ORIGINAL ARTICLE

Family discussion in the family health strategy: a working process under construction*

DISCUSSÃO DE FAMÍLIAS NA ESTRATÉGIA SAÚDE DA FAMÍLIA: PROCESSO DE TRABALHO EM CONSTRUÇÃO

DISCUSIÓN DE FAMILIAS EN LA ESTRATEGIA DE SALUD FAMILIAR: PROCESO DE TRABAJO EN CONSTRUCCIÓN

Silvia Matumoto[1], Silvana Martins Mishima[2], Cinira Magali Fortuna[3], Maria José Bistafa Pereira[4], Maria Cecília Puntel de Almeida[5]

ABSTRACT

The objective was to follow the working process of a family health team in their regular meetings held to discuss family cases. This study used a qualitative approach, founded on the theoretical and methodological framework institutional schizoanalytic analysis. Seventeen meetings were followed, which counted with the participation of an average of 7 to 8 of the 17 workers participating in the study. The team held discussions on the families, and classified them according to the risk criteria, reviewed what had been accomplished in the meting and searched for action alternatives. There were disagreements when participants faced differences and difficulties to be heard by their colleagues, which were gradually overcome, and made it possible for the members to share care situations they had in common. The team made an effort to analyze the how they take care of the families and to get them to integrate. It was concluded that the meetings favor the production of care and the construction of group work as the team, while delivering care, deals with the subjectivities produced in their practice.

DESCRIPTORS

User embracement
Public health nursing
Primary health care
Institutional management teams
Family health

RESUMO

Objetivou-se acompanhar o processo de trabalho de uma equipe de saúde da família em suas reuniões de discussão de casos de famílias. Estudo de abordagem qualitativa, apoiado no referencial teórico-metodológico da análise institucional, linha esquizoanalítica. Acompanhou-se 17 reuniões, com participação média de 7 a 8 dos 17 trabalhadores que foram sujeitos do estudo. A equipe realizou discussão sobre as famílias, classificando-as segundo critérios de risco, refletiu sobre o que foi realizado e buscou possibilidades de ação. Houve estranhamentos ao se depararem com diferenças e dificuldades de escuta entre seus membros, que gradativamente foram vencidas, possibilitando situações de cuidado compartilhadas. A equipe empreendeu esforços para analisar o modo como cuida das famílias e para conseguir integração. Concluímos que as reuniões favoreceram a produção de cuidados e a construção da grupalidade na medida que a equipe, no cuidar lida com a subjetividade produzidas no trabalho.

DESCRITORES

Acolhimento
Enfermagem em saúde pública
Atenção primária à saúde
Equipes de administração institucional
Saúde da família

RESUMEN

Se objetivó acompañar el proceso de trabajo de un equipo de salud familiar en sus reuniones de discusión de casos de familias. Estudio cualitativo, apoyado en referencial teórico-metodológico de análisis institucional, línea esquizoanalítica. Se acompañaron 17 reuniones, con participación media de 7 a 8 de los 17 trabajadores sujeto del estudio. El equipo discutió sobre las familias, clasificándolas según criterios de riesgo, reflexionó sobre lo realizado y buscó posibilidades de acción. Hubo sorpresa al repararse en dificultades de escucha entre sus miembros, que gradualmente fueron vencidas, posibilitando situaciones de cuidado compartidas. El equipo emprendió esfuerzos para analizar el modo de cuidar a las familias y para conseguir integración. Concluimos en que las reuniones favorecieron la producción de cuidados y la construcción de grupalidad en la medida en que el equipo, al cuidar, se enfrenta con la subjetividad generada en el trabajo.

DESCRIPTORES

Acogimiento
Enfermería en salud pública
Atención primaria de salud
Equipos de administración institucional
Salud de la familia

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[1] Professor, University of São Paulo at Ribeirão Preto, College of Nursing, Maternal-Infant and Public Health Department.Ribeirão Preto, SP, Brazil. smatumoto@eerp.usp.br [2] Associate Professor, University of São Paulo at Ribeirão Preto, College of Nursing. Ribeirão Preto, SP, Brazil. smishima@eerp.usp.br [3] Professor, University of São Paulo at Ribeirão Preto, College of Nursing, Maternal-Infant and Public Health Department.Ribeirão Preto, SP, Brazil. fortuna@eerp.usp.br [4] Professora Associada da Escola de Enfermagem de Ribeirão Preto da Universidade de São Paulo. Ribeirão Preto, SP, Brasil. [5] Full Professor, Associate Professor, University of São Paulo at Ribeirão Preto, College of Nursing. Ribeirão Preto, SP, Brazil. *In memorian*.

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INTRODUCTION

The Family Health Strategy (FHS) was proposed as a response to the crisis currently faced in the Brazilian health system, to break with the logic of the medical-centered, biologicist health care delivery, with an emphasis on productivity. The FHS recommends that team care practice is centered on the needs of the population, to promote health actions through social participation and respect for the knowledge of all those involved in the process through the establishment of bonds and responsabilization of collective and individual health actions[1].

The FHS is the main focus of primary health care as the re-organizer of the Brazilian health system. It is the main entrance into the health system, for acquiring care in all the phases of life for people, with varied and sometimes unspecific demands and problems, and that do not always fit into patterns and protocols[2]. Hence, both the FHS and the characteristics of the primary health care itself require teams to permanently transform work processes, always keeping in mind the view of health and disease that grounds the FHS[3].

The work process in the primary health care system in its established format follows the dynamic of hospital organization in relation to the way workers and users behave. The center of attention is the dynamic of relationships of power, in which the dependency of users and a focus on procedures and sporadic care, among other issues, stand out[2-3]. However, the complexity of life and issues people have brought to the health services challenge workers at all levels (managers, administrators, workers from the primary health care network and others) to seek new ways to deal with and produce health[4].

The meeting space for discussions of families under care in the teams' work process has the potential to create collective projects on health care and to constitute these groups of workers as a team as they perform their function of caring for users.

The meeting space for discussions of families under care in the teams' work process has the potential to create collective projects[5] on health care and to constitute these groups of workers as a team as they perform their function of caring for users[6]. However, one needs to be attentive to recognize the logic that constitutes the axis of the organization of teamwork, that is, it is either about the logic of hospital organization or there is a new logic being constructed for the primary health care delivery.

Therefore, even though this study was carried out in 2002, it is still relevant because the challenge presented in the reorganization of the work process within the FHS still persists[2]. This paper contributes to current scientific production given its methodological/theoretical framework and the exposure to tensions verified in the work process in the production of care jointly with the monitored families. This is an original article, not previously published, part of a larger study addressing the relationships between workers and users from the perspective of the welcoming reception provided by an FHS team.

Schizoanalysis[7] was the theoretical framework, which is one of the branches of institutional analysis[8], through which different surfaces composing reality were explored. The reality explored here was the work process of an FHS team used in meetings to discuss the cases of the monitored families.

Schizoanalysis is suitable to be applied in groups[9] so that these can perform self-analysis and self-management. Self-analysis consists of a process in which collectives can express and understand their problems, needs, non-knowledge at the same time in which they produce self-management. They organize themselves to produce the *dispositfs* required to improve their lives based on a new understanding of reality. When performing such analyses, the team can unveil occult aspects in work relationships. These are directly related to the way institutions that compose a society conform to the standards and rules of functioning for this same society. There are some examples of institutions in the field of action of FHS: health, family, hospital, medicine, professions, and the church, among others. Institutions are always in movement, oscillating between maintenance and creation, conservation and dissolution. Maintenance processes are those already established and processes of transformation and creation are forces that compose the instituting movements[7-8].

The workers and the population are *used* to the established traditional hospital logic focused on individual medical and technological care. It is necessary to construct a *culture* of family care, of health care, of care that enables individuals to become emancipated and to exercise their citizenship. This change can be put into operation as the team works, and gradually reformulate the expectations and concepts of health, disease and family health care. This work seeks to enable the population to understand they can demand attention from the team on issues that go beyond biological disease. These demands refer to the social production of the health/disease continuum such as violence, drugs, unemployment, inequality, and other social needs. The production of this demand is done through the bond established in the daily relationships between users and the team. We highlight that when the team is faced with demands it offered itself, it lacks tools to deal with such problems.

The inclusion of a community agent in the team was a concrete change. This agent has to reside in the area, be familiar with the people's way of living, with their histories, suffering and how they express it, which are elements that are part of their knowledge and instrument of work.

When the community agent arrives, s/he introduces strangeness into the team, causes de-territorialization.

Workers do not know how to deal with this new member and with the new information s/he provides. This de-territorialization – a state from which one cannot return once it is reached, because one has already become another, something has happened, and the new proceeded with[10]. The change has great potential to open cracks, so that new ways of acting are devised based on what was experienced, that is, based on the way of life, on pain and suffering, sharing decision-making, joy and frustrations among workers and users. This is the power that comes with the introduction of the community agent. This element puts into operation a "machine" that sees neither standardization nor any other impediment, and creates a unique and unrepeatable encounter, an action, a singular act the difference of which is the meaning it has for those involved.

But this instituting power can be captured. The community agent is also subject to the hospital logic and the needs of workers to the detriment of the needs of the population. Hospital standards and rules, specialties, the number of slots, schedules and scope areas also guide the community agent. The community agent can also be captured in the team's relationships; the power-knowledge of technicians can overlap the power-knowledge of users and populations. In an unequal fight, people silence themselves, users submit themselves, and community agents adapt (to keep their job perhaps)[11]. The workers are also affected; they feel powerless when they do not know how to deal with problems never faced before in the scope of their specialty and that now cross their daily routine, even if they do not want to, through the presence and voice of the community agent. Workers do not have tools to face them, so they repel them. Hence, users and community agents are *not listened to* and if they are not listened to, there is no reason to talk. There is neither exchange nor dialog. There are no prospects to integrate the team to produce health actions[12].

Schizoanalysis[7] is proposed to explore the map of predominant lines and surfaces that constitute the reality in production. It acknowledges both the institutions and the way the studied group functions, as well as the power and resistances to produce new forms of caring for families. The map is constructed based on the experience of the analysis with the FHS team itself, uncovering new meanings and non-meanings that are undertaken in the work process, producing knowledge concerning the experienced reality. In schizoanalysis this process is called cartography, which constitutes its research method[13].

We need to think about change in health and make it effective though the creation of intermediations to produce actions that satisfy users and workers, realizing desire and other subjective demands. Engendering are collectives and put at stake, within us and outside us, as multiplicities, affections, and events. The meetings where cases are discussed by the family health team represent an important opportunity to integrate and connect care actions and cope with the complexity of problems and health needs of individuals, families and the community[14].

The functioning of current modern societies subjects us to a global political system unified and structured through segments lines. We are segmented by lines that define strata of our living. There are three lines, jumbled together, that compose us – linear, circular and flight[10]. The first two set up codes, territories, and forms of displacement, for instance: the linear as the opposition between right and wrong; the circular departs from a central point such as the physician's work; it makes the circles of the remaining categories orbits. The lines of flight emerge in and from the daily routine. They are almost imperceptible and emerge in the act in which health work is produced, jumbled with other lines, giving space breaking established routines, enabling the creation of new forms of care delivery.

The segmentation established in the health field traps us with the known, with attributions and functions, cores of competence and the responsibility of each profession defined and regulated by professional boards; without observing the movements of lines of flight that pass through these lines that delimit doings that cause tension in work[4] relationships in the production of care.

To identify the way the teams are producing themselves as collectives and building the work process in the FHS encouraged us to use the schizoanalytical framework that points out breaches having the potential to break with the old and seek a new way of delivering health.

OBJECTIVE

This study followed the work process of an FHS team in its meetings to discuss cases of families.

METHOD

This qualitative case study based on institutional analysis in light of the schizoanalytical framerwork[7-8] worked with a family health team who experienced a process of self-analysis and self-management, focusing on their work process.

Schizoanalysis proposes that records be taken in a sort of *log book of a trip*, a singular, unique and unrepeatable cartography in which the most important is the new, the difference, the singularity. The cartography process refers to the composition of a sort of a map based on objective and subjective reports, where the meanings and loss of meanings perceived by the study subjects and the researcher given what they experience, are recorded[7].

The research process and data collection occurred through the participation of the researcher in the meetings where the FHS team discussed cases of families from January to December 2002. The team members presented cases of families during the meetings and the researcher participated mainly by making questions in order to favor

the team's self-analysis during the care process of a specific family. The questions aimed to make explicit the focus of the team's concern and the way they relate to each other during care delivery.

The researcher participated of 17 meetings where the FHS discussed cases of families. The average number of participants in the meetings was 7 to 8 from a set of 17 workers active in the unit in the research period: five community health agents (CHA), one nurse, one physician and one nursing technician composing the FHS team and the other workers in the unit included one nurse, one gynecologist, two pediatric physicians, three nursing technicians and one manager (physician). The meetings were recorded and later transcribed.

The project was approved by the Research Ethics Committee at the University of São Paulo at Ribeirão Preto, School Health Center of the Medical School, (protocol nº 0027-CEP-CSE-FMRP-USP). All the participants signed free and informed consent forms according to Resolution 196/96 from the National Council of Health.

RESULTS AND DISCUSSION

The results and discussion are presented together to maintain coherence with the methodological-theoretical reference adopted. The results are narrated through scenes given the political choice of narratives[13].

The meetings for case discussions were one of the team's first activities. These meetings were implemented in the unit aiming to enable the team to discuss the families and classify them according to risk criteria[15] by colors (green, yellow and red) from the greatest to the lowest risk so that they could systematize care provided to families.

Scene 1 – Rapidly coloring the families

The first contact with this activity caused a certain uneasiness. Early in the morning, sleepy faces and bodies slowly take their places in the room. Those who arrive late bring chairs. Some of them sit almost always in the same position and others in more or less fixed places. Some wait in silence with a lost stare. Others discuss some case or administrative issues in sub-groups while they wait. So someone proposes: *Shall we begin?*

Classifying families according to risk of illness seems to be a mandatory task. But how does each team member understand the objective of this activity? The team reproduces the technical *modus operandi* of hospital logic, the production of procedures. The service's user is included as an element of the process, more object than person, equal to any other, singularities are not considered; users are not actors or co-producers of health actions, which would be possible in such encounter.

There is always someone who presents the cases, few workers complement the main cases reports and questions are in general to clarify specific, more individual issues: *what does she do? Does she do the house chores, go to the Community Integration Program?* There is a certain hierarchy reflected in the order in which questions are posed: first the physicians, the nurses and then the rest. Requests to clarify technical terms are promptly and technically answered: *What is a colostomy bag?* The most predominant interventions are those directed to the production of procedures, pushed by the force of the hegemonic medical care model: *CA2 – I'll go visit her, see if she has done the exams, whether she'll do the surgery.*

How fast they talk about the cases also makes an impression! We do not know if the team is already familiar with the cases, though certainly not everyone in the team is familiar with them. It seems it is extremely fast, so one does not think much and *feels* even less, a technological speed to obtain domain and power, which leads to a slow death, unpowered bodies, with no identity, excluded from the process.

Somebody suggests a color, which fades quickly, has no shine. Nobody comments, the word floats in the air, and they pass to another case. The expression *Family number...* seems to mark the rhythm of the meeting. Monotonous. And affections pass through the body:

> CA2 – Whoa. I'm sleepy!
>
> Silence
>
> CA2 – Let me see what we have. Family number… (Meeting February 5th, 2002).

Coloring seems more a child's play. A certain becoming-child of the team that could bring life and energy to this task, which is so dull, a task that needs to be completed quickly.

The presentation of the cases occurs amidst an intense movement of people entering and leaving the room. Some workers seem to be just passing by, enter into the room to get stamps, forms, medication, devices and leave to answer the phone or are called by other workers to perform other tasks, so the number of individuals attending the meeting and participating in the discussion of cases in the search for care alternatives varies greatly.

The movement in the room deflects the attention of people from the case; the one responsible for presenting the cases makes an effort to keep focused. It is uncomfortable, people feel a lack of prestige, an absence of consideration that hinders team workers from developing a feeling of ownership, from understanding the relevance of what is being discussed in relation to what the group sees as it is its task at that time.

The scene reveals the phenomena involved in the team-family and workers-users relationships; it represents the attention paid by the team to the family in their discussion and shows the place that is reserved for users, or perhaps, the lack of a place or of conditions, the lack of willingness to pay attention. Sometimes this is not even the

attention due the complexity of some cases, which generates much anxiety.

The way the team works—amid so many entrances and exits, affections and dislikes—hampers teamwork and is not conducive to the team structure because it occurs as the team operates[6].

Some workers are more constant in the meetings: the community agents and the physician/manager of the unit. The last plays an essential role. She is the main listener to whom cases are reported despite the apparent chaos and general lack of interest. Careful and attentive, she listens carefully, takes notes, asks, shows interest, insists, and makes a great effort to bring about a fusion in the *between*, to open cracks in the traditional mode of disciplines, hierarchies, and rules.

The meetings to discuss cases represent an opportunity to reflect upon what has been realized to that point and consider ways to multiply possibilities of action, unveil interests and desires, power and impotence, predominantly hidden by the technical practice.

What workers have on their hands to perform this task are families' files, registration records, follow-up and monitoring concerning risks, visiting reports, individual files and especially the intensity of feelings and other resonances generated by the demands users placed on the workers, mainly the community health agents. Resonances accruing from direct contact with people's way of living, in their homes, on the streets, with pain, hunger, family conflicts, death, numerous offspring, dirt, cleaning, smelling food, an invitation to have a cup of coffee, be spied out through the closed gate... Resonances arising from identification with families, and other potential resonances that may occur when on the streets, knocking on doors, working in family health.

At the time these are discussed, emotions are intensely relived, conscious and unconscious processes. There is no way out despite the great effort spent making these unnoticed.

> CA2: Mrs. Y is 24 years old and is illiterate! [...] Really, imagine that! She's my age. She doesn't look like 24 years old, no way! [...] she has to have a gynecological exam, it's important.
>
> Nurse 2 – She's never been consulted? (Meeting – February 5th, 2002).

The strangeness and indignation manifested by the community agent in the face of the fact that the user is illiterate did not echo in those present to the point of mobilizing them to discuss the situation and seek individual or, if this same situation was found in other families, collective interventions. Deterritorialization expresses: *Really, imagine that! She's my age*, but is lost, or more precisely, it is re-territorialized into the known and safe field of the established technical-scientific issues: taking the gynecological exam is certainly important, but not the only important issue.

Discussions take place all the time on the most varied and complex themes, which is repeated in various meetings such as violence, abandonment, alcoholism, family planning for numerous families in poor living conditions, homosexuality, abandoned houses, fear of death, and many others. The team identifies problems without being able to devise any alternatives to address them, thereby leaving them in suspense. An unspoken not knowing-how-to-do hangs over and they stay in known territory, that of the technical-scientific modern medicine.

This unpreparedness of the team actually shows the unpreparedness of society, of the institutions educating professionals, health authorities, all of us. Isolated and unconnected approaches to these complex themes do not cause an impact on the problem.

> Physician 1 – There're so many abandoned houses here!
>
> CA4 – This house belongs to a doctor [...]
>
> CA2 – There's a piece of land on the [street] LC [...] that has gone to seed, there's a lot of small animals. The dentist had a wall built with his own money
>
> CA4 – There's garbage in that house for sale.
>
> CA1 – The house at the corner is even worse.
>
> Physician – Perhaps we should make a list of the abandoned houses, invaded houses (Meeting – February 8th 2002).

The challenge of building inter-sectorial, interdisciplinary and trans-disciplinary elements seems to be related to the ability to overcome the segmented nature of society and delimitations of power/knowledge established by the disciplines, of permitting incompleteness, not knowing and the need for somebody else to act.

In the context of technological speed, the team has no time to listen, to give way to the pain of one of the community agents given the death of a resident she monitored.

> CA 1 – Let me talk about something, NT4 (nursing technician) just told me that Mr. JD died (tears)
>
> Physician 1 – Did he have any problem?
>
> CA 1 – He was about to have a prostate operation.
>
> Physician 7 – The other day a patient was going to be operated on, [...] (CA 1 looks at the ground) (Meeting February 8th 2002).

Pain and loneliness, helplessness, despair. Fallen body, decayed. Gaze on the floor. The team is unable to sympathize with the pain of its fellow. Or, if there is any affect in the workers, they do not feel comfortable manifesting it. The conception that health work consists of technical knowledge that excludes emotions and feelings predominates. They do not allow themselves to live out the moment, even to plan a proposal to care for the family, to welcome the pain of loss as *someone who cares* because *someone under their care passed away*[16].

They rapidly pass to other subjects. But without realizing it, they slowly approach the theme of 'death' through the discussion of other cases, recalling positive and negative experiences, and indirectly manifesting their own fears, in a movement of successive and gradual approximations of this so-obscure learning object.

Near the end of the meeting, they outline a proposal to care for the bedridden. Could it be an indirect way to deal with the subject 'death' and 'dying'? And at the same time, open up a breach to produce care for the bedridden (those who are closer to death)? Could it be an opportunity for the team who address the theme the way it can?

> Physician 7 – we could get these more complicated cases, of bedridden patients (…)
>
> Physician 1 – for us to learn (…)
>
> Nurse 2 – We have a list. There are 21 bedridden patients. […] There're 24.
>
> CA 1 – Eleven of these are mine (Meeting February 8th 2002).

This agent tentatively expresses her pain by announcing that half of the bedridden to be monitored live in her scope area. Among the tangle of presented issues, whether they were discussed or not, considered or not, she still expects care and welcoming.

Scene 2 – A slightly more attentive view. Expressing some difficulties,

Here, the families are classified but classification is not the main issue. There is emphasis on the names of the members of families. The reason the cases were chosen is not explicit but there is space to express affections and difficulties in dealing with the cases.

There seems to be a relationship between the construction of the team's group awareness, the possibility of expressing their needs, anxieties and ability to listen, to keep calm and care for each other. However, the team does not manage to significantly modify the type of intervention proposed for the users' critical situations.

> CA 3 – […] yesterday, when I was leaving for a visit, I saw she was sitting there, you know? So I looked at her, I saw she had• being crying and I said: what happened R? You look sad, it seems… Then she cried, cried, didn't stop crying. […] they were in a meeting, right? There were Dr. physician 7, Dr. Physician 1 and Nurse 1, right? And… […] She said that she hadn't … nothing was worth it… she couldn't … she would end her life, you know? I got desperate, I said: Oh God! I didn't even know what to say to her?[…] Then, she started to tell me the whole history, you know? […] So she said he said like: -mom, buy a DANONE for me? And I couldn't buy•, you know? And she cried, said: - wow! She said: - he has nothing to wear […]
>
> SILENCE (Meeting April 23rd 2002).

At the end of the case discussion we realize that the predominant way our society functions is to put the responsibility on and blame the individuals themselves for their own situations, not considering the complex process of historical-social production. The response reveals what was possible to do at that point, to protect oneself from pain, from the pain another causes, from the inability to sympathize with another for his/her pain and suffering, putting the responsibility on the person; to protect oneself from the impotence to deal with the situation; protect oneself from one's own suffering that accrues from the way the facility and the care network functions[5]. The result is sheltering in the omnipotence embodied as health workers.

It seems that the space where case discussions occur is reserved for a sort of administration of relationships among the various workers and their cores of professional knowledge[4], without however clearly defining who would be the manager of such care, what the contribution of community agents would be. Paradoxically, this worker with lower technical qualification and less power within the team is the one more capable to heed and care for issues with the required subtlety and tenderness.

Hence, the agents share the experience of being caregivers the way they can and at the same time seek to sensitize the other team members to care about the cases, the families, opening up opportunities to pass on caregiver abilities to the team, to care about the cases, support the agents and care for themselves as a team.

Slowly the team gets involved and discovers from a case a breach through which to pass a line of flight, in the field of family planning, sketching a cross-sectional practice from the perspective of being a woman, from a marital relationship point of view:

> Physician 1 – [...] Hum... this is actually a thing for women, isn't it? This low self-esteem... And it is not only among low class women, no! We've seeing it around, girls who study, go to college, get involved in relationships…[…] Totally pathological relationships, submission, you know […]
>
> Participant – And this doesn't happen only with young girls. Older women also. And it happened…
>
> Physician 1 – So, I guess that this is something we should, with this woman, we should rescue her. She is not some appendix of men, right? […] I guess that someone should talk to this girl, you know? And… like, a pregnancy is also a risk for her in this situation […] (Meeting, April 23rd 2002).

But this energy they had there did not become sufficiently intense to engender a desirable machine, a resonant body that finds another body in compatible resonance, capable of producing a *dispositif*. A *dispositif* that detonates new forms of *womanhood* in a society like ours, capable of mobilizing women and men to break with the established modes and discover more creative ways of affectionate, gentle, tender living, of producing and reproducing themselves.

And so, there is certain blindness in the team, a certain difficulty getting more involved, perhaps because most were women. And in these circumstances, in the face of pain and difficulties so intensely and closely experienced, how can one be able to deal with the needs of another? How can one produce caregiver actions if having contact with the case, with the anxiety of the other workers, generates such great difficulty bearing the results?

> Nurse 2 – […] ok, but if let her (user) get on our nerves? […] if we let her drive us crazy, then the situation becomes untenable […]
>
> CA 2 – none of us do that!
>
> Nurse 2 – You get here like [...] Oh my! The pain!
>
> CA 2 – […] She isn't eating […] He was supposed to go there yesterday and he said he couldn't go visit her because he had to supervise a resident. You weren't here yesterday (Meeting February 8th, 2002).

It is difficult to bear suffering that accrues from work. The workers do not pay attention to the telltale noises that reveal the team's way of working: a movement that refuses pain. Examples are: the anxiety of the nurse because she could not bear the agent's outflow, the dissatisfaction of the agent because the physician did not visit the patient the day before and because she could not count on the nurse who was out of the unit. These are ingredients that compose the network of relationships in the team.

Scene 3 – The construction of group awareness and coping with difficulties in the production of care.

Group awareness is being built. The team faces the pain of being imperfect, of depending on each other. It undertakes an effort to accomplish the task of analyzing itself despite movements of resistance. The team strives to integrate.

In the effort to see itself, the team finds a way to cope with the difficulties of interacting and choosing to discuss cases of families that receive private medical care or care from other services. Slowly the team brings cases it monitors, often with explicit differences, disagreements and competition.

> Physician 2 – and then they've scheduled with me. I said… And then there's this history, ah no, it's from the Family Health […] I'm in my room, I make the consultation with good will. I have no bonds with the child and… the people who were seeing the child will lose their bonds with this child… and I get kind of lost, don't know what to do, because I received this child I didn't care for before and who was… Who has a return visit in five days and there wasn't any active search. If the child didn't come… we let it be…(Meeting - September 3rd 2002).

When the worker expresses his/her limitation in dealing with the case, despite the outflow of repressed feelings, fear, pain, insecurity, helplessness, there is the possibility to create a mutual support to strengthen, to help the user to endure his/her pain.

> Nurse 2 – and I guess that we need to look at ourselves, at the service and see also... There are people who can do some things easily, while other people can do other things easily. Nobody is obligated to like everything, to be able to deal with all situations and… be prepared for that, you know? […]
>
> Physician 1 – and people feel well when supported, right? […] And I keep in mind […] given all the, the difficulty, Nurse 2 expressed, you know, I'm not super man but […] I'm willing to do the follow-up, I like to do it, you know. (Meeting - October 1st 2002.

Slowly, workers found ways to cooperate with each other in order to deal with the difficulties faced at work and thereby produce health actions. In the movement to seek ways to help users to deal with their problems, the meetings to discuss the cases also serve to deal with the case of the team[17]. They discuss and inform of administrative and general issues. In some meetings, the discussion was focused on the difficulties among workers, enabling them to express the differences in the way they work, caring for each other, for others, for the service's material and equipment, how they help each other and receive help, express doubts, difficulties, resentment, indignation, and many other emotions produced in everyday life.

CONCLUSION

The discussion of the cases of families opens up the possibility of perceiving hidden landscapes and creating others. Departing from the surface of families' classification, of criteria of technical risks, possibilities to produce care given the production of subjectivities are opened up.

The stage where cases are presented is opened to the multiplication of possibilities of actions and production of care, which may emerge from lines of flight, in small breaches, allowing flows to pass, intensities and desires, though not always caring, not always liberating.

The team's established way of functioning can lead it to the continuous control of families, entering their houses, performing bureaucratic control through the community agents, transforming the strategy of change in a way to reproduce and maintain what already established.

The case discussions represent the starting point to express and deal with anxieties, fear, insecurities, and fantasies the team faces when confronted with differences. It also represents an opportunity to express and elaborate on anxieties inherent to the work process performed in primary health care so that the workers themselves support each other, becoming protagonists of health actions and capable of learning from experience, of letting others support and care for them, and also allowing themselves to support and care for others.

We highlight that the teams need to discuss not only the most difficult or insoluble cases, but also present those with which they obtained success and positive results. Learning and teaching is an everyday toil. Would the family

be able to participate in the discussion of its own case? We point here to a limitation of this study: the lack of participation of the family with the team to seek ways to deal with problems, limitations and potential, as a way to encourage individuals to become protagonists, breaking with what is already established. The discussion of cases of families with the families themselves would be a different and brave way to deal with family health.

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Correspondence addressed to: Silvia Matumoto
Av. Bandeirantes, 3900 - Campus da USP
CEP 14040-901 - Ribeirão Preto, SP, Brazil