to rescue their place in here too (INF02).

It is, therefore, observed that along with the production and reproduction of the biomedical model, the practices based on popular knowledge remain alive among the community, and are performed with the objective to maintain or achieve wellbeing. The following statement reinforces this understanding.

> (...) it is one more place for them in the community, which is actually confirming what already exists. We are not creating anything. We are giving them room and the chance to speak to people who already have that space in the community (INF02).

The participation of the community, valuing their voice and acknowledging their importance for the attainment of healthcare practices was the strategy used by one of the participants:

> When I worked in the FHP of G., we had the local council (...) which was elected by the community and the participants we started to refer to them as community collaborator (INF03).

> (...) a we know we don't work alone and that popular participation is very important, the community talks loud, you see? And the community has a very strong power. And we must join forces with that community, with people we already have a strong bond (INF03).

The need to acknowledge and reaffirm the importance of the community as well as their constitutional rights and duties, reveals that clients are still denied their place in health services, much likely due to a care focused on procedures, with an excessive regulation of the actions, and centered on disease, always above the subjects.

In this view, Popular Participation appears to be placed as the purpose of the working process by the participants, although motivated, at a first moment, by a regulation. Another highlighted purpose refers to the Promotion of Health, which guides the efforts for the operationalization of the actions.

> We are going out, we are working, making action, we are promoting health, we are in their environment, at school (...) (INF05).

> (...) it started due to our need of meeting one of the principles of the SUS, which is popular participation. An then se were searching a strategy to work on that (INF03).

> So we are rescuing the places of health promotion, because this is health promotion (INF02).

Be including the healers, the popular knowledge regarding the understanding and coping of the health-disease process, become the means or instruments of the working process of the participant, which points to the possibility of integrating popular and technical-scientific knowledge to effectively meet the health needs of the clients. The participant also reported that, although they offer this alternative, they do not lose sight of the origin and consistency of its utilization.

> The process is not a result, it is the origin. She emerges from the need of the community, she knows exactly what need praying and what does not, you see? (INF02).

In view of this possibility, it is important to understand that each specific knowledge (either evidence-based or obtained from historically produced popular practice and experiences), corresponds to possibilities and limitations that must be recognized, at the price of including inadequate instruments in the working process to work with a certain object with a specific purpose. In the following statement, the referred limitation is recognized, which encourages the professional to seek in other knowledge and practices more adequate means, because they are more resolving and less harmful to the nature of the identified health problem.

> This made me curious to research the physiopathology of pain. And I reached the following conclusion: the physical response to the painful stimulus, the organism always responds the same way, by shortening muscle fibers and releasing chemical mediators. And a great part of them are not excreted or annulled with common nonsteroidal anti-inflammatory drugs (INF01).

Once this limitation is recognized, the massage emerges as an important resource, which, in the addressed experience, has been of great contribution to solve tensional pain in young people, adults, and children in primary healthcare, without the need to turn to referrals or drug prescriptions, which are usually unnecessary and inefficient.

DISCUSSION

The analysis of the statements revealed that when the professionals sought alternative strategies, they reported the insufficiency of some interventions developed to meet the health needs of clients effectively. Once centered on the diseases, these actions homogenize the needs and possibilities of treatment, disregarding the specificities of each client, as well as the social nature of the health-disease process.

In this view, the motivation to promote alternative experiences to the regular practices of the services emerges at very particular times of care, when the professionals look beyond what is explicitly shown as a healthcare demand. In the statements, this look is revealed at different times, either in the identification of the constraint caused by the clients' incapability to sign their name on the service forms which materialized into an experience of literacy for adult and elderly clients; or by understanding that it is possible and necessary to provide the physical structure for popular healer practices; or by a clear statement regarding the insufficiency of the primary healthcare devices and clinical practices to understand and effectively and adequately meet the subjects' health needs, which encouraged a professional to see massages as a form to solve pain, overcoming the indiscriminate drug prescription.

From this perspective, the present study results reinforce the understanding about the force with which the curative model is produced and reproduced in the everyday practice of healthcare services, the meeting between professionals and clients can be an important time for identifying the needs that are not reduced to the prevention and control of diseases.

Considering that the proposal of primary healthcare is focused on approximating health professionals and services to the life reality of the population, the most immediate outcome would be establishing an everyday relationship between the professionals and the social, cultural, and subjective aspects of subjects and collectivities. Nonetheless, this approximation has been incipient, with a weak perception of the disease process and the health needs of subjects and collectivities, generating inadequate and inefficient interventions[12] according to some reports.

Regarding the working process elements, the object involved are the healthcare models in the context of the clinical practice in primary healthcare, which are centered on the disease and on the medicalization of health needs, and, thus, are insufficient to adequately meet the clients' health needs.

Maintaining healthcare centered on the disease has relevant ethical implications, as it results in practices performed through strong mechanisms of exclusion, which are produced historically and reproduced in the everyday practice of healthcare services, although it is often affirmed that they have the power to produce health because they guarantee the accessibility to goods and services. The quality of healthcare, however, is not reduced to the possibility to obtain goods and services, but, rather, it presupposes the accessibility to interventions that have the power to meet the needs of the population effectively[13]. In view of this perspective, the construction of new ways to understand and cope with health problems and needs necessarily implies denying any form of reductionism, favoring comprehensive care.

Health, from a comprehensive view, is a complex and multiple-character social production that demands the active participation of all the subjects involved in its production (clients, social movements, healthcare workers, administrators of the health department and other sectors) and in the assessment, formulation, and implementation of policies, guidelines and actions that aim at improving the quality of life[14].

In this sense, the professionals highlight other important aspects regarding the *purpose* of the working process identified in the concepts of Health Promotion and Popular Participation. Thus it is observed that the purpose defined in these two concepts approaches the possibility of rescuing the clients' leading role in the health interventions, increasing their participation and exercising a look that seeks to truly see their needs.

Popular Participation, as a purpose of the working process in health appears to result from the statement of a new health management paradigm, founded on two essential premises: the necessary popular participation in policy management, incorporating several actors of civil society, and the local valorization, based on the principle that issues can be solved better locally, provided that the voices of the community are heard and considered[15].

The Health Promotion paradigm has, in its foundation, the power to approach health problems, focusing on the ways that the social actors involved in health promotion think and act. By adopting the broader concept of health, it is considered that solving problems and answering needs resides in the power to aggregate and mobilize the social subjects and communities[16]. Thus oriented, the healthcare actions contribute with establishing a network of commitments and co-responsibilities, aiming at a joint and connected creation of the necessary strategies to maintain life.

It should be noted, however, that despite the statements recognizing that the development of a collective and democratic health project must involve dialoguing and exchanging experiences between different knowledge with the purpose to promote health and include subjects and collectivities in the discussion and when making decisions in the sector, the health practices often are incapable of make these statements effective[17].

The popular knowledge that promotes a certain understanding and intervention about the health-disease process and those regarding integrative and complementary practices, traditionally founded on the oriental rationale emerge as instruments of the working process in health in the studied reality. Traditionally marginalized in this context, as they not always meet the premises or rationality and scientificity, these practices are sought as a means of solving identified health problems.

In fact, the nature, itself, of health work demands acts and actions from the workers that are not founded only on knowledge, methods and techniques they acquired in their professional training, and, thus, it is necessary for them to combine values and knowledge produced and shared between them and the clients in everyday health practices[18]. Nevertheless, it was also found that a combination between their knowledge (of healers and healthcare professionals) remains utopic, because although they are in the same setting, they do not talk much and only respect each other.

In addition, the working process in health it is crucial to know the instruments that can be combined and that, simultaneously, affect the elements to achieve the purposes. It is observed that that in the Family Health Strategy, the health units and teams turn to different instruments, without, however, knowing if they are capable of recognizing the health needs and it they can deal with them[19].

Therefore to overcome the *trench* separating the technical-scientific knowledge and practices of the disease dynamics and cure from the popular world, the health systems must learn to consider clients who are ill or susceptible to illness within their relationships, contexts and representations, thus comprising a radically diverse way of understanding health and disease, and of organizing the services to intervene on their determinants[20].

CONCLUSION

The analysis of the working process revealed a fragile connection between the different elements that comprise it, indicating that the way that the professionals organize their work in their daily practice, despite being aimed at the transformation of healthcare models, finds significant resistance due to the capacity of production and reproduction of knowledge and practices of tradition healthcare models, which are, in essence, inefficient, ineffective and excluding.

Furthermore, since the identification of a specific need, which implies from limiting working objects according to the purpose of meeting that need, to the selection of instrument and means considered necessary and sufficient to achieve that purpose, healthcare professionals apparently state that it is possible to transform the reality imposed by hegemonic models, by overcoming the invisibility of the subjects in healthcare services, and, above all, by assimilating, combining, and legitimizing knowledge that has been historically denied, but are equally effective to guarantee the quality of the interventions.

In this view, it is concluded that the existence of alternative strategies and skills within the working process of nurses and physicians of the family health team is an embryo to be developed to transform working processes and overcome the healthcare models that remain in the opposite direction of the reform that is intended for the sector, in the sense of providing quality care that is more comprehensive and humanized. To do this, it is emphasized that it is necessary to recognize and involve the management in these initiatives, particularly through the devices that permit a continuous problematization of the current concepts and practices, in the everyday practice of each team, challenging professionals and the institution to incorporate new knowledge and activities to make the interventions adequate to the life and health reality of the population.

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