

The medical student in front of the homeless population: Collaborative Work as a tool

O acadêmico de Medicina frente à população em situação de rua: Trabalho Colaborativo como ferramenta

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ABSTRACT This is the experience report of a medical academic from Federal University Fluminense, intern of the Education Program for Work for Health/Interprofessionality, working as part of the Street Clinic of Niterói/RJ, Brazil between April 2019 and March 2020. Aiming at the recognition of challenges, limits and potential of Interprofessional Education and Collaborative Work, the narrative constructed through 44 reports sent to the Program's preceptors and tutors was used as a methodological tool, being shared not only what the practical field as a physical space brought to light, but also what came to life through intersubjectivity in the encounter with different characters. The opportunity to follow the strategy allowed the student to know more about this essential service to ensure equity in the health of the homeless population, leading to the improvement/development of skills/tools that will compose a work centered on the formation of positive bonds with service users, in the provision of comprehensive care and collaborative health practices. It was concluded that, despite the numerous barriers, Interprofessional Education and Collaborative Work are important instruments in academic training, standing out in the production of high quality health services, especially in offering comprehensive care to people in vulnerability.

KEYWORDS Comprehensive health care. Patient-centered care. Interprofessional education. Homeless persons.

RESUMO Trata-se do relato de experiência de uma acadêmica de Medicina da Universidade Federal Fluminense, bolsista do Programa de Educação pelo Trabalho para a Saúde/Interprofissionalidade, atuando integrada ao Consultório na Rua de Niterói (RJ), Brasil entre abril de 2019 e março de 2020. Objetivando-se o reconhecimento de desafios, limites e potencialidades da Educação Interprofissional e do Trabalho Colaborativo, utilizou-se como ferramenta metodológica a narrativa construída por meio de 44 relatórios enviados aos preceptores e tutores do Programa, compartilhando-se não apenas o que o campo prático como espaço físico trouxe à luz, mas também o que ganhou vida por meio da intersubjetividade no encontro com diversos personagens. A oportunidade de acompanhar o Consultório na Rua possibilitou à estudante conhecer mais sobre esse serviço essencial para garantia da equidade na saúde da população em situação de rua, levando ao aperfeiçoamento e desenvolvimento de habilidades e ferramentas que irão compor um trabalho centrado na formação de vínculos positivos com usuários do serviço, na oferta do cuidado integral e nas práticas colaborativas em saúde. Concluiu-se que, apesar das inúmeras barreiras, a Educação Interprofissional e o Trabalho Colaborativo constituem importantes instrumentos na formação acadêmica, destacando-se na produção de serviços de saúde de alta qualidade, sobretudo na oferta do cuidado integral às pessoas em vulnerabilidade.

PALAVRAS-CHAVE Atendimento integral à saúde. Assistência centrada no paciente. Educação Interprofissional. Pessoas em situação de rua.

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Introduction

It is known that it is yet little the knowledge about the students' willingness to learn about the Population Living in the Streets (PSR), even when there are curricula that are aimed to vulnerability contexts¹. However, the necessity of being able to welcome this group is essential for all professionals, especially for those who will work in a health care system that has as some of its principles the universality and the equity, such as the Unified Health System (SUS), in which the Interprofessional Education (EIP) and the Collaborative Work (TC) are fundamental.

In July 23rd 2018, the Ministry of Health published the public notice n^o 10 aiming to promote the selection of projects for the Education Program for Work for Health (PET-Saúde), in its Interprofessional edition, to foster the “qualification of the integration process of education-service-community, in an articulated manner between the [...] SUS and education institutions [...]”²⁽⁷⁸⁾, promoting the “[...] EIP and the Collaborative Practices in Health”²⁽⁷⁸⁾ and the “curricular changes aligned to the National Curricular Guidelines (DCNs) for all the undergraduate courses in the health area”²⁽⁷⁸⁾ and that would articulate

their actions with the ones of other projects that contribute to strengthen changes in the undergraduate formation in accordance with the complex necessities in health required by SUS²⁽⁷⁸⁾.

The Consultório na Rua (CnaR) (Street Clinic), that integrated the PET-Saúde/Interprofessional through the tutorat of undergraduate students, composes the Psychosocial Attention Network and foundations and guidelines defined by the National Policy of Primary Care³. This service is essential to guarantee the equitable access to health through PSR. Having as one of its focuses the integral attention, the team of the CnaR

(eCnaR) can be composed by: a) nurse, psychologist, social worker and occupational therapist; b) social agent, nursing technician or assistant, oral health technician, dental surgeon, physical education professional/teacher and professional with formation in arts and education; and c) physician. The eCnaR can be structured in three different modalities: I) constituted minimally by four professionals and obligatory formed by two among the workers mentioned in the item ‘a’ and the other professionals mentioned in the items ‘a’ and ‘b’; II) constituted by at least six professionals, being obligatory three among the mentioned in the item ‘a’ and the others, in the items ‘a’ and ‘b’; III) formed by II added by the physician⁴.

Aiming to bring the academic closer to this world, the execution of activities turned to the populations in vulnerable situation and the sharing of experiences are essential practices to the formation of future professionals. Therefore, this narrative of experiences of integration of a Medicine student to the CnaR aims to produce reflexions about education and the TC, to highlight challenges and limits in the exercise of interprofessionality, especially regarding vulnerable population, and identify potentialities in interprofessional education and work.

Methodology

This work narrates experiences of the Medicine academic of the Federal University Fluminense (UFF) experienced between April 2019 and March 2020, whilst accompanying the service offered by the eCnaR of Niterói as scholarship holder intern of the PET-Saúde/Interprofessional, being assisted by preceptors/professionals of the service and by tutors/teachers of UFF. The CnaR of Niterói, that has as its target public the PSR of that municipality, integrated the Program through this tutorat of undergraduate students of UFF of the courses of

Medicine, Physical Education and Social Service, with a scholarship holder preceptor and two volunteers.

The work carried out in the CnaR of Niterói was developed through two teams composed by a coordinator, a physician, a psychologist, two nurses, two nursing technicians, three social workers, one harm reduction agent, a dentist and two drivers responsible for transporting the team and users in two mobile units available for the service, that were important to the best development of the actions planned. Being the work essentially itinerant the main field or action was the street space, although not the only one, and interaction of the Medicine student was not restricted to the relations established with preceptors and other learners; it was also built with the eCnaR, with varied users of this strategy and with the workers of other services.

This narrative was composed based on 44 reflexive reports, written and sent weekly to the preceptor and to the tutors of the program. The re-reading of those reports made it possible to renew the look each time they were contemplated, allowing rise of new ideas regarding the stories narrated by the service users that, sometimes in a gentle manner, sometimes abruptly, were also composing the academic's story.

To produce care, it is not enough that the professional is available only to listen to stories of becoming sick. Why not to listen to life stories? To know the patient's memories is also to be involved by their narratives, not only those of illness, but also those of overcoming, conflicts, dreams... and, thus, be able to understand the patient better. The narratives perform "mediations between the 'inside' and the 'outside' to the 'I' in the relationship of being-in-the-world"⁵⁽¹⁰⁶⁸⁾, therefore, it is possible to reach, through listening, more precise diagnoses and to propose more efficient singular therapeutic projects – sometimes, for some people, the listening is the treatment itself, or at least its beginning.

Narrative of experiences and reflections

I start recalling the speech of a Medicine student that used to say that if he wanted to take care of the patient, he would be a nurse. I asked myself why such detachment of the act of caring. Is the condition of being a physician opposed to care? Is this action exclusive of the nursing professional? The care is a 'function' of one and not of the other? Belongs to one, not to another? Who produces the care? What did he had in mind when talking about care? What was for him, the definition? Such vision seemed to limit not only care and all its dimension, but also the action of the physicians, as well as reducing the practice of the nurses to the exercise of care in its most restrict sense, excluding also the patient of this process of producing their own care.

The Resolution of The National Council of Education nº 3, of June 20, 2014, that institutes the DCNs of the Undergraduate Course in Medicine, emphasizes the importance of the formation of the physicians with humanistic, reflexive, critical and ethical principles, that are capable of acting in different levels of attention in health, assuming, among others, the compromise with the defense of integral health of the human being and having the transversality in their practice⁶. From this perspective, the undergraduates will be formed to consider the diversities of the subject, working interprofessionally for the implementation of the universal and equal access to health, rooted in the reflection about their own practice and in the exchange of knowledges with other professionals in the health field and of other knowledge fields⁶.

A professional of the CnaR once asked me about what I was writing in my reports handed weekly to the preceptors and to the tutors of the PET-Saúde/Interprofessional. I told the professional that were reflections regarding my work and formation as a student and future physician. The professional asked me: "*As future physician or health professional*". I

told the professional firmly that as a health professional always, but that, facing situations such as the one previously presented about the medical work, it was that the professional, more than any other in my point of view, the one that needed to rethink the way of how they welcome the PSR and the quality of care they offer. Situations such as this and so many others experienced by me as some that strengthen my answer.

Considering the competences and abilities necessary to the formation of health professionals, the Resolution of the National Council of Health nº 569, of December 8, 2017, that expresses assumptions, principles and guidelines common to all the DCNs of all undergraduate courses for the health area, it is highlighted the necessity to “[...] approach of the process of health-disease in its multiple aspects of determination [...]”⁷ through the insertion of students, since the beginning of the formation, in varied scenarios of practices of the SUS, based on the “[...] collaborative and interprofessional perspective”⁷, leading to changes in the “[...] logic of formation of professionals and in the dynamics of production of care in health”⁷.

During the internship, I always sought to be close to the users and to listen attentively their life stories, that brought a lot of sadness, fear, loneliness, but also happy moments, construction of new bonds or re-establishment of the lost ones and hope. In some moments, when I felt there was nothing else to be done, the listening, valuable tool, became the only one I could continue using. I heard from an user of the CnaR: *“Only the fact that you gave me attention helped me out a lot! You did a lot!”*. Initially, she was agitated and crying a lot. However, despite the extreme difficulty to establish dialog, I could offer her a little bit of what she needed at that moment, which was to be listened to. On that day, I realized that I could make that someone living in the street did not feel invisible.

The territory was dynamic: it was shaped according to people, time and daily happenings.

The activities occurred mainly in the street space, although hospitals, shelters, occupations, Basic Health Units and others where the PSR could be found were also places for the team’s action. The public was diversified, being approached youths, adults, elderly people, men, women, pregnant women, families, users or non-users of alcohol and other drugs, unemployed and self-employed workers, people living in the streets for many years or for a few days, with or without formal education, with or without religion, among many others. Each one with different needs or demands – physical diseases, mental disorders, no documents, seeking for work or shelter, need for prenatal, etc. – with shred feelings or not and with a singular attitude towards their socioeconomic condition and towards the eCnaR.

During this period, it was possible to perceive the importance of not missing the moment in which the persons themselves were longing for changes in their lives, since this was the most favorable scenario, that had the greatest potential for deep and lasting changes in the individual. It was perceived that one of the key-points of the service was to work on the construction of the user’s autonomy. In many moments, I have heard the phrase *“We do not need a doctor. We are not sick!”*. In this context, another challenge was to arise in this subject the desire for self-care from actions that involved the promotion and the recovery of health and the prevention of grievances.

In a few moments, I felt anguished when emerged demands that I hardly would be able to help as a student and intern, yet without the necessary autonomy and experience to conduct the case with the team. I believe that feeling was also part of the learning process and that the feeling of impotence facing the complexity of a case can be present in some moments, even in experienced professionals, being the TC essential for the overcoming of such adversities.

In front of the exposed scenarios, I know that, even after graduating, I will not always have the necessary tools for solving the

numerous and intricate problems that will arise. I also know that this is an anxiety that invites me to reflect about this group in a vulnerable situation and enhances the professional that I long to become and the quality of the service that I wish to offer. This way of thinking and performing the medical work rooted in the shared care has accompanied me throughout my formation and although I have been using the term TC with more adequacy after participating in the PET-Saúde, its meaning was already present in me and it increased after each experience.

While getting along with the team and the users of the service, I could confirm some ideas that I already had regarding the objectives of the strategy CnaR and of the TC in health, mainly, I could add new and valuable knowledges. I know there still a lot to read, know, live and learn, but there is no doubt that the experience was rich, provoked critical reflections and contributed deeply, not only in my medical and professional formation, but also to my growth as an individual and social being.

But, after all, who is that PSR? Where can it be found? Who are the subjects who compose it? It is possible to answer, at least partially, to those questionings giving the PSR visibility through diagnosis, censuses, cartography, area mapping, etc. Those different mechanisms help the team in the identification of those people, where they usually stay, how they relate to the community and other actors that surround them³. To know how many individuals compose that population and where to find them is fundamental for the application of public health policies and creation of strategies that give visibility to those subjects. However, as important as, is the work carried out in the ambit of each service, inasmuch as it seeks for solutions for the needs and demands of each individual and population group.

In spite of the numerous difficulties for the realization of a census that reflects adequately the number of people living in the streets in the country, the Institute of Applied Economic

Research divulged in 2020 technical note that presents the estimate of the PSR in Brazil in the period of September 2021 to March 2020. The study highlighted the growth of the PSR in the course of the years analyzed and a recent acceleration of this increase, besides the greater concentration of this population in the large municipalities, where the raise was even more intense. It was found that the estimated number of people living in the street in Brazil was 221.869 in March 2020, presenting characteristics mainly urban and predominance in the Southeast, where more than half of this population can be found⁸.

Many are the factors that lead the subject to be living in the street and, among them, can be highlighted family conflicts, harmful use of alcohol and other drugs, unemployment and domestic violence. To know how to recognize such particularities in order to develop singular actions, without doubt, demands work, however, through the interprofessional practice experienced in the service produced by eCnaR, along with other sectors and professionals, the services become more capable of reaching those individuals, and the offering of a quality public health becomes increasingly palpable. Santos e Ceccim⁹⁽¹⁰⁴³⁾ highlight that:

[...] the presence of the street cabinet is not simply technical, it means a political presence in the sphere of rights, equity and justice, as well as political and cultural intervention, respecting lifestyles, health promotion and defense of multiplicity in citizenship.

When talking about PSR, we must have in mind that, although the socioeconomic conditions are similar, each territory is unique, thus it is formed by people with distinct stories and experiences, or in other words, the “territory is not limited to its material dimension; it is a force field, a web or net of relations”¹⁰⁽⁷⁴⁾, needing, therefore, that each professional hold a differentiated look capable of understanding integrally the dynamics of the processes that occur in the territory, acting in a targeted

manner, having clear the objectives to be reached and promoting equity; thus, there will be greater the possibilities of success. Nevertheless, we must have in mind that

The confrontation of those challenges demands of the health care systems great effort in the sense of offering health services coherent with the social and health demands, assuring good response and strengthening the idea of health as a right for all, duty of the State, and oriented by the guidelines of our Health System – SUS¹¹⁽¹¹⁾.

A person living in the street, like any other living regularly in a home, is crossed not only by the physical space, but also by the religious, cultural, social, political aspects it carries, and so many others that continuously build its story. To incorporate the diverse dimensions of the territory and to incorporate this living territory to the dynamics of care is to build singularity in the encounter with the other. Therefore,

[...] we can understand the territory as a compound formed by at least three dimensions: 1 as a physical space, composed by streets, houses, schools, enterprises, among others; 2 as a symbolic dimension, expressed by social, economic, cultural, religious, etc.; 3 as an existential dimension, that concerns the ways through which the territory gains sense from each personal story. Those three dimensions correspond to what we can call 'living territory' or the space, the time, the matter from which 'subjectivities are produced'. [...] For a living territory, composed by the three dimensions mentioned, it is possible to trace what we call 'Cartography', in other words an always dynamic cluster of 'psychosocial maps'¹²⁽⁸⁴⁾.

Knowing that "health is a state of complete physical mental and social well-being, and it is not only the absence of disease or infirmity"¹³, and that the situations daily presented to the professionals are diverse and complex, we can ask why there are still so many doctors that

focus only the diagnosis and the treatment of diseases.

It is important to highlight that, even if the 'clinical diagnosis' is the same, living the sickness is singular for each living person; the stains, the story and the contexts that each one experiences interfere in how they conduce their existences¹⁰⁽⁷⁷⁾.

To Ferla e Toassi¹⁴⁽⁸⁾,

[...] overcoming the logic of complaint-conduct, clearly visible in the predominant logic of assistance, includes also the identification of the singular health necessities of people and of collectivities, in concrete situations of life and of work, seeking for actions that can broaden the autonomy and life quality of individuals and groups.

Recognizing the deficiencies that prevent the offering of a quality service is one of the necessary steps in the path of overcoming them. It is impossible to think that the psychosocial maps approached can be bought to light by individualized and specialized actions only, since each professional, acting in the field of subjectivity, can contribute to a different view regarding what is presented, that is to say, with a contribution that goes beyond their initial technical formation. "[...] The work in health, to favor the production of care, needs to be constructed in a collective and shared manner [...]"¹⁰⁽⁷⁴⁾. Therefore,

[...] It becomes central the debate about the necessary competencies to act in accordance with the care necessities to this population and the ability to do collaborative and net work¹⁵⁽⁴⁾.

Unfortunately, it is great the unpreparedness of numerous professionals, especially of those recently graduated, when dealing with situations and populations for which they were not prepared during their formation, such as the populations in vulnerable

situation. Although a few disciplines have the proposal of bringing the academic closer to this world, it is perceived they are not enough. The medical humanistic contents – those turned to the human relations in the field of intersubjectivity – are frequently available to students as elective disciplines or complementary activities¹⁶.

Machado e Rabello¹⁵ suggest that a professional formation with gaps would result in the lack of necessary competencies for the systematization of the work and would move away the professionals from carrying out a work that considers the construction of a story with the PSR. Therefore, when thinking about strategies to strengthen the health system, we shall also consider the adequate professional formation to obtain such purpose. In this scenario, it is necessary to reflect about which educational models would be capable of conducting the development of these new professional practices¹⁷.

To materialize this way of producing health, it is essential that the professional and the student broaden their view and see the individuals integrally, understanding them in their diverse dimensions, since this subject is not only a ‘patient of the CnaR’, they are people that have a name, a family, formed by blood bonds or not, that may be or not user of alcohol and other drugs, that is a father or a mother, a worker or unemployed, with or without mental disorder, that has suffered prejudice, that is away from their homeland etc. This way of seeing the patients in their totality was originated with the emerging of the biopsychosocial attention model, highlighting an attention to health that views the subjects in their subjectivity, seeing them beyond a sick organism¹⁶.

When the broaden concept of health is at focus and its universal and equal access by the PSR, the formation of bonds with all the team is essential to reach the results planned together with the user. However, this approximation with the service can,

initially, occur through the creation of ties only with a determined professional, that may be the physician, the social worker, the harm reduction agent, the driver or any other that has clear their participation in the promotion of shared care and that, thus, will be able to see this possibility of bringing closer to all the team and to the service this individual.

To allow that multiplicities of the care plan be experienced and managed by multiple subjects in production, refers to the understanding that each subject is multitude and that we are constituted in the multiplicity¹⁸⁽³¹⁸⁾.

This way, according to Ceccim¹⁹⁽⁵²⁻⁵³⁾,

[...] it does not make sense, in the world of care and of the cure, that more important than the necessities of the users of actions in health, are the necessities of maintaining the corporate manner of acting or the primacy of the preservation of professional borders that result in designs of professions, not in the integral attention to health.

The conviviality with the users of the CnaR and its demands requires that the work be carried out collaboratively by the professionals and that those have the capacity to perceive the real demands and necessities of the subjects, even if they are not verbally exteriorized. However, sadly, there is yet a “[...] mismatch between the academic qualification offers and the real demands of the streets that are presented to the workers”¹⁵⁽²¹⁾. According to Merhy²⁰⁽¹¹¹⁾,

[...] the higher the composition of the tool boxes (here understood as the range of knowledges that is available for the action of producing the acts of health) used for the conformation of the care by the health workers, individually or in teams, the higher will be the possibility of understanding the health problem faced and the higher the

capacity of facing it adequately, for the user of the service and for its composition of the work processes.

The study carried out by Feldman et al.¹ about the necessities of a curriculum that would include people in street situation highlighted the importance of the exposure to these subjects as strategy to make the students understand the iniquities and the social determinants in health, being the learning rooted in the experience focused on this specific group valuable for the acquisition of knowledges that may be used when dealing with other groups in vulnerable situation. The study also highlighted that the students feel fear and anxiety when facing the work perspective in the street ambient and that the learned rooted in experience, besides allowing the development of new abilities, would also be an opportunity for the students to work with a variety of health professionals and be exposed to other ambients of practice, filling, that way, the existing gap between the classroom and reality¹.

Observing the action field of the eCnaR and the necessities of health and its public, we have a wide range of possibilities that leads the Medicine student, accustomed only to the classroom ambients, wards and cabinets, to dive into the universe of interprofessionality in different spaces. The student can, through participation in team meetings, in field works, in visits made to shelters and hospitals, in projects realized with determined groups, such as pregnant women, in talking to the users etc., develop increasingly the feeling that the accountability for the patient shall come from all those who act in the service, allowing each one to contribute with the formation of the therapeutic project that responds to the real demands and necessities of the citizen. However, the realization of a shared work requires the effort of each professional involved.

Final considerations

Unfortunately, there are numerous barriers to be transposed when talking about the equal and universal access to the health services and about offering a service of high quality, especially when the featured subject is that one in the situation of greater vulnerability, such as people living in the street. Those limitations begin in the academic formation and continue in the professional action, since, during the formation process, fewer are the opportunities available for the Medicine student that aim to make the student familiar with groups such as PSR.

Besides this unpreparedness when dealing with individuals in a situation of higher vulnerability arising from the lack of visibility given to such people during the Medicine course, the absence of view of the subjects in their integrality reduces the care and proposes, in different moments, actions that are little resolute regarding the complex and varied necessities and demands of such a heterogeneous group as the one composed by the people living in the street. To acknowledge that those people exist and that they are subjects endowed with singularity, although sharing the same space – the street – are key-points for the construction of strategies oriented to overcome this reality.

Among some of those strategies for the adequate removal of these obstacles that impose themselves daily are the interprofessionality and the TC in health, once they constitute important means for the acquisition of new abilities and tools in care and in the formation of positive bonds with users of the services. This act of taking care, belongs – or should belong – to the action of every health professional, without a doubt will best developed during the processes of exchange with students of different courses in the interaction with professionals from varied formations.

Certainly, are numerous the challenges to be endured for the adoption of a EIP by

the universities, such as the budgets and political, the lack of spaces for the accommodation of students, the great number of learners in each class, the lack of interest in dealing with populations in vulnerable situation, the unpreparedness of teachers in front of this new way of education-learning etc., and knowing how to identify them is the first step to begin this endurance. To think about future physicians that value other professions, that are opened to the exchange process with other workers, that act beyond their preordained technical formation or, in other words, that promote a Collaborative Work, is, before, to think about students being prepared in the immersion of the interprofessional logic.

Collaborators

We inform that the material presented is the work of conclusion of the Medicine course of Elisabete D'Oliveira Paula Sousa, oriented by Magda de Souza Chagas. Sousa EOP (0000-0002-0474-5806)* contributed for the conception, the construction and the methodology of the narrative, the design of the structure of the text, the discussion, the final structure and the text production. Chagas MS (0000-0002-3616-6745)* contributed to the conception, the methodological construction of the narrative, the design of the text structure, the discussion and for the final structure. ■

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