

Challenges and Opportunities of Teamwork in Primary Health Care (PHC)

Desafios e Potencialidades do Trabalho em Equipe na Atenção Primária à Saúde (APS)

Retos y Potencial del Trabajo En Equipo en la Atención Primaria de Salud (APS)

RESUMO

Compreendemos que o trabalho em saúde aciona mecanismos diversos para a produção afetiva e efetiva do cuidado. Nesse diapasão, tem-se por **Objetivo:** investigar os processos de trabalho na atenção primária à saúde à luz das relações de trabalho e produção de cuidado. Para tanto, propusemo-nos a verificar como o trabalhador se percebe na produção de cuidado e analisar os processos de trabalho em saúde, implicados nessa produção. **Método:** tratou-se de uma pesquisa-ação, com abordagem qualitativa, realizada com 17 profissionais de saúde de uma unidade de atenção primária em Fortaleza, Ceará. **Resultados:** as polifonias produzidas revelam que o trabalhador da saúde encontra seus processos de trabalho fundamentados em ações produtoras de data para parametrização de atividades e tomada de decisões de saúde. **Conclusão:** Apesar de se sentirem diminuídos em suas dimensões cuidadoras, os profissionais desenvolveram estratégias de resistência. Foi possível identificar potencialidades e situações limitantes no desenvolvimento do trabalho na APS.

DESCRIPTORES: Atenção Primária à Saúde; Acolhimento; Trabalho em saúde; Saúde Coletiva.

ABSTRACT

We understand that health work triggers various mechanisms for the affective and effective production of care. With this in mind, our **Objective:** is to investigate work processes in primary health care in the light of work relations and the production of care. To this end, we set out to verify how workers perceive themselves in the production of care and to analyze the health work processes involved in this production. **Method:** This was an action research project with a qualitative approach, carried out with 17 health professionals from a primary care unit in Fortaleza, Ceará. **Results:** The polyphonies produced reveal that health workers find their work processes based on actions that produce data for parameterizing activities and making health decisions. **Conclusion:** Despite feeling diminished in their caring dimensions, the professionals developed strategies of resistance. It was possible to identify potentialities and limiting situations in the development of PHC work.

DESCRIPTORS: Primary Health Care; Reception; Health Work; Collective Health.

RESUMEN

Entendemos que el trabajo sanitario desencadena diversos mecanismos para la producción afectiva y efectiva de cuidados. Teniendo esto en cuenta, nuestro **Objetivo:** es investigar los procesos de trabajo en la atención primaria de salud a la luz de las relaciones laborales y de la producción de cuidados. Para ello, nos propusimos verificar cómo los trabajadores se perciben a sí mismos en la producción de cuidados y analizar los procesos de trabajo sanitario implicados en esta producción. **Método:** Se trató de un proyecto de investigación-acción con abordaje cualitativo, realizado con 17 profesionales de salud de una unidad de atención primaria de Fortaleza, Ceará. **Resultados:** Las polifonías producidas revelan que los trabajadores de salud encuentran sus procesos de trabajo basados en acciones que producen datos para la parametrización de las actividades y la toma de decisiones en salud. **Conclusión:** A pesar de sentirse disminuidos en sus dimensiones asistenciales, los profesionales desarrollaron estrategias de resistencia. Fue posible identificar potencialidades y situaciones limitantes en el desarrollo del trabajo en APS.

DESCRIPTORES: Atención Primaria; Acogida; Trabajo Sanitario; Salud Colectiva.

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INTRODUÇÃO

The production of knowledge based on lived experience has been a constant topic of debate in public health among universities and health systems and services. The proposal for techno-assistance and healthcare models that promote guaranteed health rights has generated important discussions and recent proposals⁹. For the Ministry of Health⁴, the technological aspect is not limited to the selection of technical-scientific resources, but is shaped by the approximation of reality with social needs and contact with local diversities.

In 1978, in response to decades of social demands in the health field, related to the quest to bring health care closer to the population, the World Health Organization (WHO) held the first International Conference on Primary Health Care in Alma-Ata, Kazakhstan. According to the Official Declaration of this Conference, Primary Health Care (PHC) should be based on health care for individuals, families, and communities, with full participation and at costs that the local community and the country can bear. The main forms of health care were strongly linked to the prevention of infant and perinatal mortality, through an emphasis on childhood immunization, prenatal care, and well-child care. 18 In Brazil, PHC

adapted relatively well, mainly because it was in line with the principles of the struggle for Health Reform. Giovanella (2013)¹³ reveals that the use of scientifically proven and socially accepted technologies was promoted, with an emphasis on community participation and the democratization of knowledge, including traditional health practices, midwives, and community workers, reducing the paradigm of medical knowledge.

In the current municipal management of health services, with the implementation of a new techno-care model, strongly based on spontaneous patient care, we empirically find obstacles in health promotion and disease prevention activities, as well as a lack of coordination between the typical programmatic activities of the ESF as a form of primary health care. Furthermore, there are serious difficulties in effective teamwork, with evidence of reduced health accountability, difficulties in team coordination across time and space, and a loss of the caring dimension in health care activities.

Healthcare workers find themselves forced to provide healthcare based on the biomedical model, in which the patient seeks health and the professional offers treatment, rather than care. This model should have been overcome by now, given the many struggles for healthcare in Brazil, especially the Health Reform.

That said, in this research, I believe it was essential to promote a discussion about healthcare workers' perceptions of their own healthcare work processes, specifically in Primary Health Care (PHC). This fact was relevant when we realized how essential it is for healthcare workers to feel a sense of belonging and involvement in their work, as well as to understand the concrete nature of their health-promoting actions.

Without the intention of generalizing processes, we delved deeper into issues in a primary care unit to contribute to a project to raise awareness and enhance their work. Starfield 23 produces a series of concepts that, as we have seen today, form the pillars of a health system widely applied throughout Brazil, the Family Health Strategy. The ESF emerged in the mid-1990s from a paradigmatic tension provoked by the discourse of the Health Reform Movement and the practice generated by the implementation of health care models that were alternatives to the privatized medical care model. Initially, it was easy, especially in remote areas of Northeast Brazil, to implement a techno-care model that followed the guiding principles of the SUS and was not centered on the physician.¹

Peduzzi and Schaiber (2008)¹⁸ conceptualize the work process as something that concerns the microscopic dimension of daily work, and there-

fore, the practices of healthcare workers, within the daily production and consumption of healthcare services. The same authors also emphasize that this conceptualization should be applied to the most diverse areas within the healthcare field, in order to allow the approach of social practices beyond specific professional areas.

Another technology present in production processes, called by Mehry (1998)¹⁵ of soft technology, emerged from the shift in relationships between professionals, users, managers, and professional categories, and from the understanding that health work is entirely relational, meaning it always occurs through the encounter between individual and collective subjects. Soft technologies are fundamental in the production of care, as they are represented by a practice of care production¹⁵. We can say that soft technologies of care production manifest themselves in the dialogue between patients and professionals, in the aesthetics of care delivery, in the affective listening, and in mutual respect for cultures.

With these concepts in mind, some questions arose: how do PHC workers perceive their work as care production? What actions and relationships are carried out in daily work, regarding the care of individuals? How do healthcare workers relate to the production of care in their workspace/time? In this context, according to Franco's (2006) definitions¹¹, Regarding the daily actions of individuals in their relationships with each other and in the context in which they find themselves, and also: what knowledge would this worker have about the existence of the relational movement that promotes acts of care?

We can feel involved in the search for anti-hegemonic alternatives regarding the health service project intertwined with the commercialization and marketing of processes. Struggles are now more appropriate-

ly directed toward the organization of democratic work processes, with shared decision-making processes and a commitment to user-centered logic. Meanwhile, we observe models of care and management of health services that reduce the decision-making capacity of workers.²⁰ We believe that this lack of governance over their actions implies a reduction in their autonomy and sense of belonging at work, but it serves the values of the production model.

The current model in healthcare services, in practice, operationalizes the maintenance of curative and mechanized activities, which value medical specialties and are increasingly dependent on machine technologies, thus serving macroeconomic interests legitimized by the media. Campos⁷. He also denounced that the work of healthcare teams was influenced by Taylorism, reflected in the accumulation of administrative norms and technical standards, guided by the naive belief in standardizing the entirety of healthcare work. Healthcare work is meaningful only when created within the collective realm and, therefore, far from homogenization. It is practiced by a multiplicity of professional categories that perform activities necessary for the maintenance of the institutional sphere².

In current legislation, Brazil demonstrates consistency with democratic theoretical foundations through the implementation of the National Primary Care Policy (PNAB), the most recent version of which dates back to 2011. The PNAB emerged as a way to foster PHC as an instrument for promoting comprehensive health care in the country on a regular basis. To this end, the PNAB addresses access to health services, health guarantees for users, and the organization of work processes in PHC to ensure successful care delivery.

Specifically regarding healthcare workers, the PNAB stands out for ad-

ressing workforce qualifications as a means of providing the best service to users. It emphasizes that continuing education is an extremely important aspect for promoting and consolidating successful PHC work.

The PNAB, therefore, outlines an important strategy to promote the education of in-service workers. We believe it was designed to embody dialogue and promote the decision-making capacity of healthcare workers in their workplace. However, Fertoni et al. (2015)¹⁰ in their research, they warn us that it is necessary to refocus our attention on the process of worker training while still in academia. The authors state that the hegemonic biomedical model has influenced the training of health professionals since undergraduate studies, in addition to guiding the organization of health services and directing the production of health knowledge.

METHOD

Action research aims to assist in promoting desired/necessary change and presupposes critical perception, both on the part of the research subjects and the investigators, of the problems themselves and the facts that determine them to establish the research objectives and conditions⁷. We therefore set out to contribute to the awareness of the research subjects in this study. Through this exercise of perception and self-understanding, it was possible to learn more about the emancipated and autonomous discourse of these subjects, contextualize and problematize it for awareness-raising, and generate learning, autonomy, and emancipation.

The research subjects, who make up the PHC workforce at this health unit where the interviews were collected, were included according to the following criteria: a) inclusion criteria: mid- and high-level workers from the aforementioned PHC unit

with any form of employment relationship, who were directly involved in health care and care delivery, who had worked with the team for at least one year, and who were willing to freely participate in the research; b) exclusion criteria were applied to workers who were on vacation or leave during the data collection period.

In all circles, the majority of participants were public servants, except for the dental health assistant, who had participated in the first and third circles. This employee, as well as the current nursing assistants and technicians, had no employment relationship with the Fortaleza City Hall at the time of data collection for this research, and their monthly salary was received through the acronym RPA, which refers to "Receipt of Individual Payment." This year, a municipal public selection process was held to fill mid-level positions for these professional categories. Furthermore, this research was conducted in the municipality of Fortaleza, Ceará; more specifically, at a Primary Health Care Unit in the Bom Sucesso neighborhood, which is within the geographic coverage area of Regional Secretariat³.

Three meetings were held between August and September 2015. The physical space, a meeting room, despite the high local temperature, was well-ventilated and private, which prevented outside interference. There was a table approximately two meters long, which allowed the group members to all sit at the table, together with the researcher.

1st meeting followed by the 1st culture circle

We initially held a dialogued presentation about the purposes of the work we were undertaking, the constitution of this group, and clarifications on the researcher's approach at this time. Dialogue was considered an essential part of the meeting strategy, as each person needed to feel com-

fortable speaking or remaining silent. We also agreed to respect each other's voice, allowing for the opportunity to agree and disagree within their own time. We communicated our willingness to contribute to addressing any problems that might be identified and our desire to bring about transformations within the unit.

2nd Circle of Culture: Affective Work

This second meeting aimed to discuss a key point from the previous one: the workers' need to develop their work with affection. This affection was established as a power they possess and use to develop teamwork.

We began the meeting by dividing the eight participants into two teams of equal size. Each team was asked to think of a way to graphically represent the meaning of affective work on a board, using paper and paper and a marker. During this time, many questions were raised, but each team kept their voices somewhat lower. When questioned about this, members of both teams smiled, expressing their fear of having their ideas copied. At the end of this meeting, we asked anyone who felt comfortable sharing the group's work.

3rd meeting: ethical behavior at work

This meeting was permeated by the discussion of what it means to be ethical at work and how this behavior impacts the delivery of care. The participants themselves chose this topic as a trigger for debate, as they felt it had not been discussed in depth at the previous meeting. The dialogue was built first to generate a conceptual consensus about what ethics is and then on what it means to act ethically.

Ethical behavior among coworkers, between workers and patients, and between patients was discussed. The discussion of ethical behavior among coworkers brought to light many dis-

agreements. It was discussed that conflicts between colleagues are difficult to deal with; however, it was affirmed that ethics lies precisely in knowing how to resolve conflicts respectfully.

Throughout the preparation of this material, we maintained a commitment to respecting the principles established by Resolution No. 466 of December 12, 2012, of the National Health Council. This resolution addresses the maintenance of bioethical principles focused on the individual and the community, namely: autonomy, non-maleficence, beneficence, justice, and equity.

RESULTS

In this study, we learned that healthcare work is fundamentally relational and eminently ethical. We say it is relational because it is through the interaction between professionals from multiple categories, SUS users, and managers that the healthcare production process emerges. The work of delivering healthcare requires the encounter between individual or collective subjects, and it is a service consumed at the moment it is produced.

They believe in the ability to empathize and put themselves in the other's shoes. To deliver care, they perceive, there must be empathy, a way of acting with justice, based on the perception of the person's real healthcare need. In theory, the worker is sensitive to the calls of healthcare production, feels compelled to act affectionately and empathetically with their patient, and tends to demonstrate interest in this practice. In contrast, the discourse reveals workers who are weakened, constrained, and domesticated by institutionalization, with difficulty expressing their unhappiness to those responsible for the service. They feel more confident sharing their indignation in small, homogeneous groups. Perhaps to favor a defense mechanism, which is victimization.

In groups, in teams, professionals feel safe. They believe they protect each other from the hardships inflicted by management, and together they are able to fuel their willpower to continue working. The teams demonstrated a sense of unity through informal meetings in the hallways and offices. The interviews revealed no signs of strengthening care delivery or working relationships through sitting together to plan. One of the workers even noted difficulty in expressing friendships.

We propose the use of culture circles as a replacement for the management circles that have been simply eliminated, thus ceasing to have spaces and times for dialogue. Empowered for this, each worker can become a facilitator of circles one at a time, per meeting, in a cyclical manner, to avoid centralization of knowledge and intervention capacity. To achieve this, agency is needed so that management demonstrates a willingness to accept proposals that seek to restore autonomy, not the automation of individuals.

We believe that cultural circles can contribute to the development of relationships based on affection and encounters that redefine joy as a powerful force for recovering desired results. The workers demonstrated openness to knowledge, sensitivity to the beauty of healthcare work, and spurred by challenges that push them toward bureaucratization, but which they persistently strive to overcome. However, they are aware of their limitations.

DISCUSSION

CATEGORY 1 - PRODUCING CARE TO CREATE SHARING ACCOUNTABILITY

This first category was identified by the perception that the initial question, posed in the first culture circle ("What comes to mind when you talk about producing care?"), resonated in the subsequent meetings. Participants

felt compelled to first conceptualize the production of care, so that, as the circles developed, they could seek to highlight their own ways of producing care in their work dynamics.

Franco and Mehry (2013)¹¹ reaffirm that the work processes in Family Health are, in themselves, its greatest challenge, since the production of health care occurs fundamentally through relational dynamics and their applicability, as well as through work technologies. The authors highlight the need for professionals who comprise Family Health teams to relearn their work based on relational dynamics that enable the integration of diverse knowledge.

By expressing their concern for patients' ability to take care and responsibility for their own health, and educating them about self-care, these workers are considering new forms of production and circulation of power within the health field. Furthermore, we believe they are seeking to act in line with what the National Health Plan (PNH) calls for: the construction of autonomy and empowerment among the individuals for whom the SUS is intended.

CATEGORY 2 - "WORKHORSE, CANNON FODDER!"

We recognize the commitment of healthcare professionals to changing the way people care for their health and believe in self-care. Cooperation, solidarity, and a willingness to open up to others to seek out what they don't know or what they lack seem to permeate the discourse of the workers interviewed. However, in the work process that has been implemented recently, there is still a heavy focus on supporting the production of biomedical models, inspired by mechanics, curative, and procedures.

Far from providing society with solutions to the issues limiting the healthcare system, the institutions managing the service seek to shape

care models that promote, at the very least, an increase in the number of people served at the system's entrance. This directly impacts the way professionals perform their work, their participation in the work process, their passions, and their desire to promote healthcare. It could not be otherwise. One cannot expect supportive behavior from individuals who cannot see their own precariousness and insufficiency in the suffering and fragility of others.

The devaluation of their clinical skills (devalued by their sole role as prescribers), the loss of the expanded clinical perspective toward the mechanized promotion of healthcare work, compromises the productivity that workers verbally desire. The intense suffering at work, represented by the expression "workhorses" and "cannon fodder," is directly related to the fact that, for primary care healthcare workers in Fortaleza, the legacy of performing a function, not a profession, has been handed down.

We understand that the precariousness of employment relationships has repercussions not only on the inefficiency of care-promoting actions, but also on low productivity, poor service quality, and low worker self-esteem. These, however, are empirical hypotheses and, if transformed into problematizing questions, could generate new research.

CATEGORY 3 - ETHICAL AND AFFECTIVE ACTION IN HEALTHCARE WORK

Exploring the dynamics of care delivery with these workers led us to follow the emotional pathways that, they believe, constitute their primary work territory. Freire (2010)¹² discusses the workers' impressions in this regard because, according to him, they are assuming themselves as historical, thinking, communicative beings, capable of transforming, creating, realizing dreams, of anger and love.

Love cannot be limited by physical barriers; it must expand to produce effects in all actions that permeate daily healthcare. One of the commitments of healthcare professionals is to embrace correct thinking and ethical action that is consistent with their work efforts. Therefore, the team stated that love for work fosters solidarity, ethics, patience, and understanding.

The National Policy for Popular Education (PNEPS) is a SUS strategy that aims to reaffirm the principles of the SUS and promote the guarantee of health rights by expanding popular participation in decision-making and educational processes in the health sector. Among the theoretical and methodological principles for effective implementation of the PNEPS, philosophical, political, and ethical dimensions of health work stand out, including: dialogue, problematization, shared construction of knowledge, emancipation, commitment to building a democratic and popular project, and, across these axes, lovingness⁵. The appreciation of lovingness implies the incorporation of emotional exchanges to increase sensitivity and dialogue in caring relationships. In Borges' studies⁶, we understand that Freirean ethics seeks to place human actions at the center of decision-making and, therefore, must be grounded in ethics, in right action, in what will be beautiful and beneficial, "neither better nor worse" for anyone and, at the same time, for everyone. It is in this dialogical-problematizing relationship that citizenship is sustained.

The ethics we find in Paulo Freire's readings are not based on dogmatism or neutrality. On the contrary, it is an ethics engaged in communion with the oppressed⁶. Struggles, joys, hope, solidarity, and tolerance are some examples of the fundamental principles that emerge from Freirean ethics and seem to be most strongly linked to the discourse of UAPS workers.

We learn from this category that to

be a healthcare worker is to commit to one's own ethics, both particular and general, that advocates rigor in the comprehensiveness of healthcare actions and the promotion of dialogue, so that all those involved in this process feel capable of understanding and acting toward the production of care as a future intervention in the world.

CONCLUSION

In this study, we learned that healthcare work is fundamentally relational and eminently ethical. We say it is relational because it is through the interaction between professionals from multiple categories, SUS users, and administrators that the healthcare production process emerges. The work of delivering healthcare requires the encounter between individual or collective subjects, and it is a service consumed at the moment it is produced.

The charm of healthcare work lies in the fact that it demands a practice of producing care that is dialogical, affective, and aesthetic. We can also affirm that healthcare work is eminently ethical because it requires respect for freedom and autonomy, the decision-making capacity of those involved in this encounter, and the cultures of the subjects. Respect for the autonomy of the worker and the dignity of each subject involved in the healthcare production process is an ethical imperative, not a favor we may or may not ask for.

They believe in the ability to empathize and put themselves in another's shoes. To provide care, they realize that empathy is essential, a way of acting with justice, based on the perception of the person's real health needs. Theoretically, the worker is sensitive to the demands of health care, feels compelled to act affectionately and empathetically with their patients, and tends to demonstrate interest in this practice. In contrast, the dis-

course reveals workers who are weakened, rigid, and domesticated by institutionalization, struggling to express their unhappiness to those responsible for their work. They feel safer sharing their indignation in small, homogeneous groups. Perhaps this is to foster a defense mechanism, which is victimization.

We propose the use of culture circles as a replacement for the management circles that have simply been eliminated, thus ceasing to have spaces and times for dialogue. Empowered to do so, each worker can become a facilitator of circles at a time, per meeting, in a cyclical manner, to avoid centralization of knowledge and intervention capacity. To achieve this, agency is necessary so that management demonstrates a willingness to accept proposals that seek to restore autonomy rather than the automation of individuals.

We believe that culture circles can contribute to the creation of relationships based on affection and encounters that redefine joy as a power to restore the desired results. Workers demonstrate an openness to knowledge, sensitive to the beauty of healthcare work, and instigated by challenges that pull them toward bureaucratization, but which they persistently strive to overcome. However, they are aware of their limitations.

With this research format, we were able to visualize culture circles as spaces where each person brings something of themselves to the group and, at the end of each meeting, takes something from the group. We observed that the workers initiated a feedback process of the discoveries and gains arising from these meetings, as they were developing autonomy to propose generative themes for subsequent meetings and perceived, within the research environment, a safe space for dialogue.

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